

# Chapter Two

## Definitions for HIV Prevention Interventions and Standards of Practice

### **What are the Definitions and Standards?**

See the introduction to this chapter.

### **What is its Significance to Community Planning?**

See the introduction to this chapter.

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### Introduction

HIV prevention community planning is an ongoing, comprehensive planning process that is intended to improve the effectiveness of State, local, and Territorial health departments' HIV prevention programs by strengthening the scientific basis, community relevance, and population- or risk-based focus of prevention interventions. Since in 1994, Colorado's community planning group, entitled Coloradans Working Together: Preventing HIV/AIDS (CWT), has brought together representatives of affected populations, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff, and others interested in preventing HIV/AIDS. Together, CWT has analyzed the course of the epidemic in Colorado, assessed and prioritized HIV prevention needs, identified HIV prevention interventions to meet those needs, and developed a series of comprehensive HIV prevention plans that respond to the epidemics in Colorado.

This chapter of the 2004 – 2006 *Comprehensive Plan for HIV Prevention* is intended to describe minimal standards and practices for the Colorado Department of Public Health and Environment (CDPHE) STD/HIV Section and the programs

contracted by CDPHE through its Technical Assistance and Training Program (TATP). This Plan is also intended to describe the vision that the community has established for HIV prevention in Colorado for agencies not funded by the CDPHE. The information provided in the *Comprehensive Plan for HIV Prevention* is presented in such a way as to help all these entities develop effective programs that will become an integral part of a comprehensive HIV prevention system throughout Colorado. The Definitions and Standards Committee meets annually to develop and update the *Definitions for HIV Prevention Interventions and Standards of Practice*, including the standards for Health Education/Risk Reduction, Counseling, Testing and Referral, Prevention Case Management, Partner Counseling and Referral, Public Information, Capacity Building, and Research and Evaluation with the goal of making them understandable, reasonable, and reflective of the latest effectiveness research. This chapter of the Plan is intended to establish best practices for programs in Colorado, as well as to establish standards for evaluation and monitoring. The “spirit” of these Definitions and Standards will be included in all state contracts.

## DEFINITIONS AND STANDARDS

### Part 1 – Characteristics of Successful HIV Prevention Programs and Theoretical Considerations

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#### Section A: General Characteristics of Successful HIV Prevention Programs

- 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.

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### Section B: Theoretical Considerations

*(Technical assistance and capacity building services concerning this Section B, Theoretical Considerations, are available as described in Chapter 12, Capacity Building, of this plan.)*

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 brief summary 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.

#### **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

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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

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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.

### **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

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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:  
[www.cdc.gov/hiv/pubs/HIVcompendium.pdf](http://www.cdc.gov/hiv/pubs/HIVcompendium.pdf)

Denver STD/HIV Prevention Training Center  
Denver Public Health,  
Care of: Terry Stewart  
Denver STD/HIV Behavioral Interventions  
605 Bannock, MC 2600  
Denver, CO, 80204-4507  
Phone: (303) 436-7263  
Fax: (303) 436-3117  
[www.aidscentral.com/BTC.html](http://www.aidscentral.com/BTC.html)

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### Part 2 - Competence Regarding Culture, Disability, and Other Diversity

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CWT has passed three separate Decision Items that promote competence/proficiency in regard to culture and other diversity. The first Decision Item deals specifically with culture and communities of color; the second deals with disability status; the third deals with other diversity issues (age, gender, substance use, socioeconomic status, sexual orientation, linguistics, disabilities, and geographic settings including migrant, seasonal or resort workers).

#### a) CWT Decision Item Regarding 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.”<sup>1</sup> 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.

#### b) CWT Decision Item Regarding People with Disabilities, Who are Deaf, or Hard-of-Hearing

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

- 1) 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.
- 2) 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.
- 3) Agencies are encouraged to recruit and hire a culturally diverse workforce including people with disabilities.

#### c) CWT Decision Item Regarding Diversity

CWT has addressed the issue of providing competent/proficient services to communities of color. We have addressed the issue of access and

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<sup>1</sup> Singer, Merrill, “Confronting the AIDS Epidemic Among IV Drug Users: Does Ethnic Culture Matter,” *AIDS Education and Prevention*, 1991, 3 (3): 258-283.

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respectful services to the deaf/hard-of-hearing and disabled communities. These issues are essential for effective HIV prevention programs. With this Decision Item we acknowledge yet a third component necessary to provide comprehensive effective programming. 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.

### **d) Assessment of Competence Regarding Culture and Other Diversity**

To make meaningful progress in achieving the types of competence and proficiency voiced in these Decision Items, 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:

- Client demographics
- Background of agency staff and management
- Involvement of target populations in developing and implementing policies and procedures
- HIV program language capacity
- Training and other capacity building activities
- Efforts to assess and improve programs
- Challenges faced in doing HIV prevention work.

## **Part 3 – Code of Ethics for HIV Prevention Providers**

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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.

### **a. 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.

### **b. 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.

1. 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.
2. 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

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for assessing their competence for the responsibilities assumed.

3. 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.

### c. 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.

1. Personal gain and advantage should not subordinate service and public trust.
2. An HIV prevention practitioner should conduct prevention activities fairly and accurately, resisting pressures to unduly censor or mislead.
3. 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.
4. An HIV prevention practitioner should not misrepresent, directly or by implication, professional qualifications or affiliations.
5. An HIV prevention practitioner should not be associated directly or indirectly with services or products in a way that is misleading or incorrect.

### d. Relationships with Clients

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

1. An HIV prevention practitioner does not engage in sexual acts with current clients.
2. 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.

3. An HIV prevention practitioner does not engage in business relationships with clients that present the potential for conflict of interest.
4. 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.

### e. Confidentiality

1. 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.
2. 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.
3. 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.

### f. 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.

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### Part 4 – Public Health Orders

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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).

### Part 5 – Client Feedback

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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.

At a minimum, every client must be notified of feedback procedures of the agency delivering the services as well as their option to appeal directly to CDPHE. Clients may elect to file anonymously, but they must be notified how anonymity may hamper agency response.

Specific agency procedures regarding feedback vary from agency to agency. CDPHE feedback procedures are as follows. (In addition, CDPHE staff will review contractor feedback systems and results on at least an annual basis and take action as appropriate.)

Note: These procedures apply only to compliments, complaints, or grievances of a programmatic nature, not an alleged breach of

confidentiality. Any allegation of a breach of confidentiality will be handled according to the suspected breach policy of the Disease Control and Environmental Epidemiology Division (DCEED) at CDPHE.

#### **If the feedback is received via telephone at CDPHE:**

1. Telephone calls regarding citizen/organizational feedback will be directed to a supervisor or lead worker in the HIV program directly related to the feedback. If for any reason one of the above individuals is not immediately available, the caller will be given the option of a return call by the first available supervisor or given the option to speak with the most senior person present.
2. The supervisor/lead worker should:
  - a. Determine the general nature of the feedback. If the subject of the call may be more directly addressed by another program (e.g., a call about staff or

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service provided by another CDPHE program), the call should be transferred to the appropriate area. If the caller prefers not to transfer, the supervisor/lead worker should take all appropriate information. Information should be as detailed as possible and documented on a Feedback form within 24 hours of receiving the initial call. This would include, but not be limited to, the caller's/client's name, the name of the contractor or CDPHE staff, and a synopsis of the specific situation. The caller should be given the name, program, and extension of the individual to whom the concern will be forwarded. The caller should also be given the option of a return call (within 48 hours) by program staff in order to assure the caller that some type of action has been initiated.

- b. Identify the type of remedy the caller feels would be appropriate. When the caller identifies a remedy that the supervisor/lead worker feels may be unreasonable, the caller should be assured that the matter will be addressed, but that the caller's remedy may not be possible.
- c. Ask the caller if they require a response, either in writing or by telephone. If so, the caller must leave information that will allow the program to make contact for further information or disposition (name, address, phone number, etc.). If the feedback is from an individual who wishes to remain anonymous, explain that anonymity may limit the efforts the program can make toward resolution. If the caller is calling on behalf of another individual, every attempt should be made to talk to the individual who was involved in the situation that resulted in the feedback. Due to confidentiality concerns, the limited amount of discussion that may be carried on with the third-party may hinder/preclude a complete investigation.

The time required for response will be largely determined by the nature of the call. The caller should be made aware of the estimate for completion of the

action and when follow up with the caller, if required, will occur (usually within 24 - 48 hours of the call).

- d. Inform (in person or via voice mail) the relevant CDPHE Program Manager that feedback has been received immediately after taking a call.
  - e. Record pertinent facts of the call in the Feedback Log within 24 hours.
3. The supervisor/lead worker taking the initial call may be able to provide direct feedback and a solution within their scope of authority. If the person taking the call cannot satisfactorily provide a solution, the feedback will be forwarded to the next higher level. All calls will be forwarded to a higher level any time a caller requests.
  4. The disposition of a feedback incident should be documented on the original Feedback Form filed in the logbook in a secured location at CDPHE with limited access. The relevant Program Manager will review and sign off on all dispositions of complaint or grievance calls for consistency with Department guidelines. The CDPHE Program Manager will inform the Division Director of each complaint and the actions taken to resolve them.
  5. All feedback addressed within an outlying CDPHE Field Services office will be handled in the above manner, by the program representative for that region. Within 24 hours, the outlying supervisor will be notified of the concern/complaint by telephone (voice mail would be considered adequate). A brief memo describing all aspects of any call of this nature will also be immediately sent to the supervisor, who will insure appropriate disposition according to these guidelines.
  6. If the client feedback involves a contractual provider of HIV prevention services, a copy of the Feedback Form will be forwarded to the director of the contractor agency and all staff members who are directly related to the incident involved in the feedback. If so requested by the client, all identifying information will be deleted before this form is forwarded to the contractor agency. A

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letter will accompany the form from the relevant CDPHE program manager describing further steps contemplated by CDPHE, such as further investigation.

### **If the Feedback is Received via Written Correspondence at CDPHE:**

1. Per the procedures of the DCEED at CDPHE, all correspondence regarding complaints or concerns are reviewed by the Division Director or State Epidemiologist, who determines the appropriate person to draft a response.
2. The response is reviewed by the division director, state epidemiologist, or designated CDPHE program manager for consistency with departmental policies and guidelines.
3. When legal issues are involved, a copy of the correspondence will be faxed to the Attorney General's office for review prior to the mailing of a response.
4. Per the departmental procedures, depending upon the person to whom the letter was first addressed, the program manager, the division director, or the executive director will sign the written response. The response is typically provided within 10 days of receipt of the complaint concern, and other staff to be notified of the concern/complaint and its resolution. This other staff includes other CDPHE division directors, the staff of the Information Center, staff of the Office of Public/Private Initiatives, and the Public Relations Officer.
5. With approval from the director of the DCEED, when a CDPHE HIV prevention program manager receives feedback in writing, the manager will complete the Feedback Form, record the incident in the Feedback Log, and complete steps three

through six described above in regard to feedback received via telephone.

### **Note for Both Types of Feedback:**

Completed Feedback Forms and the Feedback Log will be kept in a secured location at CDPHE with limited access. The following will be recorded on each Feedback Form:

1. Date of the feedback incident.
2. Name, address and telephone number of the individual making the call or signing the letter.
3. Name of the individual(s) handling the feedback.
4. Brief description of the feedback.
5. Brief description of the disposition. Include dates forwarded to another individual/program and dates information is received from those individuals/programs.
6. Date of the follow up call or letter. In the case of a call, record the initial caller's responses.

Information about a CDPHE staff or contractor who is the subject of a complaint/concern call should be recorded on a Feedback Form and not on the log.

All feedback that meets the criteria above should be addressed. At a minimum, the relevant HIV Prevention Program will investigate specific allegations and interview any program staff or contractors named in a complaint. Complaints concerning policy will be addressed directly by the program management team. Any CDPHE personnel actions that might result will follow Department of Personnel procedures, and any contractual action will follow Colorado State government's rules.

## **Part 6 – Harm Reduction Principles Applied to Drug Use and Sexual Behaviors**

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(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

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problems. The individual is the primary agent in reducing the harm from their 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 a “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.

## Part 7 – Program Review

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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:

A. 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.

B. 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.

C. The materials or program content do not directly encourage homosexual or heterosexual activity or intravenous substance use.

D. The materials or program content are not deemed “obscene” according to applicable community standards.

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- E. 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.

## Part 8 - Counseling, Testing, and Referral (CTR)

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HIV Prevention Counseling is a client-centered and harm reduction oriented exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV and test to learn their HIV antibody status. There are two critical components to this definition. Client-centered means that counseling is tailored to the behavior, circumstances, and special needs of a person. Equally important is its focus on personal risk assessment, development of a personalized action plan, (see note 3 at the end of this section) and the decision to test.

CTR programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Providers must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

### Goals For The Intervention

- To provide a convenient opportunity for persons to learn their current serostatus;
- To allow such persons to receive client-centered and harm reduction oriented HIV prevention counseling to help initiate

incremental behavior change to prevent the transmission or acquisition of HIV;

- To help persons obtain client-centered, specific, and facilitated referrals to receive additional medical care, prevention, psychosocial, and other needed services;

- To provide prevention services and client-centered referrals for sexual and needle sharing persons. (See note 1 at the end of this section)

"The objectives of a brief HIV prevention counseling session is to assess actual and self-perceived HIV/STD risk, to help the participant recognize barriers to risk reduction, to negotiate an acceptable and achievable risk-reduction plan, and to support patient-initiated behavior change." (See note 2 at the end of this section)

### Target Population

Individuals who have a history of one or more of the following shall be considered to be at high/increased risk: injection drug use, sex with a person with HIV/AIDS, sex with a man who has sex with men, sex with an injection drug user, a sexually transmitted disease, exchanging money or drugs for sex.

A special emphasis should be placed on members of the following groups who engage in high/increased risk behaviors: young men who have sex with men, people of color, and women.

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### Cultural Competence/Proficiency

All providers of CTR should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence/proficiency regarding culture, disability, and other diversity).

### Where Delivered

Possible sites for CTR services include counseling, testing, and referral locations, local health departments, community-based organizations, substance abuse treatment centers, sexually transmitted disease clinics, family planning clinics, public sex environments CDPHE staff and contractors provide CTR services in the following three settings:

- Site-based: Providing services at the agency during established business hours. Clients must come in for services.
- Community-based: Services are provided in the community. Clients must still "come in" for testing, however, testing has been taken into the community.
- Outreach: Services are provided outside of a clinic or agency location in areas of high morbidity and/or areas frequented by individuals who engage in high/increased risk behavior for HIV infection. Outreach testing does not require the client to "come in" - agencies go where the clients are and offer testing services. See additional standards, listed below, in regard to HIV counseling and testing conducted in an outreach setting.

CDPHE strongly encourages agencies to develop a collaborative relationship with agencies within their area that have a relationship with and access to individuals engaging in high/increased risk behavior for HIV infection.

### When Delivered

Site-Based CTS is typically provided during regular business hours. Evening, weekend hours and walk-in services are strongly encouraged.

Community-based and outreach HIV testing is typically provided at a time most convenient to the client.

People are encouraged to seek CTS services at the following points in their lives when they are

engaging in behaviors that put them at risk for HIV infection:

- If never tested before, six-weeks after a high/increased risk behavior.
- Every six-months for those engaged in a risk-reduction plan who have not yet achieved minimal risk behavior.

Once a year for those individuals who have successfully engaged in a risk reduction plan who have achieved minimal risk behavior and possibly retest for the support and positive reinforcement of that behavior change.

### Duration of the Intervention

- Pretest counseling, testing and referral (average 20 minutes).

- Posttest:

Negative (case by case basis/average 10 - 15 minutes).

Positive (case by case basis/average 60 minutes).

- Second post-test positive (case by case basis/average 60 minutes).

In the case where a client can demonstrate that they have been pretest counseled in a manner that complies with the Colorado Board of Health Regulation 7. A. 1. and the provider determines that the benefits of further risk-reduction counseling and referrals are negligible, the provider may choose to offer testing only.

It is important to recognize that many clients may need multiple sessions to achieve optimal reduction in their risk behavior, i.e. minimal chance of HIV transmission. Such clients will need to be referred to interventions that include multiple sessions.

### Content and Methods Employed

#### Intervention Methods

HIV prevention counseling is a six-step process shown to be effective in helping clients achieve a specific goal that reduces risk. The six steps are:

Step 1: Introduce and Orient the Client to the Session.

Step 2: Identify the Client's Personal Risk Behaviors and Circumstances.

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- Step 3: Identify If/How the Client Can Reduce His/Her Risk.  
Step 4: Assist in the Development of the Client's Risk-Reduction Plan.  
Step 5: Make Referrals and Provide Support.  
Step 6: Summarize and Close the Session.

These steps involve knowledge of:

- a. Determinants that affect behavior change,
- b. Essential counseling concepts,
- c. Basic counseling skills,
- d. Effective use of open-ended questions,
- e. How to give information simply,
- f. Behavior change model,
- g. Informed consent,
- h. How to assess the client's readiness to test through a cost/benefit discussion (see below regarding readiness to receive positive results).

Additionally, counselors must be particularly proficient in providing effective referrals. This includes

- Helping the client define their priorities
- Discussing and offering options
- Offering referrals
- Making referrals to known and trusted services
- Assessing whether your suggested referral works for the client
- Facilitating an active referral
- Developing a follow up plan after giving the referral.

It is important to recognize that many clients may need multiple sessions to achieve optimal reduction in their risk behavior (i.e. minimal chance of HIV transmission). Such clients will need to be referred to interventions that include multiple sessions.

### Standards for Giving Results

1. Assess the client's readiness.
2. Interpret the results.
3. Renegotiate or reinforce the client's existing plan for reducing risk.

### Make Referrals and Provide Support

If a counselor determines during the posttest decision discussion that a client may be unable to handle HIV positive results (e.g., the client states that if they test HIV positive they will kill themselves/others), the counselor should defer giving results and refer the individual

appropriately. At sites providing HIV prevention counseling, testing, and referral services, negative HIV results can be obtained over the telephone if the client reported having engaged in low-risk behaviors for HIV infection, pending changes in Colorado Board of Health regulations. For clients reporting a history of high-risk behaviors for HIV infection (see above, "Target Populations), the feasibility, acceptance and efficacy of clients receiving results via telephone should be explored further.

### Confidential and Anonymous Testing

At state-designated counseling and testing sites (CTS) confidential testing is the preferred method for the detection of HIV infection, as stated in CRS 25-4-1405.5.

The statute also allows for the availability of an anonymous testing option at CTS sites if approved through a public hearing held by the local board of health. Anonymous HIV testing should be available to increase options for individuals seeking to learn their HIV status. In this age of effective treatment, it is increasingly important for people to know their HIV status. Recent studies show that eliminating the availability of anonymous HIV testing services has a deterrent effect on some people's willingness to come forward for testing. People with legitimate concerns about discrimination or people who are unfamiliar with or distrust the public health system are able to gain access to the system through anonymous testing and subsequently receive referrals for needed treatment, care, or prevention services (CDC Update, Linking Science and Prevention Programs, June 1998).

Only those individuals testing confidentially may receive their result 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.

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

### Specimen Collection

Any FDA-approved collection method that has been validated by the CDPHE Laboratory and Radiation Services Division is acceptable. To date these include serum (venipuncture, dry blood spot) and Orasure oral collection method.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### **Qualifications for HIV Prevention Counselors**

Colorado Board of Health Rules and Regulations Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection -- Regulation #6 (A-1):

Counselors may be paid staff or volunteers. Whether paid staff or volunteers all counselors (contracted) providing counseling, testing, and referral services must have successfully completed the CDC course "Fundamentals of HIV Prevention Counseling" or an approved equivalent of not less than 16 hours. All equivalent need to be approved by the CDPHE STD/HIV Technical Assistance and Training Program.

All CTR providers receiving funding or other CTR resources from CDPHE must document that they are performing CTR under the supervision of a physician licensed in the state of Colorado. This standard applies regardless of setting (site-based, community-based, or outreach).

### **Continuing Education Requirement for Prevention Counselors**

Colorado Board of Health Rules and Regulations Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection -- Regulation #6 (A-2).

All counselors providing 10 or more pre or posttest counseling sessions per calendar quarter (every three months) are required to attend one state-approved continuing education course per year. Those contractors that do not have any counselors providing 10 or more pre or posttest counseling sessions per (calendar) quarter are

required to have a minimum of one counselor per year attend a state-approved HIV continuing education course.

### **Consent and Confidentiality Considerations**

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 will also state the protocol for any grievance procedures. A consent form specified by the CDPHE or an approved equivalent must be used at all CTS.

Individuals must be informed of the "CRS 25-4-1404 - Use of reports section" which currently states:

- 1(a) Release of information may be made for statistical purposes in a manner such that no individual can be identified.
- (b) Release of information may be made to enforce the provisions of CRS 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 to medical personnel in a medical emergency to the extent necessary to protect the health or life of a named party.
- (d) An employee of the CDPHE or a local health department may make a report of child abuse to an agency responsible for receiving or investigating such reports. Only the following information shall be included in this report:
  1. The name, address and sex of the child;
  2. The name and address of the person responsible for the child;
  3. The name and address of the person suspected of the abuse, if known; and
  4. The nature of the child's injury.

The State of Colorado has developed formal guidelines and procedures pertaining to legal and operational protection of confidential HIV and communicable disease public health reports and records. Failure to follow these procedures may constitute an unauthorized release of information and result in contract cancellation and other penalties. See Part 13 of these Definitions and Standards.

No officer or employee of CDPHE or local county health department shall be examined in any judicial, executive, legislative, or other proceeding as to the existence or content of any

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individual's HIV record. The only exceptions to this are those described in state law and regulations.

### Quality Assurance

All providers will provide a system for client feedback; see Part 5.

CDPHE will assess contractor adherence to standards (in the manner described below) on at least an annual basis. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

Colorado Board of Health Rules and Regulations Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection – based on Regulation 8 (A, 1-6):

- a. A semi-annual analysis by the CDPHE of the overall number of tests and results at each contracted agency.
- b. A minimum of one annual onsite observation, evaluation, and quality improvement action plan per contracted agency.
- c. A semi-annual analysis of testing trends (anonymous vs. confidential) conducted by the CDPHE.
- d. A semi-annual review of counseling and partner notification forms for completion and accuracy conducted by the CDPHE.
- e. A minimum of one annual audit of charts conducted by the CDPHE.
- f. Accuracy and completion of the posttest counseling reimbursement form submitted to the CDPHE.
- g. Development of a site-specific quality improvement action plan.
- h. Continued technical assistance as needed.

The contractor agrees to meet with the CDPHE following the annual evaluation to develop a quality improvement action plan. The terms of this plan will be determined at that time by the contractor and the state.

### Penalties for Violating Standards

Colorado Board of Health Rules and Regulations Pertaining to the Reporting, Prevention, and Control of AIDS, HIV-Related Illness, and HIV Infection - Regulation #8 (B 1-4)

1. The CTS will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The CTS will be given a probationary period to comply and meet the standard.
3. The CTS will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### Evaluation

On CDPHE supplied forms, providers will be asked to provide the following types of information:

1. Agency Identification/Agency Type (CBO, Academic, State/Local Health Dept., etc.)
2. Reporting Month/Year
3. Setting of Intervention (Street, School, Clinic, etc.)
4. Client Demographics
5. Client Risk Behaviors
6. Intervention episodes/sessions
7. Numbers of referrals made by type.

### Other

Providers of CTR should have protocols in regard to the safety of clients, volunteers, and staff.

### Additional Standards Regarding Outreach Testing

#### When Delivered

Outreach HIV CTR should be delivered at a time that is convenient for the client. For crisis situations, particularly outside business hours, the provider must demonstrate a plan to assure client access to needed services.

#### Where Delivered

Outreach HIV CTR should be delivered at a location that is convenient for the client. However, the setting should be conducive to quality, confidential counseling (that is, with a

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minimum of distractions and private enough that normal conversation could not be readily overheard). For crisis situations, the provider must demonstrate a plan to assure client access to needed services.

### **Consent and Confidentiality Concerns**

Performing outreach HIV CTR in a location where clients can be readily observed receiving HIV testing or where the conversation can be easily overheard may be considered a breach of confidentiality. Records containing confidential client information must remain in the custody of the HIV counselor at all times while in the outreach setting and must be delivered to secure

storage as soon as practical, not to exceed 24 hours.

Notes:

- 1) HIV Counseling, Testing and Referral Standards and Guidelines, U.S. Department of Health and Human Services.
- 2) Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases, JAMA. October 7, 1998 - Vol 280. No. 13.
- 3) 1993 MMWR.
- 4) The Core Planning Group of CWT added this paragraph in July of 2002.

## **Part 9 – Health Education/Risk Reduction Interventions**

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### **Group Level Interventions**

There are two subcategories of Group Level Intervention (GLI): Group Risk Reduction Education and Comprehensive Health Programs for Youth.

#### **Group Risk Reduction Education**

Group Risk Reduction Education (GRRE) provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiating and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

#### **Goal of the Intervention**

GRRE seeks to lower risk behavior among small groups of individuals who are at high risk of acquiring or transmitting HIV infection.

#### **Target Population**

GRRE occurs in a small-group setting with approximately five to 20 individuals who are at high risk of acquiring or transmitting HIV infection.

#### **Cultural Competence/Proficiency**

All providers of GRRE should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence/proficiency regarding culture, disability, and other diversity).

#### **Where Delivered**

The locations are convenient and accessible to members of the target group (as determined by formative evaluation).

#### **When Delivered**

The meeting times are convenient to members of the target group (as determined by formative evaluation).

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### How Much

The intervention should allocate adequate time to each of the content areas listed below, whether in single or multiple sessions. Multiple sessions are generally preferred because this allows for opportunities to develop and discuss topics in more depth, "real world" experience between sessions, and time for reinforcement of skills, without overwhelming the clients.

### Content and Methods Employed

Educational interventions include: the promotion and reinforcement of safer behaviors; interpersonal skills training and support in negotiating and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services.

Content and methods of delivery may include group discussion, role-plays, skill building exercises, games, demonstrations, and appropriate referrals to known and trusted services (see "Characteristics of Successful HIV Prevention Programs and Theoretical Considerations," Part 1). When feasible and appropriate, the seven steps for making an active referral should be followed (see description in Part 8, "Content and Methods Employed").

The educational methods, content, and length of presentations are appropriate and acceptable to the target audience (as determined through formative evaluation).

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of People To Do This Work

Providers of GRRE should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The educators may be peers or professionals who are competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### Continuing Education/Ongoing Training Requirement

Providers of GRRE must receive at least 8 hours of updated HIV prevention training per year.

### Consent/Confidentiality Considerations

Programs must insure confidentiality of program participants (see confidentiality provisions of the Code of Ethics in Part 3).

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

Supervisors within contracted agencies and CDPHE project officers should assure the quality of the group instruction and facilitation through periodic observations. Regular meetings should be held among facilitators/instructors and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### Evaluation

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of services.

### Formative Evaluation Standards

1. All interventions 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.

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Comments: 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests (rehearsals of workshop activities like role plays, mock interviews, etc.), pre-testing of materials (letting people review drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them), and focus groups to discuss the best ways to recruit participants and present information.

### 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. 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 individualized plans for monitoring intervention outcomes.

### **Penalties for Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### **Other**

Providers of GRRE should have protocols in regard to the safety of clients, volunteers, and staff.

### **Comprehensive Health Programs for Youth**

Comprehensive Health Programs (CHP) for Youth involve group sessions or workshops that address broad health topics such as HIV and STD prevention, nutrition, substance abuse prevention, mental and physical health, and suicide prevention. Such programs encourage research-based approaches to HIV prevention addressing the behavioral, race, ethnicity, and subpopulation priorities set for children (age zero to 12) and high-risk adolescents (age 13 - 19) as reflected in the CWT plan. This intervention is not intended for young adults (20 - 24). They involve a comprehensive health program (CHP) framework, ideally utilizing a curriculum previously funded under this category. CHP must include clear and measurable educational goals.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

### **Goal of the Intervention**

CHP programs encourage research-based approaches to HIV prevention meant to lead children and youth from behaviors that put them at risk for HIV infection to a wellness orientation.

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### Target Population

CHP targets children (age zero to 12) and high-risk adolescents (age 13 - 19) as reflected in the CWT plan. This intervention is not intended for young adults (20 - 24).

### Cultural Competence/Proficiency

All providers of CHP should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2, for further information on competence regarding culture, disability, and other diversity).

### Where Delivered

CHPs are delivered in schools or other settings convenient and accessible to members of the target audience (as determined through formative evaluation).

### When Delivered

CHP are delivered at times which are convenient to this audience (as determined through formative evaluation).

### How Much

CHP should be delivered in multiple sessions.

### Content and Methods Employed

CHP ideally uses a curriculum previously funded under this category. If a curriculum for the targeted group is not available or does not address all the relevant topics for that group, an existing previously funded curriculum may be adapted or a new curriculum developed. Any curriculum used must be produced by persons or agencies experienced in curriculum development.

Any curriculum used must include the following topics: medically and scientifically accurate HIV transmission information, comprehensive human sexuality, abstinence as the only 100 percent effective method to prevent sexual transmission of HIV, skills necessary for healthy relationships, refusal and negotiation skills, condom availability, education on the proper use of condoms, cultural competence, peer education and support models, needle hygiene education, and the relationship between substance use and risky behaviors.

CHP involves appropriate techniques and content based on the identified needs of the

target population(s) and on the setting. The content and methods include peer group discussions, role plays, skill building exercises, games, demonstrations, and appropriate referrals (see "Characteristics of Successful HIV Prevention Programs and Theoretical Considerations," Part 1). When feasible and appropriate, the seven steps for making an active referral should be followed (see description in Part 8, "Content and Methods Employed").

Methods must be acceptable to the target audience (as determined through formative evaluation).

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of the People To Do This Work

CHP must involve Health Department and community-based organization staff and members of the targeted population as content experts.

Providers of CHP should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The educators may be peers or professionals who are competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### Continuing Education/Ongoing Training Requirement

Providers of CHP must receive at least eight hours of updated HIV prevention training per year.

### Consent/Confidentiality Considerations

Programs must insure confidentiality of program participants (see confidentiality provisions of the Code of Ethics in Part 3).

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

Supervisors within contracted agencies and CDPHE project officers should assure the quality of the group instruction and facilitation through periodic observations. Regular meetings should

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be held among facilitators/instructors and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### Evaluation

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating or reformulating of services.

#### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 pilot tests (rehearsals of workshop activities like role plays, mock interviews, etc.), pre-testing of materials (letting people review

drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them), and focus groups to discuss the best ways to recruit participants and present information.

#### 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. 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 individualized plans for monitoring intervention outcomes.

#### Penalties For Violating Standards

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

#### **Other**

Providers of CHP should have protocols in regard to the safety of clients, volunteers, and staff.

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### Individual Level Interventions

There are two subcategories of Individual Level Interventions (ILI): Outreach and Individual Level Health Education.

#### Outreach

Outreach programs seek to change individual behavior by providing motivation, knowledge, risk-reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. The distribution of materials (brochures, safer sex kits, bleach kits, etc.) by itself is not considered as outreach.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

#### **Goal of the Intervention**

Outreach seeks to lower risk behavior in individuals by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change.

#### **Target Population**

Outreach is directed towards a clearly defined target population of individuals at high risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and/or geographic location.

#### **Cultural Competence/Proficiency**

All providers of outreach should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

#### **Where Delivered**

Outreach programs access at-risk individuals on the street, or in malls, parks, bars, or other

community settings (outside a classroom, workshop, or clinic) where members of the target audience are likely to be located (as identified through formative evaluation); the provider goes out to the client making the intervention accessible to the community.

#### **When Delivered**

Outreach occurs at times when members of the target audience are likely to be present (as identified through formative evaluation).

#### **How Much**

Outreach strives for consistency and ongoing contact and reinforcement with individuals.

#### **Content and Methods of Delivery**

Outreach should be delivered in a client-centered and harm reduction oriented manner, that is, tailored to the behavior, circumstances, and special needs of a person.

Outreach involves one-on-one contacts that include the distribution of materials, referrals, and educational discussions on sexual risk, needle-sharing behaviors, and the overall relationship between substance use and risky behavior. The distribution of materials (brochures, safer sex kits, bleach kits, etc.) by itself is not considered as outreach.

Outreach workers strive to help clients develop skills and motivation to adopt and maintain safer behaviors over time. They disseminate information (verbal, written, or recorded) which is accurate, up-to-date, culturally appropriate, and non-judgmental. They distribute materials that are of good quality/effective, current/non-expired, and appropriate to need, and they make referrals to appropriate services (see "Characteristics of Successful HIV Prevention Programs and Theoretical Considerations," Part One). The process for making referrals includes:

- Helping the client define their priorities
- Discussing and offering options
- Offering referrals
- Making referrals to known and trusted services
- Assessing whether your suggested referral works for the client
- Facilitating an active referral.

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In addition, when possible, the process should include developing a follow up plan after giving the referral.

Methods must be acceptable to the community (as determined through formative evaluation).

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### **Qualifications of People To Do This Work**

Outreach workers are usually peers or have extensive experience in working with the target group(s), are knowledgeable about available resources, and are able to refer clients to them.

Outreach workers speak the same language as the clients.

Providers of outreach should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing outreach must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### **Continuing Education/Ongoing Training Requirements**

Providers of outreach must receive at least eight hours of updated HIV prevention training per year.

### **Consent/Confidentiality Considerations**

Programs must insure confidentiality of program participants (see confidentiality provisions of the Code of Ethics in Part 3).

### **Quality Assurance**

All providers will provide a system for client feedback (see Part 5).

Supervisors within contracted agencies and CDPHE project officers should assure the quality of the outreach through periodic observations. Regular meetings should be held among outreach workers and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### **Evaluation**

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of services.

#### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests of intervention activities (for example, a rehearsal of outreach in a new setting or with a new approach), pre-testing of materials (letting people review drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them),

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and focus groups to discuss the best ways to locate participants and present information.

### 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.

### **Penalties For Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### **Other**

Outreach programs have a field safety plan in place to protect outreach workers.

### Individual Level Health Education

Individual Level Health Education (ILHE) programs seek to promote and reinforce safer behaviors among at-risk individuals through one-on-one contact. Interactions are meant to be short-term, but often involve more than one session. These programs assist individuals in assessing their own risk for getting or spreading HIV and in building the skills and abilities necessary to implement behavior change. ILHE offers training in the interpersonal skills needed to negotiate and sustain appropriate behavior change as well as referrals to appropriate services. This intervention is not intended to duplicate prevention case management.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

### **Goal of the Intervention**

ILHE programs seek to promote and reinforce safer behaviors among at-risk individuals through one-on-one contact. They aim to help individuals assess their own risk and to build skills to lower risk.

### **Target Population**

ILHE targets individuals who are high risk for getting or spreading HIV infection.

### **Cultural Competence/Proficiency**

All providers of ILHE should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

### **Where Delivered**

ILHE may occur in clinic or agency settings (e.g. drug treatment centers, family planning offices, community health centers, mental health centers, independent living centers, etc.) in the context of other services, or may occur in other settings. Interventions must be accessible to the target audience.

### **When Delivered**

ILHE is delivered when at-risk persons come into the clinic or other setting.

### **How Much**

Interactions are meant to be short-term, but often involve more than one session.

### **Content and Methods Employed**

ILHE should be delivered in a client-centered and harm reduction oriented manner, that is, tailored to the behavior, circumstances, and special needs of a person.

ILHE offers training in the interpersonal skills needed to negotiate and sustain appropriate behavior change as well as referrals to appropriate services.

The format of ILHE interventions vary and may include such things as role-plays, individual education, and games dealing with safer sex messages and prevention techniques.

Effective ILHE programs begin with an assessment of the specific HIV/STD prevention

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needs of the client, and involve the client in identifying appropriate goals/objectives concerning the adoption and maintenance of safer behaviors.

Effective programs should also employ client-specific skills building exercises, enhance abilities of clients to access appropriate services (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations), and may include repeated contacts, though this intervention is intended to be short-term.

The process for making referrals includes:

- Helping the client define their priorities
- Discussing and offering options, offering referrals
- Making referrals to known and trusted services
- Assessing whether your suggested referral works for the client
- Facilitating an active referral.

In addition, when possible, the process should include developing a follow up plan after giving the referral.

Methods must be acceptable to the target audience (as determined through formative evaluation).

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of People To Do This Work

Trained professionals or peers can deliver ILHE.

Providers of ILHE should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing ILHE must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### Continuing Education/Ongoing Training Requirement

Providers of ILHE must receive at least eight hours of updated HIV prevention training per year, with a focus on client-centered counseling.

### Consent/Confidentiality Considerations

Programs must insure confidentiality of program participants (see confidentiality provisions of the Code of Ethics in Part 3).

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

Supervisors within contracted agencies and CDPHE project officers should assure the quality of the counseling through periodic observations. Regular meetings should be held among counselors and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards").

Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### Evaluation

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of services.

#### Formative Evaluation Standards

1. All interventions 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.

Comments: Formative evaluation methods are used in the planning and development phase of an intervention to learn more about, as well as throughout its implementation, to gain a more in-

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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 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests of intervention activities (for example, a rehearsal of workshop activities like role plays, mock interviews, etc.), pre-testing of materials (letting people review drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them), and focus groups to discuss the best ways to recruit participants and present information.

### Process Monitoring 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior,

knowledge, attitudes, and beliefs. 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 individualized plans for monitoring intervention outcomes.

### **Penalties for Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### **Other**

Providers of ILHE should have protocols in regard to the safety of clients, volunteers, and staff.

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### Population Level Interventions

There are two categories of Population Level Interventions (PLI): Community Level Interventions and Community Identification Process.

#### Community Level Interventions

Community Level Interventions (CLI) seek to change the attitudes, norms, and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. CLI are based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation. Ideally, CLI programs utilize peer networks within a community as a means of increasing the effectiveness of CLI and of sustaining intervention efforts after professional service providers are gone. Effective community level interventions also may incorporate ILI and GLI activities.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

#### **Goal of the Intervention**

CLI seek to change the attitudes, norms, and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. They are meant to move the members of the community, incrementally, one step at a time, closer to healthier sexual and needle use behaviors.

#### **Target Population**

The target audience is a well-defined community or target population that can be distinguished according to geography, ethnicity, sexual orientation, gender, age, behavior, or some self-defining criteria.

#### **Cultural Competence/Proficiency**

All providers of CLI should strive toward proficiency in regard to culture and other aspects

of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

#### **Where Delivered**

Interventions are delivered in convenient and appropriate community settings (as determined by formative evaluation). Programs must be accessible to the target audience.

#### **When Delivered**

Interventions are delivered at times that are appropriate to the target audience (as determined by formative evaluation).

#### **How Much**

CLI are meant to saturate the environment on a consistent and ongoing basis with prevention messages.

#### **Content and Methods Employed**

CLI is based on the concept that certain norms, values, beliefs, and social environmental factors influence how members of the community act. This includes influence on sexual and drug use behavior.

CLI include research (such as a community identification project) that is designed to capture community beliefs and other factors and circumstances that influence high-risk behaviors and that could influence behavior change. Such research incorporates an intensive, qualitative, formative evaluation phase, using extensive interviews and focus groups with community members and persons who work with or relate to the community. The content and methods of the intervention are based on the needs of the community as identified through the formative evaluation. Community members at all levels should be enlisted to participate in some capacity in the delivery and reinforcement of the intervention.

Based on the research findings, messages are developed, and a selection of activities and materials are designed to relay the messages. Activities may include community outreach, mobilization and organization; widespread dissemination of appropriate prevention materials (e.g. condoms, bleach kits, pamphlets,

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role model stories, posters, etc.); peer-to-peer discussions; 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 and prevention materials 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. 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.

Methods and content must be acceptable to the target audience (as determined by formative evaluation. See Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations.)

Standards concerning referrals should reflect whether the intervention is conducted on an individual level, a group level, or in the form of public information (see standards for individual and group interventions and public information).

When engaging members of the targeted community one-on-one, HIV prevention should be delivered in a client-centered and harm reduction oriented manner that is tailored to the behavior, circumstances, and special needs of a person.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### **Qualifications of the People To Do This Work**

Formal and informal community leaders and peer networks deliver the messages throughout the entire community by means of these various activities.

Providers of CLI should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing CLI must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### **Continuing Education/Ongoing Training Requirement**

Providers of CLI must receive at least eight hours of updated HIV prevention training per year.

Programs must insure confidentiality of program participants (see confidentiality provisions of the Code of Ethics in Part 3).

### **Quality Assurance**

All providers will provide a system for client feedback (see Part 5).

Supervisors within contracted agencies and CDPHE project officers should assure the quality of the outreach through periodic observations. Regular meetings should be held among outreach workers and supervisors to discuss relevant issues (successes, problems, barriers, etc.).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors; see "Penalties for Violating Standards." Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

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### Evaluation

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of services.

#### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests (rehearsals of intervention activities), pre-testing of materials (letting people review drafts of scripts, pamphlets or other intervention materials before finalizing them), and focus groups to discuss the best ways to recruit participants or to present and disseminate information.

#### 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. 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 individualized plans for monitoring outcomes OF COMMUNITY LEVEL INTERVENTIONS.

#### **Penalties For Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

#### **Other**

Providers of CLI should have protocols in regard to the safety of clients, volunteers, and staff.

#### **Community Identification Process**

Community Identification Process (CIP) is designed to identify, qualitatively and quantitatively, baseline norms, values, shared meanings, and social and environmental circumstances that influence behavior among members of a target audience. This knowledge is the foundation on which effective messages and strategies are built. Understanding where and when to access the community by learning about the social networks will enhance the ability to intervene most effectively.

Programs must include general characteristics of successful HIV prevention-oriented research programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

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### Goal of the Intervention

The CIP is based on, and will result in, qualitative and quantitative analysis of baseline norms, values, shared meanings, and social and environmental circumstances that influence behavior within target populations. Implementation of the research methods produces information about the target audience, their risk behaviors, the context of their risk behaviors, and their views on the appropriate content and delivery of HIV prevention interventions.

### Target Population

The target audience is a community or population that can be defined according to geography, ethnicity, sexual orientation, gender, age, risk behavior, or some other distinguishing criteria.

### Cultural Competence/Proficiency

All providers of CIP should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

### Where Delivered

The research is carried out within community settings in locations that are acceptable and accessible to the target audience (as determined by formative evaluation).

### When Delivered

The research is carried out at times that are convenient to the target audience (as determined by formative evaluation).

### How Much

A combination of observations, interviews, surveys and focus groups are conducted until the goals of the study are complete.

### Content and Methods Employed

Research methods include literature review; observation/participant observation; focus groups; life histories and unstructured, semi-structured, and structured interviews with members of the target audience and gatekeepers.

The CIP guides full implementation of appropriate HIV prevention interventions and may include: appropriate and effective

prevention strategies, access points into the highest priority target populations, peer network recruitment strategies, venues geographically close to the highest priority target populations, intervention media and materials, and the number of networks needed to adequately saturate highest priority target populations.

Methods must be acceptable to the target audience.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of the People To Do This Work

Data gathering involves skilled interviewers and observers, using the help of key members of the population to gain baseline information, access to the population, and "buy in" from the population.

Providers of CIP should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing CIP must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

Researchers must have received formal training and/or training and technical assistance through CDPHE in how to select and utilize appropriate research methods, including the construction and implementation of interviews and survey design.

### Continuing Education/Ongoing Training Requirement

Providers of CIP must receive updated training on topics relevant to their projects.

### Consent/Confidentiality Considerations

All research must be carried out with the knowledge and consent of participants (see confidentiality provisions of the Code of Ethics in Part 3).

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

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Supervisors within contracted agencies and CDPHE project officers should periodically observe the implementation of research methods and hold regular meetings with researchers to discuss the course of the study.

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### Evaluation

Formative, process, and outcome evaluation must be utilized. Ongoing evaluation should occur concerning the effectiveness of the methods being used, and instruments and methods should be revised as necessary to insure the validity of the data collected. Selected

participants in the study should be involved in the evaluation of the study's findings.

### Penalties For Violating Standards

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### Other

Programs must be based on a process of formative evaluation in which input drawn from the target population is utilized in the research design, data gathering methods, and evaluation of results.

This information must be made available to agencies interested in working with the highest-priority target populations.

CIP projects should demonstrate that they are not duplicating previously completed projects, populations, and geographic areas.

Providers of CIP should have protocols in regard to the safety of clients, volunteers, and staff.

## Part 10 – Partner Counseling and Referral Services

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Partner counseling and referral services (PCRS) are services offered to people infected with HIV and other STDs (e.g., gonorrhea, chlamydia, or syphilis) and describes index client and health department efforts to notify persons of a possible exposure to HIV. The goal of PCRS is to stop the unintentional spread of HIV by providing risk-reduction education to persons who are infected and to those at risk of infection. It involves a confidential discussion between the index client and a trained health professional about the client's risk, the course of the infection, options for health care follow up, measures to reduce the risk of disease transmission, and at-risk sexual and needle-sharing partners, and how these partners will be notified of exposure and providing referrals to

other HIV services. The index client may decline to be interviewed or to name partners. Index clients may choose to notify their partners of an unsafe exposure without health department assistance (client referral), have the health department notify partners (provider referral) or elect a combination approach (combination referral) in which the index client and health department are both involved in the notification of partners. PCRS services are integrally linked to other HIV prevention interventions that support the movement of index clients and their partners toward the practice of safer behaviors.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social

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science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

### Goal for Intervention

The goal of PCRS is to stop the unintentional spread of HIV by persons who are infected by negotiating a client-centered risk-reduction plan and by providing referrals to medical and other prevention services. Additionally, it is the goal of PCRS to help those who are at risk of infection gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment options, and other prevention services.

### Target Population

People who test positive for HIV or have been diagnosed as having AIDS, sexual and needle-sharing partners of HIV/AIDS clients, perinatally exposed children and other individuals at increased risk of acquiring HIV infection.

In conjunction with CDPHE, the PCRS provider will develop standards and criteria defining which clients will be eligible for PCRS. The eligibility criteria should be evaluated annually based on client needs, disease trends, and new treatments available for HIV.

### Cultural Competence/Proficiency

All providers of PCRS should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity. In addition, see "Other" section below for standards regarding people who are disabled, deaf, hard-of-hearing, monolingual Spanish speaking, or non-English speaking).

### Where Delivered

PCRS is carried out in a variety of settings appropriate to client needs.

### When Delivered

Once the facility or private medical doctor has given permission for PCRS follow up the PCRS provider will contact and interview clients at the earliest appropriate time. When the client utilizes

PCRS for the referral of sexual and needle-sharing partners, a client-centered plan will be developed for the proper timing and method of referral (client, provider or dual referral). As the plan allows, the sexual and needle-sharing partners of clients will be counseled at the earliest appropriate opportunity.

PCRS will also be provided under the following circumstances: when a need is identified by PCRS staff; upon request by clients; or as indicated by health care providers, citizens, medical and/or other epidemiological information.

### How Much

PCRS is typically conducted in one or more sessions, with number of sessions and duration of services based on client need and PCRS provider assessment.

### Methods Employed

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

PCRS involves a one-on-one confidential client-centered discussion between the index client and health professional trained in PCRS. At a minimum the discussion includes conveying information regarding confidentiality, that PCRS is voluntary and at times an emotional process. PCRS services include: assessment of risk, the course of the infection, options for health care follow up, measures to reduce the risk of disease transmission, and at-risk sexual and needle-sharing partners and how these partners will be counseled of exposure. Index clients may choose to inform their own partners of an unsafe exposure without health department assistance (client referral), have the health department inform and counsel partners (provider referral) or elect a combination approach (combination referral) in which the index client and health department are both involved in the informing and counseling of partners. Index clients who elect to notify their partners shall be given the opportunity to notify their partners within a period of time not to exceed six weeks.

All PCRS providers will develop a client-centered system to attempt to verify that initiated partners whom the index clients decide to inform themselves have indeed been informed about the unsafe exposure. Such systems will be developed

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in accordance with confidentiality safeguards contained in state statutes and Colorado Board of Health Rules and Regulations.

All PCRS providers will perform services in accordance with Section eight spousal notification of Public law 104-146 (Spousal Notification requirements of the Ryan White CARE Reauthorization Act of 1996). PCRS providers may use the CDC-approved procedures developed by CDPHE or may develop their own procedures to ensure compliance with this law.

When PCRS staff provides HIV counseling and testing services they will perform them in accordance with the standards in Part 8.

PCRS programs are encouraged to develop network approaches in their practices. Examples include providing services (e.g., interviewing, HIV counseling and testing) for persons in the social and geographic networks of people living with HIV.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Referrals to Other HIV Services

PCRS providers will collaborate with providers of other HIV prevention services to ensure appropriate referrals of infected and uninfected clients. Such collaboration will be conducted to the extent allowed by state statute and state board of health rules and regulations.

The process for making referrals includes:

- Helping the client define their priorities
- Discussing and offering options, offering referrals
- Making referrals to known and trusted services
- Assessing whether the suggested referral works for the client
- Facilitating an active referral.

In addition, when possible, the process should include developing a follow up plan after giving the referral.

PCRS services need to be integrally linked to prevention case management (PCM), which supports, on a long-term basis, the movement of

index clients and their partners toward the practice of safer behaviors. Therefore, all PCRS providers will have protocols and procedures for referring clients to PCM with a decreased likelihood of behavior change or clients that have previously tested positive for HIV and have continued high-risk unsafe behavior. Refer to Chapter 11 for additional guidance on referrals.

### Methods for Serving 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 (CRS 25-4-1401, et seq.). As stated in CRS 25-4-1406, public health orders "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." Refer to Part 4, for additional guidance on public health orders.

### Qualifications of People To Do This Work

#### Individual Training Requirements:

1. All persons performing PCRS will have completed a course concerning PCRS and also the course Introduction to Sexually Transmitted Disease Intervention or its equivalent, as specified by the CDPHE.
2. All persons providing PCRS will have completed the HIV Prevention Counseling course or an equivalent of not less than 16 hours of training, approved by the CDPHE.
3. All persons providing PCRS will attend training opportunities as offered to provide culturally competent services to appropriately assess and address situations involving: domestic violence, people with disabilities, people who are deaf or hard-of-hearing, or people who are mono-lingual Spanish-speaking.

#### Agency Requirements:

1. All contracted agencies must be able to provide field testing and pre- and posttest counseling to clients requesting counseling and testing.
2. All PCRS providers when performing HIV pretest prevention and risk reduction counseling will: a) conduct a risk assessment, b) discuss and develop a risk-reduction plan based on the risk assessment, and c) fully and legibly complete the HIV 1 Serology lab slip for each person tested.

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3. All PCRS providers performing HIV posttest counseling will:
  - a) Inform clients in person of positive test results,
  - b) Make reasonable efforts to provide results to persons who test negative,
  - c) Explain the significance of both positive and negative test results,
  - d) Discuss and/or modify the client-centered risk-reduction plan,
  - e) Refer clients who test positive for follow up medical and counseling services as needed.
4. All PCRS providers performing HIV pre- and posttest counseling will have protocols addressing the following issues that may arise during the counseling session: suicide, domestic violence, and PCRS provider safety and confidentiality.
5. A consent form for testing specified by the CDPHE or a CDPHE-approved equivalent must be used by all contracted PCRS providers.

### Continuing Education/Ongoing Training Requirement

All persons providing PCRS services will have a minimum of eight hours of relevant HIV/STD or allied health services continuing education annually, approved by the CDPHE.

### Consent/Confidentiality Considerations

#### Consent

As stated in the Methods for PCRS, PCRS involves a one-on-one confidential client-centered discussion between the index client and health professional trained in PCRS. At a minimum the discussion includes conveying information regarding confidentiality, that PCRS is voluntary and at times an emotional process. Verbal consent from the client is necessary to continue the PCRS process.

The contracted PCRS provider shall make reasonable efforts or CDPHE to consult with the attending physician or medical facility caring for the client prior to any PCRS follow up by PCRS providers.

#### Confidentiality

All public health records held by the state and local health departments in performing PCRS investigations shall be confidential information and subject to state statutes (CRS 25-4-1401 et

seq.) and Colorado Board of Health Rules and Regulations (Regulation Four).

The State of Colorado has developed formal guidelines and procedures pertaining to legal and operational protection of confidential HIV and communicable disease public health reports and records. Failure to follow these procedures may constitute an unauthorized release of information and result in contract cancellation and other penalties. Refer to Part 13 of these definitions and standards.

Refer to additional confidentiality provisions of the Code of Ethics in Part 3.

#### Information Sharing

Information concerning field investigations (i.e., field reports, interview records and case reports) shall be shared between the contracted PCRS provider and CDPHE in a timely manner and in accordance with state statute (CRS 25-4-1401 et seq.) and Colorado Board of Health Rules and Regulations (Regulation Three).

These requirements shall not apply if the state and contracted health agencies mutually agree not to share information.

#### Quality Assurance

All PCRS providers will assess index client and partner satisfaction with PCRS services at a minimum of every two years. Contractual PCRS providers to the CDPHE will submit a summary of this assessment.

All PCRS providers will maintain a system to receive, resolve and document consumer feedback (see Part 5). For contractual PCRS providers, a summary of the number and nature of consumer feedback will be submitted semi-annually to the CDPHE.

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. Documentation will be provided to the CDPHE through use of CDPHE specified forms.

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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 on the CDPHE specified form. Documentation of investigation outcomes will include disposition codes as specified by the CDPHE, dates and location of service, and dates and location of testing (if done).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors (see "Penalties for Violating Standards"). Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

Each contracted PCRS provider's compliance with the above standards will be evaluated by the following:

- A semi-annual analysis by the CDPHE staff of the numbers of persons eligible for PCRS services and the proportion of persons receiving PCRS services. The CDPHE staff may conduct a minimum of one annual onsite observation. A semi-annual review of PCRS forms for completion and accuracy conducted by CDPHE. A semi-annual written progress report will be prepared by each contracted PCRS provider and submitted to CDPHE.

### Evaluation

#### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests (rehearsals of new questions or interviewing techniques), pre-testing of materials (letting people review drafts of scripts, pamphlets, or other intervention materials before finalizing them), and focus groups to discuss the best ways to present information.

#### 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. 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

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- 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 individualized plans for monitoring intervention outcomes.

### Penalties for Violating Standards

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

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### Other

#### Working with Persons with Disabilities or Cognitive Impairments

All PCRS providers will implement procedures for working with persons with disabilities. CDPHE will develop written procedures using information approved by the Disabilities Coalition entitled Partner Notification Guidance for People with Specific Disabilities. Local health departments providing PCRS may use CDPHE procedures or develop their own. At a minimum, procedures will include:

- Reasonable efforts to assess whether an index case or partner may have a disability. It should be recognized that there is great diversity within this community, and comprehension, language and reading levels also vary widely. An assessment regarding whether the client would want a case manager or other advocate to assist or support them during the PCRS process.

#### Working with Deaf or Hard-of-Hearing Persons

All PCRS providers will implement procedures for working with persons who are deaf or hard-of-hearing. CDPHE will develop written procedures using information approved by the Deaf/Hard-of-Hearing Coalition entitled Partner Notification Guidance for the Deaf and Hard-of-

Hearing. Local health departments providing PCRS may use the procedures developed by CDPHE or may develop their own. At a minimum, procedures will include:

- Reasonable efforts to assess whether an index case or partner may be deaf or hard-of-hearing. It should be recognized that there is great language diversity within this community, and reading and writing levels vary. An assessment of which method of communication would be best for the client. Examples include the use of sign language interpreter services, written communication (in person, directly with them only), or by telecommunications technology such as TTY/TDD machine or other assistive devices to enhance communication. Some clients may not want an interpreter to know about their particular HIV-related situation. Once the best method is identified, the PCRS provider should make the appropriate arrangements for implementation.

#### Working with Monolingual Spanish Speaking Persons

All PCRS providers will implement procedures for working with persons who are monolingual Spanish speaking. CDPHE will develop written procedures using information approved by the Latino Coalition entitled Partner Notification Guidance for the Monolingual Spanish Speaking Community. Local health departments providing PCRS may use the procedures developed by CDPHE or may develop their own. At a minimum, procedures will include:

- Reasonable efforts to assess whether an index case or partner may be monolingual Spanish speaking or may feel more comfortable communicating in Spanish. An assessment of which method of communication would be best for the client. PCRS providers should first use resources that readily available, such as staff who are bilingual/bicultural. While working toward this goal, alternatives include competent bilingual staff or qualified paid or non-paid language translators/interpreters. Some clients may not want a translator/interpreter to know about their particular HIV-related situation. Once the best method is identified, the PCRS provider should make the appropriate arrangements for implementation.

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### Working with Non-English Speaking

#### Communities

1. All PCRS providers will make reasonable efforts to assess whether an index case or partner may be non-English speaking or may feel more comfortable communicating in their own language.
2. All PCRS providers will assess which method of communicating would be

best for the client. PCRS providers should first use resources that readily available, such as staff who are bilingual-bicultural or bilingual only. Alternatives include the use of a qualified paid or non-paid language interpreter. Once the best method is identified, the PCRS provider should make the appropriate arrangements for implementation.

## **Part 11 – Prevention Case Management**

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HIV Prevention Case Management (HIV/PCM) is a one-on-one, multi-session, intensive intervention that is intended for clients who would otherwise have a poor prognosis for changing behaviors or clients for whom other, less-intensive interventions have failed. HIV/PCM clients may be either living with HIV or at highest risk of becoming infected. HIV/PCM is also intended to improve client skills in accessing community resources that support behavior change.

HIV/PCM services are not a substitute for medical case management, extended social services, long-term psychological care nor should HIV/PCM duplicate Ryan White CARE ACT case management services for people living with HIV. The Ryan White CARE Act defines case management as, “A consumer-centered, flexible, cost efficient and quality driven service. Ryan White case management provides a range of client-centered services that link clients, significant others and family members with health care, psycho-social, housing, mental health, substance abuse, financial assistance and other services of health and support services, and on-going assessment of the clients’ significant others’ and family members’ needs and personal support system.”

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Widely recognized theories include: Health Belief model, Social Cognitive Theory, Transtheoretical (Stages of Change), Ecological and Systems Theory, Empowerment Theory, AIDS Risk Reduction Model, and Theory of Gender and Power. Provider must be

able to demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk-reduction and the maintenance of good health.

#### **Goal for the Intervention**

HIV/PCM’s primary goal is to prevent and stop the spread of HIV.

#### **Target Population**

HIV/PCM is a voluntary, confidential, client-centered intervention intended for persons (regardless of HIV status) who are having, or who are likely to have, difficulty initiating and sustaining safer sexual and drug use behaviors. Therefore, HIV/PCM is intended for persons at highest risk of transmitting or acquiring HIV whose needs are not met or behavior influenced by less-intensive HIV prevention interventions, such as individual level health education, group level strategies, or HIV counseling and testing.

The following characteristics are frequently indicative of a need for prevention case management when coupled with evidence of HIV risk (i.e., risk of transmitting or acquiring HIV):

- Habitually retesting for HIV;
- Failure to respond to other, less-intensive interventions;
- High likelihood of having transmitted HIV to others, or indifference to risks posed to sexual and needle-sharing partners;
- Childhood trauma related to sexual/physical or emotional abuse;
- Cognitive or developmental disability,

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- Severe and persistent mental illness, particularly bipolar disorder or sexual addiction;
- Other acute mental health issues;
- Substance misuse;
- Exchange of sex for something of value;
- History of multiple STDs;
- Low self-esteem and feelings of powerlessness;
- Other chronically dysfunctional living situations.

### Cultural competence/proficiency

All providers of HIV/PCM should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

### Where Delivered

HIV/PCM is carried out in a variety of settings appropriate to the client needs.

### When Delivered

HIV/PCM is carried out at a time of day appropriate to the clients needs.

### How Much

HIV/PCM is intended to be carried out over multiple sessions. HIV/PCM continues until one or more criteria have been met to signal that case closure should occur.

The following are criteria for closure of open cases:

1. The client verbally refuses services.
2. The case manager's attempts to meet with the client have been largely and/or completely unsuccessful.
3. The client is lost to the intervention when they have moved to another state or without any locating information.
4. The client dies.
5. The client successfully meets the objectives in their case plan and has supports in place to maintain their behavior change.
6. The client's situation or environment is dangerous to the prevention case manager.
7. The client is categorized as "unable to locate" after three months of good-faith effort using all available resources. These may include the Post Office, homeless

shelters, jails, Department of Motor Vehicles, Internet phone record searches, and medical records.

8. The client has made negligible progress in meeting the objectives in their case plan and continued HIV/PCM would likely be a waste of resources.

Note: If a client is determined to be a danger to public health, the client may be referred to a state or local health department for further action before or after case closure (see Part 4 regarding public health orders).

### Methods Employed

HIV/PCM should be delivered in a client-centered and harm reduction oriented manner, that is, tailored to the behavior, circumstances, and special needs of a person.

Based on the literature, the ideal caseload size for a full time case management position is 20 active open cases at any given time. The caseload for a full time case management position shall not exceed 30 active open cases at any given time.

The following essential elements of HIV/PCM must be documented:

#### 1. Recruitment and Engagement

The intent of this element of HIV/PCM is to bring clients into HIV/PCM and to engage them as to the nature of the service and its potential benefit to them. Recruitment and engagement includes: a) creating referral mechanisms; b) building relationships/partnering with referring agencies; and c) actively requesting referrals for the benefit of the client. Effective recruitment and engagement should be an active process and should address the clients risk behavior as a public health concern; the client's own concerns about their risky behavior; the process of change; and the client's past and present behaviors beyond HIV risk. Building trust and rapport is a critical outcome of recruitment and engagement, and this often takes multiple sessions to accomplish. Client records must include written notes regarding recruitment and engagement as well as a signed copy of the voluntary informed consent form to accept HIV/PCM services and in a format approved by CDPHE.

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### 2. Client Assessment

The intent of this element of HIV/PCM is to engage clients to gauge client needs, strengths, and weaknesses in nine key areas: engagement in HIV-related clinical and case management services; connections with partners and other personal support systems; physical and emotional health status; personalization of HIV risk; use of alcohol and other drugs; sexual health and sexual expression; mental health issues associated with risk; financial, legal, and housing situation; and cultural issues. The assessment should be tailored to meet the client's immediate need and it provides a baseline for the HIV/PCM and the client against which future progress may be discerned. The assessment should be prospective as well as retrospective, with clarification as to future directions and ways to proceed. If possible, a prevention case manager should review the records of any referring agency. Other records may include, but not be limited to, hospital records, mental health records, substance abuse treatment records, and jails records.

An assessment tool provided by CDPHE, or an equivalent approved by CDPHE, must be utilized and included in every client record.

### 3. Development of a Client-Centered Prevention Plan

The intent of this element of HIV/PCM is to provide an HIV-prevention focus to future interactions with the client and map the future direction of HIV/PCM sessions. A prevention plan should be in writing, in a form and format approved by CDPHE, and it should be collaboratively developed with the client. It should include three to 10 objectives, the majority of which clearly reduce HIV-related harm or reduce HIV risk. The objectives should be specific, measurable, achievable, realistic, and time-phased. At least one objective must address medical evaluation for STDs (including hepatitis) at regular intervals regardless of symptom status. For those living with HIV and receiving antiretroviral or other drug therapies, at least one objective must address issues of adherence. Objective should include actions of the client, other service providers, and the prevention case manager. Objectives should change when needed and should include referrals to known and trusted providers of services and trainings. For some clients, having objectives that include community involvement are

beneficial. At the outset, the prevention plan should include planning for eventual self-sufficiency and discharge from HIV/PCM. For clients who do not know their HIV serostatus, the prevention plan must address eventual HIV testing, and periodic retesting if appropriate. A written prevention plan must be included in every client record.

### 4. Multiple Session HIV Risk-Reduction Counseling

Ongoing risk reduction counseling should be the intent of the ensuing HIV/PCM sessions. Within the larger context of HIV risk reduction, the HIV/PCM should address critical issues such as the pros and cons of disclosure; condom issues and use of condoms; symptoms of psychosocial distress and how this impacts their risky behaviors; and alternative ways of dealing with psycho-social distress.

Written documentation in every client record must include: progress made on the objectives in the prevention plan; major HIV-related changes or incidents arising in each session or reported as occurring between sessions; results of previous referrals and referral to new services; other information deemed relevant by the prevention case manager.

### 5. Coordination of Services and Active Follow Up

The intent of this element of HIV/PCM is to ensure that the services provided to the client are well coordinated and focused on the achievement of the objectives in the prevention plan. All services provided to the client should be coordinated, including, but not limited to, the case management provided by the prevention case manager; services in support of the client's employment, housing, legal and economic situation; services related to the client's relationships; substance use and mental health services; and clinical services. Referrals must be active, that is, must involve assessment of whether the referral worked for the client, facilitation of the active referral, and developing a follow up plan after giving the referral. The prevention case manager should act as an advocate for the client on a systems level as well as with individual agencies. The prevention case manager should address environmental issues impacting risk behavior. If medical care was identified as an issue, the prevention case manager should educate the client on the pros

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and cons of getting medical care, taking HIV-related medication, and issues of adherence to treatment and care. Client records must include written notes regarding coordination of services and active follow up.

### 6. Continuous Reassessment

The assessment process described in element two, above, should be an ongoing after initial or baseline assessment. The CDPHE assessment tool (or approved equivalent) must be used to document change vis-à-vis baseline.

### 7. Discharge from HIV/PCM and Maintenance of Risk-Reduction Goals

The intent of this element of HIV/PCM is to ensure that clients eventually become self-sufficient, not dependent on continuous HIV/PCM to maintain HIV risk reduction. Client records must include written notes regarding progress leading to HIV/PCM discharge, a follow up plan for each client, and client perceptions of future needs as they maintain lower HIV risk behavior.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of the People Who Do HIV/PCM

In terms of education, a person performing HIV/PCM must, at a minimum, have either a BS/BA degree in human services behavioral sciences, OR a BS/BA degree in another field (not human services or behavioral sciences) and one year of work-related experience.

In addition, a prevention case manager must have ongoing clinical supervision by a licensed mental health professional (i.e., Licensed Clinical Social Worker, Licensed Mental Health Counselor, Psychiatrist, Licensed Clinical Psychologist, Licensed Marriage and the Family Counselor and/or Psychiatric Nurse).

Providers of HIV/PCM should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

Those providing HIV/PCM must be competent in regard to culture and other diversity and able

to present the materials in an understandable and non-judgmental manner.

### Continuing Education/Ongoing Training Requirements

Providers of HIV/PCM must receive at least 16 hours of updated HIV prevention training per year.

### Consent/Confidentiality Considerations

The State of Colorado has developed formal guidelines and procedures pertaining to the items below. Failure to follow these procedures may constitute an unauthorized release of information and result in contract cancellation and other penalties. See Part 13 of these definitions and standards.

In regard to client rights:

- Each provider shall demonstrate a plan to inform about the nature of the services offered, including the right to terminate services at any time.
- Each provider shall demonstrate a plan to disclose provider qualifications to the client.
- Each provider shall demonstrate a plan to obtain informed consent.
- Each provider shall provide a plan to inform clients about formal or informal grievance procedures.

See confidentiality provisions of the Code of Ethics in Part 3. Also see Part 12, Guidelines for Legal and Operational Protection of Confidential HIV and Communicable Disease Public Health Reports and Records.

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors; see "Penalties for Violating Standards." In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal

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remedies described in the contract, up to and including withdrawing from the contract.

Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals.

Evaluation of the HIV/PCM program will include, but not be limited to, whether the program adheres to the case plan and effectiveness of outreach to targeted populations.

### **Evaluation**

Evaluation of a client's progress will include, but not be limited to, whether or not the client has initiated behavior change, maintained behavior change or harm reduction, and whether or not the client has accessed social and medical services.

### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, pilot tests (rehearsals of new counseling, risk-assessment, or case management techniques), pre-testing of materials (letting people review drafts of scripts, pamphlets, or other intervention materials before finalizing them), and focus groups to discuss the best ways to present information.

### 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 Standards

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. 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 individualized plans for monitoring intervention outcomes.

### **Penalties for Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### **Other**

Providers of HIV/PCM should have protocols in regard to the safety of clients, volunteers, and staff.

Each provider shall develop a plan for crisis intervention.

In regard to ethics, please see Part 3, which contains standards for exemplary conduct for paid staff and volunteers providing HIV prevention services, including HIV/PCM. In addition, prevention case managers agree to neither harm nor misuse clients and shall address

## DEFINITIONS AND STANDARDS

the following areas appropriate to their professional discipline and/or service modality:

1. Confidentiality
2. Boundaries
3. Dual relationships
4. Conflict of interest
5. Duty to warn and protect
6. Duty to report unethical behavior
7. Referral to other services vis-à-vis a client's changing needs
8. Liaison/collaboration with other services to assure continuity of client care.
9. An explicit protocol for structuring relationships with Ryan White Care Act case

management provider must be established and should detail how to transfer and/or share clients within the confidentiality provisions of Colorado law governing HIV related records. These confidentiality laws regarding HIV related records apply differently to state/local health departments and community based organizations. Protocols should be developed with the assistance of legal counsel, CDPHE, and reviewed by the legal counsel of the provider.

## Part 12 – Public Information

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Public Information (PI) programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

Programs must include general characteristics of successful HIV prevention programs, especially those described in the behavioral and social science literature. Each provider must demonstrate how their program flows from and is consistent with social and behavioral theory and research relevant to HIV risk reduction (see Part 1, Characteristics of Successful HIV Prevention Programs and Theoretical Considerations).

### Goal of the Intervention

PI seeks to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase

access to available services. PI programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

### Target Population

PI programs target the general public as well as specific populations. They target audiences based on needs identified through formative evaluation.

### Cultural Competence/Proficiency

All providers of PI should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment developed in conjunction with the CWT Cultural Competence Committee (see Part 2 for further information on competence regarding culture, disability, and other diversity).

### Where Delivered

PI programs are implemented in key locations (as determined by formative evaluation).

### When Delivered

PI programs are implemented at times most appropriate for reaching a large portion of the target audience (as determined by formative evaluation).

### How Much

In general, public information campaigns with repeated messages implemented over a longer term are more effective.

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### Content and Methods Employed

Methods include one-on-one or group discussions; the creation and distribution of risk reduction kits or materials (including condoms) and small media (such as brochures, posters, tapes, booklets, buttons, newspaper ads, and flyers); banners, tabletop displays, and visible presence at community events; and the use of billboards, radio, television, and the Internet.

The messages are tied to the specific goals of public information as listed in the definition.

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 pretested to assure understanding by and relevance to the target audience. This includes alternative formats for the disabled.

When feasible, recipients of PI should also receive referrals that should be made to known and trusted services.

This intervention should reflect the principles of Harm Reduction (see Part 6, Harm Reduction Principles Applied to Drug Use and Sexual Behavior).

### Qualifications of the People To Do This Work

Programs are designed by a combination of professionals and peers. For PI programs to be effective, community representatives must be involved in the planning and development of PI activities.

Providers of PI should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification, or other acceptable means.

The peers or professionals providing PI must be competent in regard to culture and other diversity and able to present the materials in an understandable and non-judgmental manner.

### Continuing Education/Ongoing Training Requirement

Providers of PI must receive at least eight hours of updated HIV prevention training per year.

### Consent/Confidentiality Considerations

See confidentiality provisions of the Code of Ethics in Part 3.

### Quality Assurance

All providers will provide a system for client feedback (see Part 5).

CDPHE will formally assess contractor adherence to standards in writing on at least an annual basis and will deliver and discuss this assessment with the contractor. This quality assurance standard will be applied uniformly to all contractors; see "Penalties for Violating Standards." Providers may also wish to use these standards to assess the quality of services of agencies to which they may make referrals. In support of this quality assurance, CDPHE includes the following provision in all contracts: "All monitoring shall be performed by the state in such a manner that it shall not unduly interfere with the work of the contractor." If a contractor feels that monitoring has "unduly interfered" with their work, there are legal remedies described in the contract, up to and including withdrawing from the contract.

### Evaluation

Formative and process evaluation should be implemented and results should be utilized in the updating of services.

#### Formative Evaluation Standards

1. All interventions 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.

Comments: 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 interviews and focus groups with

## DEFINITIONS AND STANDARDS

members of target populations to better understand risk behaviors and how best to help them to lower risk, pre-testing of materials (letting people review and give input on pamphlets, advertisements, hotline messages, public service announcements, etc. before finalizing them), and focus groups to discuss the best ways to present and disseminate information.

### 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.

### **Penalties For Violating Standards**

1. Provider staff will meet with CDPHE to develop a quality improvement action plan for improving performance in specified areas.
2. The provider will be given a probationary period to comply and meet the standard.
3. The provider will be reevaluated by the end of the probationary period.
4. Failure to meet and comply with the standard may result in contract termination.

### **Other**

PI programs differ from community level interventions in their goals, degree of formative evaluation conducted, and level of saturation of the community.

Providers of PI should have protocols in regard to the safety of clients, volunteers, and staff.

## **Part 13 – Guidelines for Legal and Operational Protection of Confidential HIV and Communicable Disease Public Health Reports and Records**

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**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

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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:
  - Colorado statutes related to HIV
  - Colorado statutes related to communicable diseases
  - Colorado Board of Health Rules and Regulations pertaining to HIV
  - Colorado Board of Health Rules and Regulations pertaining to Communicable Diseases

- 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:
    - 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.
    - Notify the CDPHE state epidemiologist, chief medical officer, or Office of Legal and Regulatory Affairs attorney within 24 hours 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.
    - CDPHE staff may contact the Attorney General’s Office for additional legal advice, as needed.
    - 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.
    - CDPHE, through the Attorney General’s Office, may additionally want to prepare its own legal arguments.

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- 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.
  - 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.
  - 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.
  - 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>

## **Part 14 – Colorado Board of Health Rules and Regulations Pertaining to HIV**

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

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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

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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:

4. 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;
5. 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

##### A. Training

1. 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.
2. 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.
3. 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.

##### B. Notification of Results

1. Of all HIV tests performed at a CTS, 90 percent of those persons testing HIV

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positive will receive results and posttest risk-reduction counseling.

2. 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.

### C. Partner Notification

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

1. 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.

2. 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

##### A. Counseling

1. 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.
2. 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.

##### B. Consent Form

1. A consent form specified by the CDPHE or an approved equivalent must be used at all CTS.

##### C. Testing Parameters

1. CTS will not provide anonymous testing to any person 12 years of age or younger.
2. 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.

##### D. Written Results

1. 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.
2. Contracting agencies may not give written results to any person testing anonymously.

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### E. Confidentiality and Record Maintenance

1. 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
2. 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

- A. Each CTS's compliance with these standards will be evaluated by the following:
  1. 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.
  2. 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.
  3. A semi-annual analysis of testing trends (anonymous vs. confidential) conducted by CDPHE staff.
  4. A semi-annual review of counseling and partner notification forms for completion and accuracy conducted by CDPHE staff.
  5. A minimum of one annual audit of charts for all contracting agencies, conducted by CDPHE staff.
  6. Accuracy and completion of the posttest counseling reimbursement form submitted to the CDPHE.
- B. Failure of a CTS to comply with and meet these standards may result in one or more of the following action(s):
  1. The CTS may meet with the CDPHE to develop a plan for improving performance in specified areas.
  2. The CTS may be given a probationary period to comply and meet the standards.
  3. The CTS may be reevaluated by the end of the probationary period.
  4. Failure to meet and comply with the standards may result in contract termination.

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### Part 15 – Colorado Statutes Pertaining to HIV

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#### 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

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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

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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 sections [25-4-1402](#) 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 section [18-4-412](#), 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

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- 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,

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- 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

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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

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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

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- 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.
- 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

### **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

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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 section [16-6-201](#), 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.