

Kentucky  
2010 HIV Prevention Projects  
Federal Cooperative Agreement  
Health Department

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Grant Application

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## Key to Abbreviations

ADD	Area Development District
AHEC	Area Health Education Centers
AVOL	AIDS Volunteers (of Lexington)
CB	Capacity Building
CBA	Capacity Building Assistance
CBO	Community Based Organizations
CDC	Centers for Disease Control and Prevention
CEP	Continuing Education Program
CLI	Community Level Intervention
CRIS	CBA Request and Information System
CPG	Community Planning Group (see KHPAC)
CRCS	Comprehensive Risk Counseling and Services
CTRPN	Counseling, Testing, Referral, and Partner Notification
CTRS	Counseling, Testing, and Referral Services
CTS	Counseling and Testing Sites
DA	Direct Assistance
DEBI	Diffusion of Effective Behavioral Intervention
DIS	Disease Intervention Specialist
DLS	Division of Laboratory Services
DOE	Department of Education
EW	Empowerment Workshop

FA	Financial Assistance
FLS	Front-Line Supervisor
GLI	Group Level Intervention
HCW	Health Care Worker
HRSA	Health Resources and Services Administration
HRTC	Heartland Cares, Inc.
IDU	Injecting Drug User(s)
ILI	Individual Level Intervention
IPAR	Inmates/Parolees At Risk
KDPH	Kentucky Department for Public Health
KHPAC	Kentucky HIV/AIDS Planning and Advisory Council
LFCHD	Lexington-Fayette County Health Department
LHD	Local Health Department
LMHD	Louisville Metro Health Department
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men/Injecting Drug Users
NASTAD	National Alliance of State and Territorial AIDS directors
NMAC	National Minority AIDS Council
OS CTRPN	Offsite Counseling, Testing, Referral, and Partner Notification
PCM	Prevention Case Management
PEMS	Performance Evaluation Monitoring System
PDHD	Purchase District Health Department
PIR	Parity, Inclusion, and Representation

PS	Partner Services
PSE	Public Sex Environment
PWA	People with AIDS
SISTA	Sisters Informing Sisters on Topics about AIDS
SQL	Structured Query Language (database)
STD*MIS	STD Management Information System (database)
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
UK	University of Kentucky
UL	University of Louisville
VOA	Volunteers of America (Louisville/Lexington)
YAR	Youth At Risk

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A. *Executive Summary*

Funding is requested from the Centers for Disease Control and Prevention (CDC) to provide HIV prevention interventions/activities for calendar year 2010. A total of \$1,881,877.00 is requested.

The cooperative agreement funds are requested for the following activities/interventions:

- \$119,955.25 Support Kentucky Health Department HIV Prevention Staffing
- \$42,003.38 Fringe for Kentucky HIV Prevention Staffing
- \$41,226.00 Travel for Kentucky HIV Prevention Staffing
- \$25,190.60 Indirect costs for Kentucky DPH HIV Prevention Staffing
- \$334,174.35 LHD Contracted HIV Prevention Staffing
- \$3,340.00 Other costs for Kentucky HIV Prevention Staffing
- \$61,775.42 Supplies for Kentucky HIV Prevention Staffing
- \$959,350.00 To support 24.0 full time community Prevention Specialist positions.
- \$238,019.50 To support health education/risk reduction activities/interventions
  - \$5,028.50 To support statewide evaluation activities
  - \$17,734.00 To support capacity building
  - \$15,950.00 To support community planning group activities
  - \$18,130.00 To support Public Information Campaign

***Highlights***

The following populations will be targeted for HIV Prevention Education Intervention:

Prevention Case Management (PCM) for HIV+, Men who have Sex with Men (MSM),

Injecting Drug Users (IDU), Men who have Sex with Men and Injecting Drug Users

(MSM/IDU), Minority/Heterosexual Contact (including Youth and Women at Risk, and the General Population). The funding will support increased opportunities for rapid testing in the jurisdiction. Prevention programs in the jurisdictions will be maintained in a manner consistent with the goals of the Community planning group.

A. *Comprehensive HIV Prevention Programs—Note: Goals for the comprehensive program must be established and described in the narrative portion of this application.*

1) *HIV Prevention Community Planning*

a) *Report on how performance on each of the three community planning goals will be sustained or improved over the project period of this program announcement.*

i) *Goal One – Community planning supports broad-based community participation in HIV prevention planning.*

Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) has a maximum membership of 30 members. Membership strives to mirror epidemiologic data by risk factors and geographical region. Meetings are open to the public and invitees include professional advisors from Kentucky Departments of Education, Corrections, Mental Health/Substance Abuse and Tuberculosis (TB), Hepatitis, Sexually Transmitted Disease (STD), and Counseling and Testing Sites (CTS) within the Kentucky Department for Public Health (KDPH).

Each KHPAC member is required to choose and participate on one of three mandatory committees. Committee membership allows participation in a smaller and less formal

environment. Monthly meetings end with the “go round” to provide each individual attending the opportunity to speak on any topic related to community planning. The KHPAC is currently revising the by-laws and committee structure with the assistance of Centers for Disease Control (CDC) to allow for increased involvement and input into the community planning process. The KHPAC will continue to recruit members from infected and affected communities and involve all members in the community planning process with training and technical assistance from KDPH and CDC.

- ii) *Goal Two--Community planning identifies priority **HIV prevention** needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction. All jurisdictions are required to prioritize **HIV-infected** persons as the highest priority population for appropriate **prevention** services. Uninfected, high-risk populations such as sex partners or needle-using partners of people living with **HIV** should be prioritized based on community needs.*

Kentucky has prioritized HIV-infected persons as the highest prioritized population. The HIV/AIDS Epidemiologist develops the Epidemiologic profile and assists the KHPAC general membership with interpreting the data and translating it to prioritizing target populations. Based on the epidemiology the KHPAC membership identifies and prioritizes prevention interventions for each targeted population listed in the profile. The KHPAC membership will continue to utilize this method of prioritizing populations based upon the epidemiologic profile developed by the HIV/AIDS epidemiologist as well as the Community Services Assessment. The KHPAC epidemiological workgroup committee will continue to make improvements to the prioritization tool as recommended

by the entire body to insure the most effective method of capturing the target populations. The state prevention team provides results from Diffusion of Effective Behavioral Interventions (DEBI) effectiveness assessments and descriptions to the KHPAC in order for the KHPAC to adequately select appropriate interventions as recommendation for the target populations to the state department.

*iii) Goal Three--Community Planning ensures that **HIV prevention** resources target priority populations and interventions set forth in the Comprehensive **HIV Prevention Plan**.*

The Kentucky Department for Public Health (KDPH) sends the HIV Prevention grant application to KHPAC members for review and comment, a minimum of one week prior to the monthly meeting. The grant application is developed by KDPH from the Comprehensive HIV Prevention Plan. This process will continue over the program period.

*b) Provide, as an attachment:*

*i) A copy of the community planning group's letter of concurrence, concurrence with reservations, or nonconcurrence. Only one letter should be submitted per jurisdiction. This letter must describe the method and timeline for the review of this application by the CPG. Instances of planning group nonconcurrence will be evaluated on a case-by-case basis. After consultation with the grantee and the CPG, CDC will determine what action is appropriate as outlined in the guidance.*

Letter of concurrence, concurrence with reservations, or non concurrence from CPG (will be forwarded after 10/27/2009 meeting).

*ii) A document that describes any updates or changes to the most recent Comprehensive **HIV Prevention** Plan provided to CDC. If CDC has the jurisdiction's most recent plan, it does not need to be resubmitted with the application. Only one statewide prevention plan or update should be submitted, and that document should summarize all regional or local planning efforts.*

The Kentucky Department for Public Health will update the 2009 HIV Comprehensive Prevention Plan during the course of the two-year program. The updated plan will address all HIV prevention activities and serve to inform decisions regarding how all HIV prevention funds are to be utilized, including federal, state, local and private resources. The plan will summarize all regional planning and community planning groups into one summary document. The 2009 statewide prevention plan is available at the following link <http://chfs.ky.gov/NR/rdonlyres/59A53531-C4E6-4C89-BA34-FD951445C28B/0/Kentucky2009PreventionandCarePlan.pdf>, The 2010 Comprehensive Plan will be available after December 31, 2009.

The Kentucky Department for Public Health will ensure that the priorities of the Comprehensive HIV Prevention Plan are reflected in the funding application to CDC. To accomplish this objective the Grant Administrator will establish a matrix that cross reference selected targeted populations from KHPAC (the CPG) target population list with those outlined in the Plan and Grant.

2) *HIV Prevention Activities*

a) *HIV Counseling, Testing, and Referral Services (CTRS)*

(i.) *Applicants should describe their plans to provide HIV CTRS,*

*including:*

(1) *How efforts to identify newly infected persons will be improved;*

Kentucky is focused on diagnosing as many new cases of HIV as possible and linking them to appropriate prevention, care and treatment services. In order to assure this focus Kentucky will avail itself of the best practices and lessons learned from jurisdictions employing rapid testing in high risk communities and in cooperation with KHPAC investigate whether any of these innovations can be incorporated into the prevention strategies employed by the state to improve methods of identifying newly infected persons. Some of these prevention strategies that have emerged, such as involvement with social networks of men who have sex with men (MSM) and increased alliances with family planning and other systems that provide services to child bearing women, will be explored.

The Kentucky Department for Public Health's HIV/AIDS Branch maintains over 200 HIV counseling and testing sites. All 120 county health departments are mandated to provide HIV counseling and testing so that any Kentuckian may receive CTRS in his/her home county. In addition to the county health departments, college health centers, state mental hospitals, Department for Juvenile Justice Facilities, and community based organizations also are maintained as CTRS providers.

All existing testing sites are required by statute to have all testing staff receive state provided CTRS training before providing the service. The HIV/AIDS Branch provides

16 CTRS trainings per year. Tom Collins, HIV Prevention Initiatives Coordinator, provides 10 trainings annually in English and 2 annually with Spanish interpretation. Terry Stalions, HIV Prevention Specialist with Heartland Cares Clinic, and Cindy Mangrum, nurse with Purchase District Health Department, provide 4 CTRS trainings per year in the western region of the state. Mr. Stalions is Bilingual and provides the training in both English and Spanish.

All participants in the trainings are made aware of the CDC's 2006 Revised Recommendations for HIV Testing and are encouraged to explain the benefits of routine testing to patients/clients presenting for other services. All testing sites are encouraged to participate in special testing campaigns and are invited to submit proposals for additional assistance (both financial and staff support) in order to conduct additional testing with individuals in high-risk populations.

*(2) How the provision of test results (especially positive results) will be improved;*

Expansion of rapid testing is expected to provide a better overall rate of provision of preliminary test results. The state plans to expand rapid testing to at least 5 newly added testing sites in 2010 and continue to pursue availability of rapid testing in local health departments. Statewide Kentucky has less than 1% seropositivity rate from testing performed at state sponsored testing sites. The return rate for test results for traditional conventional testing is approximately 55%. Due to the low seropositivity rate this jurisdiction does not have a significant issue with non-return of individuals who have tested positive. However, the state is fully aware that the potential for an issue does exist, since Kentucky law mandates the provision of anonymous testing. Each provider of

CTRS is taught to encourage confidential testing in order to avoid issues with non-return of individuals testing positive. 85% of testing performed in 2008 through state sponsored testing site were confidential tests.

*(3) Plans for providing and tracking the completion of referrals for persons with positive test results.*

Kentucky uses the CDC-Program Evaluation and Monitoring System (CPEMS), which allows the state to track HIV testing by using the scan forms. Unfortunately, CDC does not provide report capability to track referrals for individuals testing positive. Branch staff will use Statistical Analysis System (SAS) to analyze the SQL database to track these referrals at the end of a reporting period. Branch staff will also visually check all Form 2's submitted for clients testing positive in order to ensure that required referrals have been made. When referrals are not indicated on Form 2 scanning, staff (Tom Collins) contacts the testing site by phone for a corrective action. Additionally, branch staff in the services section uses CareWare software to track referrals.

*ii. Applicants should describe how they will work with:*

*1. Departments of corrections in their jurisdictions to encourage and, when appropriate, support routine voluntary **HIV** screening and referral in corrections facilities;*

The Continuing Education Program (CEP) of the HIV/AIDS Branch works with the Department of Corrections (DOC) in bringing their HIV training courses up to statute, including recommendations within the course to provide routine voluntary screening. Pre-release planning includes risk assessments and referrals. Kentucky Department for Public Health is also involved in a DOC 20-week program called "Prison to the Streets"

designed to present inmates with information necessary to help them with their re-entry into society. In addition, KDPH worked with DOC on legislation for mandated prison testing. This process is ongoing and will continue in the new grant year.

2. *Medical care entities to encourage and support routine HIV screening in medical settings;*

CEP now requires CDC's screening recommendations to be taught to all licensed Health Care Workers (HCW's) in Kentucky. "Epi Notes" (a monthly KDPH publication to physicians and health care workers) publishes the CDC's HIV testing recommendations at least twice per year. National HIV testing days are also promoted through "Epi Notes" and on the state web site.

2. *Community-based organizations' efforts to provide CTRS;*  
*and*

All contracted agencies provide CTRS. KDPH provides CTRS training to whoever requests training. Non-contracted CBOs also provide testing with KDPH support (e.g., AVOL, Matthew 25).

3. *Any other providers of CTRS.*

University student health programs which included CTRS have been implemented at Morehead State University, Western Kentucky University, the University of Kentucky, and soon will be implemented at Kentucky State University. Services to include CTRS are being developed for Planned Parenthoods, Hope Center, and several churches.

Opportunities for persons to receive anonymous CTRS are not provided during partner service because the identity of the exposed partner is known. However, if an individual

does not wish to test confidentially during the partner service, the individual will be referred to an anonymous test site.

*iii. Describe how the integration of CTRS and STD services will be encouraged.*

In order to ensure that the appropriate HIV CTRS are provided in settings most likely to reach persons who are likely to be infected, but are unaware of their status Prevention staff and STD staff are cross trained. Staff has been instructed to conduct appropriate referral services for individuals not linked to care. Currently, there are 45% no return test rates, which means that 45% of those taking the initial HIV test do not return for the results, however 99% of those testing are negative. CTRS is provided in setting with high HIV prevalence. Louisville is the only site in Kentucky with over 1% seropositivity rate, and KDPH has rapid testing in all sites in Louisville (Namely: VOA, Louisville-Metro Department of Public Health and Wellness (multiple sites), AHEC, Planned Parenthood, and several church sites). Staff at all test sites are required to have STD cross-training provided by KDPH. Sites that cannot perform STD testing provide referrals to testing agencies.

*iv.) Describe how data to determine the scope and reach of your programs will be collected and analyzed, and how the applicant intends to use these data to evaluate program components in order to guide and adjust future activities.*

Kentucky has a unique opportunity to collect and analyze data because staff has been trained to extrapolate data beyond the PEMS system. Additional data analysis can be performed because staff has been trained in SAS. In areas with increased seropositivity

KDPH has augmented the availability of rapid testing, which eliminates return visits for negatives. Individuals with reactive rapid tests are referred for confidential (if acceptable) confirmatory testing. Those who receive confidential testing are easier to locate in order to deliver results. Each testing site submits scanning forms monthly. Each year KDPH uses the CTS data reports to determine the non-return rate. This data will continue to be helpful in supporting the expansion of rapid testing.

*b) Partner Services (PS)*

- i). Applicants should describe their plan to offer and provide partner services.*

Kentucky ensures that Partner Services are a high priority within the jurisdiction's HIV prevention activities. HIV positive individuals are prioritized as first in the population prioritization process performed by KHPAC, corresponding Partner Services are addressed, and services are assured by the HIV Program via funding support through the STD program by Disease Investigation Specialist (DIS) positions.

Publicly Funded Counseling and Testing Sites:

Confidential Testing- The provision of partner services to individuals diagnosed with HIV are of special concern because of: 1) the ability to transmit and spread the infection to others; 2) the need for risk reduction counseling and 3) the need to be referred to an AIDS Care Coordinator who can assist them in obtaining a variety of medical, financial and other services.

The provision of partner services to HIV positive individuals who test confidentially is initiated through STD surveillance. All HIV Counseling and Testing Sites within Kentucky utilize the Division of Laboratory Services (DLS). DLS reports all positive

western blot labs to the STD program surveillance unit. STD surveillance performs a record search utilizing STD\*MIS as well as the HIV/AIDS surveillance program.

Patients who are newly diagnosed are initiated for post-test counsel and partner services and forwarded to the local level.

Disease Intervention Specialist (DIS), who has successfully complete the following training; Kentucky's Fundamentals of HIV, Employee Development Guide (EDG) and Introduction to STD Intervention perform all partner services. DIS can make initial contact by phone; however, no mention of HIV status is permissible by phone. Phone contact is primarily conducted to arrange a face-to-face meeting with the patient.

Because of the need to maintain confidentiality, interviews are conducted in environments that are private. Partner Services can take place in the field or in a clinical setting as long as privacy is ensured. The time and location of the interview is more at the preference of the patient than that of the DIS. With the exception of an interpreter or supervisor no other person can accompany the DIS. Referral letters may be mailed or left at a residence. However, they may not contain medical information and must be sealed in a non-descript envelope and stamped, "confidential" or "private".

Partner services are provided with the following in mind:

Partner notification is provided to sexual and Injecting Drug Users' (IDU) partners whose exposure was during the preceding 2 years and to spouses within the preceding 10 years.

Partner services are offered as rapidly as possible after being identified by the partner services program. Patients are advised that informing of exposure can be done directly by the patient themselves or by a DIS. Those electing to self refer will be reminded that in doing self referral their right to confidentiality is forfeited and that there is no way to

assure that the contact, once informed of exposure, will not reveal the patient's identity to others. The DIS or certified counselor will then explain to the patient that the only way to completely protect confidentiality is to let the DIS take full responsibility for informing contacts with the absolute guarantee that their name, nor any other information, will be revealed. Patients who prefer to make self-referral will be provided with information about how to accomplish referral. Referrals by DIS are always undertaken in a manner that fully protects the patient's identity and which avoids placing the contact in an awkward, compromising, or embarrassing position.

Anonymous Testing – Patients who seek anonymous testing and have a positive HIV result cannot be followed in the same manner as a patient who tests confidentially.

Patients who maintain their anonymity cannot be actively pursued for partner or referral services due to the lack of identifying and locating information. Partner services to anonymous patients are provided only if the patient returns to the Counseling and Testing site to receive their test results. During the post-test counseling session, the patient is referred to a qualified counselor or DIS for partner services.

Private Sites:

To ensure that partner services are offered to persons newly diagnosed with HIV regardless of where they are diagnosed, Kentucky's STD and HIV/AIDS Programs are working together to expand partner services to include individuals who test positive through the private sector. Partner Services (PS) for patients who test positive from private sites will be initiated from the HIV/AIDS surveillance program. Upon receipt of a new HIV positive lab result (Western blot), the HIV/AIDS surveillance program will contact the private provider and request permission to provide partner services. Once

permission is granted, the lab information will be forwarded to the STD program to be initiated for follow-up.

Prior to the implementation of partner services to individuals testing positive in the private sector, policies for data sharing and partner services will need to be completed.

Following activities are in progress:

- 1) STD Security Protocols for
  - a) electronic storage of information and
  - b) physical storage of records.
- 2) Protocol for the exchange of lab information between HIV and STD

*ii) Describe plans to collaborate with:*

*(1) STD programs to reduce duplication of PS activities;*

The Kentucky STD program is the only provider of partner services; therefore duplication of services is non-existent. During the provision of partner services, Disease Intervention Specialists (DIS) refers HIV positive patients who test confidentially to an HIV/AIDS Care Coordinator. The name, address and telephone number of an AIDS Care Coordinator is given to the patient prior to the conclusion of partner services. When feasible and with the patient's consent, appointments with the AIDS Care Coordinator is made on the patient's behalf and given to him/her before the conclusion of the interview. The appointment date and time is documented in the patient's case management file. When feasible, the DIS contacts the HIV/AIDS Care Coordinator to verify whether the patient kept the first appointment. The results of the first appointment are documented in the case management file.

*(2) HIV or STD surveillance programs or both, and plans to utilize surveillance data to maximize the number of persons identified as candidates for PS; and*

To provide PS to HIV-infected persons who have been tested either anonymously or confidentially in CDC-funded sites, the HIV/AIDS surveillance coordinator, in collaboration with the STD branch, has established a process to perform data linkages. Currently, the STD data manager is authorized to conduct record searches with HIV/AIDS surveillance to complete reports they receive from disease intervention specialists. The STD branch will migrate their database from a stand-alone computer to the same server that HIV/AIDS surveillance holds their eHARS database to increase security. Once this migration has taken place the feasibility of record linking will be determined. CTS program coordinator and the HIV/AIDS surveillance coordinator are examining the most effective methods of linking information. Presently, the CTS office is collecting information on confirmatory test forms to determine whether the case has been reported to the HIV/AIDS surveillance branch. If it has not been indicated that the case has been reported, the CTS manager will contact the testing agency and encourage/facilitate reporting to the HIV/AIDS surveillance unit.

Currently, when a case is reported to the HIV/AIDS surveillance section by a private physician, staff often asks if Partner Counseling and Referral Service are needed. The surveillance staff provides a brief overview of the program. If the physician's office says it is needed, the information collected is then forwarded to the PCRS manager for distribution to the proper DIS by region of the case.

*(3) Non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide PS.*

Kentucky Department for Public for Public Health does not have any non-health department providers that provide Partners Services. However, providers are encouraged to contact the local health department for Partner Services provided by the DIS.

*iii) Describe any plans to implement new techniques and approaches to increase utilization and acceptance of PS.*

The STD Program will increase utilization and acceptance of partner services through the enhancement of DIS skills. The Assistant Program Manager will provide training to Disease Intervention Specialists who provide partner services. Training to enhance skills in the area of interviewing, case management and field investigations will be provided which in turn will increase DIS confidence and ability to provide PS.

*iv) Describe how data to determine the scope and reach of your programs will be analyzed, and how this information will be used to evaluate program components in order to guide and adjust future activities.*

Data collected and reported on prevention activities for HIV-infected persons as specified in CDC's data reporting requirements will be utilized by KDPH and the community planning group for planning, local program monitoring, and program improvement purposes. This process will be facilitated with the implementation of STD\*MIS 5.0 which will enable the program to download PS data into the PEMS data base. The Kentucky STD Program is awaiting the release of STD\*MIS 5.0. Downloading this data will provide an opportunity to analyze and examine trends contained in the data.

*c) Prevention for HIV-Infected Persons*

- i) Applicants should describe how they plan to provide **prevention** services for HIV-infected persons.*

Per CDC guidance Kentucky has prioritized HIV+ individuals as the highest priority population. Prevention services specifically include interventions for HIV+ individuals in the form of the DEBI; Healthy Relationships, and CRCS. Three agencies are contracted to provide these intervention. This makes one provider available in each of the three designated prevention regions of the state. In addition to specific prioritization of HIV+ individuals, there is a sub-prioritization within other at-risk populations. This sub-prioritization lists HIV+ individuals with certain risk factors as highest priority within that risk category. For example, among MSM , HIV+ MSM would be prioritized higher than HIV– MSM.

- ii) Describe the plan to provide financial assistance to CBOs and other HIV prevention providers (including local health departments) and to collaborate with health care providers to provide prevention services such as prevention counseling to HIV-infected persons.*

KDPH contracts with CBOs to provide prevention services such as prevention counseling to HIV-infected persons. Funding allocations to agencies to facilitate the provision of prevention programs is included in the budget.

- iii) Describe how primary care clinics will be encouraged to integrate prevention and care services.*

The Ryan White Part B program maintains an existing medical referral system with primary care entities throughout Kentucky. This referral system varies from region to

region depending on the number and availability of primary care facilities and physicians. This system also includes three facilities (Ryan White Part C) that provide medical case management, medical treatment, and other supportive services. While not unique to HIV/AIDS related services, facilities of this type are often referred to as “one stop shops”.

The state Prevention and Ryan White programs facilitate an annual combined training for prevention and Ryan White Part B sub grantees regarding current trends and issues in prevention case management. In 2009, the annual mandatory training was conducted on May 21<sup>st</sup>, at the Holiday Inn Hurstbourne in Louisville, Kentucky.

Through State sponsored publications, community primary care clinics that serve persons at risk for HIV have been advised of the CDC’s revised recommendations for routine testing as well as the recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection (MMRW, November 7, 2008).

*iv) Describe how the offering of partner services to all persons newly diagnosed or reported with HIV will be ensured.*

Three agencies have been contracted to provide HIV prevention services to HIV+ individuals. Persons living with HIV or AIDS that are found to be at risk for transmitting the virus to others due to behavioral and situational issues will be offered CRCS. The counselor will work with the client and service providers to help the client make behavioral or situational changes that will reduce the risk of them infecting another person. Additionally, the DEBI intervention, Healthy Relationships, has been selected to assist HIV+ individuals deal with their status.

The assurance of partner services to all persons newly diagnosed or reported with HIV can only occur for patients who test through publicly funded HIV Counseling and Testing Sites and on individuals whose private physician grants permission for partner services follow-up. Partner services will be monitored and evaluated through the use of the STD\*MIS data management system. Records initiated to DIS at the regional area for partner services will be monitored for open/closed status. Delinquent records will be communicated to the Front-Line Supervisors at the regional area to resolve outstanding records. Partner Services outcomes for each individual will be communicated to the central STD office in Frankfort and input into STD\*MIS.

The provision of positive test results from publicly funded HIV counseling & testing sites to individuals who test confidentially is provided by the STD program via Partner Services (PS). HIV Counseling and Testing sites utilize the Kentucky State Laboratory to process HIV specimens. Positive results are reported from the lab to the STD Program. The STD Program notifies a Disease Intervention Specialists (DIS) at the local level when an individual has a positive test. The DIS is responsible for locating the individual and providing PS. Posttest counseling in the field will be done when possible, but only when the setting is one in which strict privacy is assured.

*v) Describe how data to determine the scope and reach of your programs will be collected and analyzed, and how these data will be used to evaluate program components in order to guide and adjust future activities.*

Referrals made by HIV prevention providers and CTS providers will be tracked through PEMS. All prevention contract employees responsible for provision of CTS were trained

in 2008 to collect information on service referrals. This information is currently being entered in PEMS and will be evaluated on an annual basis to examine linkage to care trends. Additionally, the Ryan White Part B program is tracking case management services information in its database (CARE Ware) regarding clients being referred to those programs and the specific services being accessed. An annual comparison of the information in PEMS and the data in CARE Ware will be conducted to determine gaps in referral services. Based on these analysis program adjustments will be considered.

*(d) Health Education and Risk Reduction Services (HE/RR)*

- i) Applicants should describe their plan to provide HE/RR, either directly or through the provision of financial assistance to **prevention** providers (e.g., CBOs). Explain any anticipated instances of non-competitive award of CDC funds. Identify existing providers by prioritized populations and interventions that are currently funded. Also prepare a separate list identifying interventions that will be funded.*

The attached Budget Narrative outlines Kentucky's plan to provide HE/RR, through the provision of financial assistance to prevention providers. The process for identifying interventions and providers begins with the prevention coordinators reviewing interventions listed on the CDC Compendium and presenting the information to CPG. KHPAC uses epidemiological data and needs assessments to determine the appropriateness of interventions and makes prioritizations accordingly. KDPH's HIV/AIDS Branch follows the prioritization by making sure prioritized interventions are included in bid blocks for contracts.

State law requires all licensed health care professionals to receive continuing education on HIV. Courses must be approved by the HIV/AIDS Branch. All courses include a resource inventory provided by the Branch which is updated regularly. Additionally a semi-annual report is published with new HIV/AIDS statistics for Kentucky. All this information is also available on the website maintained by the HIV/AIDS Branch.

All contractors are required to use DEBI interventions. State program coordinators are certified trainers for the interventions used. Any adaptations or tailoring of interventions must be approved by state program coordinators. Program coordinators monitor the delivery of interventions through site visits and data collections on a monthly basis.

The following table is a summary of recommended providers and intervention allocations.

<b>Provider</b>	<b>HIV+ FTE</b>	<b>MSM FTE</b>	<b>MSM/IDU FTE</b>	<b>IDU FTE</b>	<b>HRH FTE</b>
VOA-Louisville	2	3	0	2	1
VOA-Lexington	0	2	1	0	1
Heartland Cares	1	1	0	1	1
LFCHD	1	0	0	2	1
LMHD	0	1	1	0	1
PDHD	0	0	0	0	1
Total Staffing	\$159,850.00	\$278,050.00	\$79,300.00	\$200,250.00	\$241,900.00

<b>Interventions</b>	<b>HIV+</b>	<b>MSM</b>	<b>MSM/IDU</b>	<b>IDU</b>	<b>HRH</b>	
CRCS	X	X	X	X	X	
Outreach						
Healthy Relationships	X					
Materials Dist.	X	X	X	X	X	
GLI	X	X	X	X	X	
Making Proud Choices!					X	
CLI (d-up!)		X				
Intervention Totals by Pop	\$14,200.00	\$64,400.00	\$5,800.00	\$13,000.00	\$20,000.00	

						Non-Pop Total
Community Mobilization	X	X	X	X	X	\$52,000
Offsite CTS	X	X	X	X	X	\$68,619.50

*ii) Applicants should describe their plan for monitoring prevention providers to ensure that the criteria for funded services identified in section 2.d under “Grantee Activities” are met.*

For Counseling Testing and Referral monitoring the Kentucky Department for Public Health employs three program coordinators who are responsible for holding contracted community based organizations and local health departments accountable for completing

contracted interventions as indicated. Program coordinators conduct actual monthly site visits in order to evaluate the fidelity of interventions as they are being conducted. The HIV Prevention Grant Administrator conducts site visits to meet with program supervisors. An agency evaluation tool has been created and is completed after each visit. A copy of the evaluation is provided to each agency and the Prevention Grant Administrator keeps an electronic copy. Required corrective action cited within the evaluation reports is addressed through various means, including: a) further staff training, b) follow-up site visit with to evaluate the implementation of recommended changes, and c) meeting with all involved parties to discuss and outline a response plan to address the issue.

In addition to site visits each coordinator collects program data from each of contracted agency and enters that data into PEMS. Each coordinator has access to PEMS and conducts monthly data entry. Data entered into PEMS is monitored in order to determine whether contractual obligations are being met. To ensure fidelity, contracted agencies must submit mandated electronic data submissions monthly. Coordinators also provide a monitoring form to help ensure that agencies are following policies and procedures. Information is also disseminated through quarterly trainings.

For Health Education and Risk Reduction program coordinators monitor the delivery of interventions through site visits and data collections on a monthly basis.

*iii) Describe how data to determine the scope and reach of programs will be collected and analyzed, and how this information will be used to evaluate program components in order to guide and adjust future activities.*

Program coordinators use contracts to develop a scope of work (which includes quality assurance and adherence to policies and procedures) for each contracted agency.

Supervisors of these agencies are required to attend a meeting with program coordinators and the grant administrator to assure that the supervisors are knowledgeable about the scope of work. The grant administrator conduct agency reviews with the supervisor quarterly.

The grant administrator and the prevention coordinators analyze the data received from agencies to assess program performance. This information is compiled in an annual review and state staff present data for KHPAC to consider in future prioritizations and planning processes.

*e) Public Information Programs Note: Applicants should complete this section only if they are requesting **program** funds to support public information programs.*

- i) Describe the planned public information efforts and how they are consistent with the jurisdiction's Comprehensive **HIV Prevention Plan***
- ii) Describe any plans to develop and carry out HIV prevention public information programs. Describe the basic approach and messages that will be developed, including how and where the information will be disseminated.*

Kentucky plans to initiate a new prevention public information program in order to address a need for Kentucky's poor, uneducated, and otherwise underserved female population. To develop a better understanding of the need to attend to their own health status, the Kentucky Commission on Women (KCW) will collaborate with University of

Louisville Health Care, Inc., University of Kentucky Healthcare, St. Andrew Development Inc., several entities, and the Kentucky Department of Public Health to develop, install, and monitor one dozen Women's Health Information Guides (WHIGs). WHIGs are a mobile system of information kiosks that will provide free, essential health-related information in an easily accessed format placed in locations commonly frequented by Kentucky's underserved women.

Easy to understand, touch activated, and bilingual WHIGS would be strategically placed into communities where early detection and awareness messages often go unheard or undirected. Users will be pleasantly "greeted" by a diverse group of women who introduce themselves speaking in familiar regional dialects essentially sharing their own "health story" and the steps they took to address their own need. The WHIG covers a range of topics including HIV/AIDS, sexual transmitted diseases, smoking cessation, breast health, breastfeeding, asthma, diabetes, weight management, depression, cervical health, domestic violence, oral health, and heart health. Each WHIG, complete with audio capability, will provide healthcare definitions, preventive measures, a list of questions for users to ask a healthcare provider, and be equipped with telephones that are programmed to connect the user with immediate healthcare assistance if they desire.

*iii) Describe the purpose and desired outcomes of any planned public information programs. Explain how the effort supports the applicant's other funded HIV prevention activities (i.e. increasing awareness of the availability of HIV testing, increasing acceptance of partner service by potential clients).*

The purpose of the Women's Health Information Guides (WHIG's) is to increase awareness and provide information that empowers Kentucky's underserved female population. This effort is consistent with the state's funded HIV prevention activities and addresses needs identified in the epidemiological profile.

*iv) Describe how data to determine the scope and reach of public information programs will be collected and analyzed, and how this information will be used to evaluate program components in order to guide and adjust future activities.*

State-wide publicity campaigns, educational events and awareness seminars are developed around the following events: National HIV Testing Day, World AIDS Day, National Black HIV/AIDS Awareness Day and National Latino AIDS Awareness Day. Non traditional partners such as minority churches, historically black colleges and universities (HBCUs), migrant farm worker health programs, and African American sororities & fraternities will be sponsored to conduct education, awareness and testing events statewide. The annual African American and Hispanic/Latino Leadership Conference and the Minority Youth Conference are conducted in central Kentucky (but attended by statewide participants) in order to provide information to minority youth, community leadership, and service providers targeting these populations. Events are often attended and monitored by HD staff to provide feedback for improvement. Each conference workshop is evaluated by participants and the information is collected and reviewed to identify improvement opportunities. To evaluate first time and/or one time funded events, the Prevention Grant Administrator has created an evaluation tool

completed by the funded entity. The Prevention Grant Administrator keeps an electronic copy that will be used to evaluate such funded programs and assess future funding.

<b>Program</b>	<b>Location</b>	<b>Target Population</b>	<b>Key Messages</b>	<b>Funding Rationale</b>
National HIV Testing Day	Statewide	General Population	Promoting Routine HIV Testing	2006 CDC Recommendations
World AIDS Day	Statewide	General Population	Increase HIV Awareness	Overcome Stigma Surrounding HIV/AIDS
National Black Awareness	Statewide	African Americans	Increase HIV Awareness & testing Among African Americans	Disproportionately Affected/Infected Population and Reducing Stigma
National Latino Awareness	Statewide	Latino Americans	Increase HIV Awareness & testing Among Latinos	Disproportionately Affected/Infected Population and Reducing Stigma
African American/Hispanic Leadership Conference	Central Kentucky	Minority Populations	Motivating and Mobilizing Minority Communities	Increase Community Involvement
Minority Youth Conference	Central Kentucky	African American and Latino Youth	Promote HIV Testing and Prevention Education While Gaining Knowledge and Skills	To create new energy and ideas to increase knowledge about HIV/AIDS with youth
Juntos Program	Bluegrass Region & Northern Kentucky	Latino Populations	Promoting HIV Prevention Education and Testing	Increase Community Involvement
Gay Pride Events	Louisville, Lexington	MSM	Promoting HIV Prevention Education and Testing	Highest Prioritized Population

f) *Perinatal HIV Transmission Prevention*

*If the applicant will not receive funding for enhanced HIV perinatal prevention:*

*i) Describe plans to work with health care providers to promote routine, universal HIV screening to their pregnant patients. Describe how the applicant will work with organizations and institutions involved in prenatal and postnatal care for HIV-infected women and their infants to ensure that appropriate HIV prevention counseling, testing, prevention interventions and therapies are provided to reduce the risk of mother to child transmission.*

KDPH works with health care providers to promote routine, universal HIV screening of all pregnant patients early in pregnancy; and works with organizations and institutions involved in prenatal and postnatal care for HIV-infected women to ensure that appropriate HIV prevention counseling, testing, and therapies are provided to reduce the risk of transmission.

In an effort to insure universal testing practices for pregnant women and protections for the unborn child, an article was written in “EPI Notes”, a monthly publication that was forwarded to all physicians and health care providers.

Additionally, Family Planning at local health departments provides opportunities for counseling and testing. It is Kentucky’s policy to educate every pregnant woman on the importance of HIV testing and to recommend taking a test. However, testing is optional. As stated in the Kentucky PPHR, a pregnant woman who receives prenatal care through the local health department system will be counseled on HIV, including identification of risk factors and risk reduction methods. Regardless of risks, initial prenatal HIV testing is recommended, but not required. Patients advised of the risk of before receiving an HIV

test, but have a right to refuse testing. Refusal of the HIV test at the initial visit or at the recommended retesting time frame for those individuals at risk should also be documented in the medical record. KDPH is committed to providing additional prevention and health educational materials and training to all providers in local health departments, in addition assessing the needs for improving provider/client communication and routine prenatal HIV testing.

The language on the mandatory HIV testing of pregnant women bill- "KRS 214.160" was proposed last year. Kentucky Statute KRS 214.181 and KRS 214.625 states as follows:

“A person who has signed a general consent form for the performance of medical procedures and tests is not required to also sign or be presented with a specific consent form relating to medical procedures or tests to determine human immunodeficiency virus infection, antibodies to human immunodeficiency virus, or infection with any other causative agent of acquired immunodeficiency syndrome that will be performed on the person during the time in which the general consent form is in effect. However, a general consent form shall instruct the patient that, as part of the medical procedures or tests, the patient may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if a doctor orders the test for diagnostic purposes. Except as otherwise provided in subsection (5) (c) of this section, the results of a test or procedure to determine human immunodeficiency virus infection, antibodies to human immunodeficiency virus, or infection with any probable causative agent of acquired immunodeficiency syndrome performed under the authorization of a general consent form shall be used only for diagnostic or other purposes directly related to medical treatment.”

Kentucky State Statute KRS 214.625 section three (3) states “ In any emergency situation where informed consent of the patient cannot reasonably be obtained before providing health-care services, there is no requirement that a health-care provider obtain a previous informed consent. “ In 2008 the Kentucky State Legislature amended this section to “allow for treatment of women and their newborns based on a reactive rapid test at time of delivery.” The department is in the process of working with the commissioner's office to propose language during the 2010 legislative session.

*If the applicant is eligible for enhanced perinatal HIV prevention funding:*

- i) Describe current and planned perinatal HIV prevention activities.*
- ii) Include a budget detailing the planned funding for targeted perinatal HIV prevention programs, using as the amount per year of perinatal funding the jurisdiction has historically received for targeted perinatal HIV prevention.*
- iii) For the five states in which there is a CDC directly-funded city, provide evidence of formal collaboration between the state and city.*
- iv) Indicate the applicant’s willingness to carry out evaluations of their planned targeted perinatal HIV prevention activities as detailed in the “Perinatal HIV Prevention Programs Evaluation Protocol.”*

### *3) Program Monitoring and Quality Assurance*

- a) Applicants should describe how they plan to staff the program monitoring activities listed in the Program Monitoring section under “Grantee Activities.” Discuss how the applicant will ensure that sufficient staff is assigned to this activity and how the staff responsible for data collection, entry, and analysis will*

*be adequately trained and supported. Describe how the applicant will identify and meet any technical assistance (TA) needs associated with meeting the monitoring requirements.*

Presently the HIV prevention program employs three prevention initiative coordinators that provide program monitoring activities. Each coordinator is assigned programs by at-risk population as follows:

Beverly Mitchell coordinates prevention initiative targeting HRH, Minorities, and Inmates and Parolees.

Michael Hambrick coordinates prevention initiatives targeting IDU and MSM/IDU risk categories.

Tom Collins coordinates prevention initiatives targeting MSM and HIV positive risk categories.

All coordinators along with other prevention staff share the responsibility of scanning test forms. Mr. Collins oversees the training of new counselors and testers and aspects of the CTRS system. As a part of assigned program management each coordinator will conduct eight site visits with each prevention specialist of the contracted agencies for their program. Site visits are conducted to monitor the delivery and effectiveness of prevention programs. Weaknesses observed during site visits will result in plans for corrective measures including additional training and capacity building assistance. Each program coordinator has received certification to provide necessary training for assigned interventions to contracted staff.

In addition to site visits each coordinator collects program data from each of contracted agency and enters that data into PEMS. Each coordinator has access to PEMS and

conducts monthly data entry. Data entered into PEMS is monitored in order to determine whether contractual obligations are being met. Mandated quarterly data submissions to CDC are conducted by Mr. Collins who serves as the PEMS coordinator.

The coordinator process is set up in this manner to help keep prevention activities flowing smoothly throughout the contract period. HIV prevention programs in Kentucky are experiencing high turnover rates. Our system provides access to training in a timely manner when new staff members are brought onboard. It is our goal to make sure that all new hires are completely trained within 90 days of their hire date.

Our system facilitates early recognition of programmatic errors, failure to complete contracted interventions, and failure to submit data. Each coordinator is responsible for assuring that interventions are completed with fidelity to the respective program and in a timely manner. Data regarding these interventions is submitted to the Department by the 15<sup>th</sup> of each month following the service delivery. Coordinators provide technical assistance to agencies not meeting these goals.

The three program coordinators were not originally intended to be responsible for the CTRS system. The additional responsibilities have decreased the amount of time available to devote to their respective programs. CTRS was housed within the STD program of the Kentucky Department for Public Health, but was moved to the HIV/AIDS Branch when the new scanning system went into effect in 2008. It is essential that the state has a dedicated staff-person assigned to CTRS since the scope of CTRS is so large and so important to all other aspects of HIV prevention. This staff-person will be responsible for ordering and distributing testing materials, communicating with and

coordinating testing activities with all testing sites, and compiling and analyzing reports from the CTRS database.

*b) Describe plans to assure the quality, security, and confidentiality of HIV testing data and other HIV prevention intervention, client, and agency and budget data. Please utilize the HIV Prevention Program Data Security and Confidentiality Guidelines where applicable.*

The HIV Prevention Program Data Security and Confidentiality Guidelines are strictly adhered to without exception. All individuals with access to data signs the appropriate confidentiality agreements and are annually trained in Health Insurances Portability and accountability Act (HIPAA) regulations as well as applicable state statutes. All requirements for the security of these data are strictly maintained.

**CTRS/PS - Partner Services:** The STD Program maintains quality assurance for partner service activities through the utilization of quarterly audits. Front-Line Supervisors (FLS) in each regional area observe and review DIS activities in a variety of functions such as interviewing, field investigations and case management. Audits are intended to identify deficiencies and strengths in DIS skill sets as well as ensure adherence to security/confidentiality policies. Verbal and written feedback is provided to each DIS regarding skill strengths and deficiencies. DIS who are identified with deficiencies are provided specialized training by their FLS. A quarterly assessment of DIS performance outcomes will also be performed by regional FLS. The assessment will include items such as timeliness to interview, partner index, and partner exam rates. The element of “linkage to care” will be an added variable to the Interview, Case Management and Re-interview case management forms. In addition, “linkage to care”

information will be added to case management forms and each FLS will review cases for completion and accuracy. “Linkage to care” information will be communicated to the central STD office in Frankfort via the STD “Interview Record” and captured in the STD\*MIS system. HIV partner services information will be downloaded into the PEMS data base after the implementation of STD\*MIS 5.0.

- c) Provide a description of local program monitoring and data management system functions and copies of statewide uniform data reporting forms, if they exist*

The HIV Prevention Coordinator conducts annual monitoring visits for program performance and contract compliance. Desk monitoring and review of submitted invoices is conducted monthly. Independent audits are required by contract annually. KDPH has established a committee to discuss and review issues related to rapid testing in Kentucky.

- d) Describe planned quality assurance efforts regarding CTRS, PS, HE/RR, data collection, training, procedures, and any other relevant programmatic areas for which the applicant has quality assurance plans. Describe how data collected through the monitoring process will be used to continually assess and improve program performance.*

**CTR** - The STD/HIVCT Program office and area supervisors will closely monitor all CTS activities. Personal visits and audits will be made to CTS when it is observed that deficiencies exist or if complaints are received about the quality and/or sensitivity of services provided. All activities conducted in CTS will be closely monitored by area supervisors and administrative staff to ensure that counseling is nonjudgmental, sensitive to the needs of patients and effectively communicates risk reduction information,

especially to those who are infected or at increased risk. The performance of counselors will be monitored and remedial steps taken when indicated.

**PCRS** - Audits of DIS by the area supervisor will be documented on appraisal sheets specifically designed for measuring effectiveness of counseling and investigations.

Copies are sent to the STD Program office. STD management staff will consult with the area supervisor about any DIS who consistently shows weakness in counseling and investigations to determine the necessary steps for improved performance.

**HE/RR** - The quality assurance plan for HE/RR includes periodic review of program materials, prevention strategies and data. KDPH will also conduct periodic observation of Prevention Specialists during interventions with a checklist for program content and materials. Client file audits will be conducted for Prevention Case Management.

Unscheduled visits are also conducted periodically for observation and quality assurance.

**Data collection** - CDC data forms are collected monthly from Prevention Specialists by KDPH Initiatives Coordinators during scheduled visits.

**Training** - Training is scheduled quarterly and is mandatory for Prevention Specialists funded under this grant application. This allows for networking and the increased capacity and skill building of Prevention Specialists.

**Procedures** - Individual care plan forms are standard across the state and will be reviewed by KDPH Initiatives Coordinators during client file reviews.

- e) Describe plans to ensure that sufficient staff is assigned to this activity and how the staff responsible for data collection, entry, and analysis will be adequately trained and supported.*

Program coordinators use contracts to develop a scope of work (which includes quality assurance and adherence to policies and procedures) for each contracted agency.

Supervisors of these agencies are required to attend a meeting with program coordinators and the grant administrator to assure that the supervisors are knowledgeable of the scope of work. The grant administrator will conduct agency reviews with the supervisor quarterly.

In addition to site visits each coordinator collects program data from each contracted agency and enters that data into PEMS. Each coordinator has access to PEMS and conducts monthly data entry. Data entered into PEMS is monitored in order to see if contractual obligations are being met. To ensure fidelity, contracted agencies must submit mandated electronic data submissions monthly. Coordinators also provide a monitoring form to help ensure that agencies are following policies and procedures. Information is also disseminated through quarterly trainings.

The grant administrator and the prevention coordinators analyze the data received from agencies to assess program performance. This information is compiled in an annual review and state staff present data for KHPAC to consider in future prioritizations and planning processes.

4) *Capacity-Building Activities*

- a) *The applicant should discuss how they will assess (for the first time, as well as update) capacity-building needs throughout the project period. Discuss any plans to assess the capacity-building needs of funded HIV prevention service providers or any partners.*

It should be noted that Kentucky has not conducted a full and formal capacity building assessment, questions regarding capacity were included in the 2007 Needs Assessment and the 2009 Statewide Coordinated Statement of Need (SCSN). The information gathered through these instruments will provide foundational data for a formal capacity building assessment to be conducted in year one of this grant. The time line involves the state developing a capacity building survey to be administered on an annual basis to all identified HIV stakeholders. These stakeholders are identified through the resource inventory which is continually updated. The survey will be used to determine capacity building needs. Contracted agencies will automatically be included in the capacity building survey. In year two the identified capacity building needs will be reviewed and prioritized by state prevention staff. Efforts to provide capacity building assistance will be made. Assistance may be provided by state staff or through requests for CBA from national providers. Identified CBA needs may require requests for assistance through the CRIS system which can make available assistance in each of the listed categories.

- a. *Describe any capacity-building activities with the health department, **HIV prevention** service providers, and other **prevention** agencies/partners including CBOs. Include the plan(s) if already developed.*

Identified capacity building needs will be reviewed and prioritized by state prevention staff. Efforts to provide capacity building assistance will be made. Assistance may be provided by state staff or through requests for CBA from national providers. State staff will collect evaluations of all capacity building assistance provided and determine if CB needs were met. If CB needs were not met, additional CBA will be pursued.

- b. Discuss plans to strengthen capacity-building activities over the two-year project period for this **program announcement**.*

Strengthening capacity-building activities has been identified CBA needs may require requests for assistance through the CRIS system which can make available assistance in each of the listed categories. All state staff is required to complete HIV testing and counseling training. Each staff member is also required to participate in at least 2 testing events per year.

The state provides 10 counseling and testing courses throughout the year (2 in Spanish). All state HIV testers must be certified for rapid testing. All licensed health care providers in Kentucky must receive state-approved continuing education on HIV/AIDS. CDC's routine HIV testing recommendations are a required part of these trainings, as well as information about rapid testing.

*5) **STD Prevention Activities***

*Describe plans to collaborate and coordinate with local **STD prevention** efforts, particularly as they relate to **HIV prevention** activities and screening and treatment for STD.*

All HIV prevention staff of the contracted agencies are provided STD cross-training. Likewise they are required to complete CTS certification. In providing CTS, clients are asked about STD histories, risk factors and symptoms. Frequent referrals are made for STD testing and treatment. Some of the Prevention Specialists are also DIS. This close association provides familiarity between HIV prevention efforts and STD referrals.

KHPAC has not directed any funding to the augmentation of STD detection services.

Most of our contracted HIV prevention providers cannot provide STD testing, but do conduct HIV rapid testing. During the counseling session which accompanies HIV testing, counselors ask about other STDs and make referrals for testing and treatment. All funded HIV prevention activities include components for other STDs. Cross-training is provided to all new hires of contracted agencies. The program highlights the close connection between HIV and other STDs and takes advantage of every opportunity to provide education and make referrals for testing and treatment.

None of the contracted CBOs provide PS. We provide training to all prevention personnel on PS and how to facilitate a referral for PS. We provided opportunity through state conferences, and encourage networking between prevention personnel and PS providers.

6) *Collaboration and Coordination*

*Describe plans to collaborate and coordinate with the programs and groups listed under activity 6 in the “Grantee Activities” section of this announcement.*

*Also, describe the intended outcomes of all collaboration and coordination efforts and plan to strengthen these activities over the two-year project period.*

Surveillance programs: Collaboration with surveillance programs can increase the number of persons offered HIV prevention services and can improve the quality of the data collected and reported through the surveillance program.

The Cabinet for Health and Family Services has recently created and filled a new position of Adult Hepatitis Prevention Coordinator. KHPAC will include this coordinator in its planning of future collaborative efforts.

7) *Laboratory Support*

*Briefly describe all laboratory support activities funded under this announcement, including participation of any laboratory(ies) in a performance evaluation program for HIV antibody testing, and the use of various testing technologies.*

Funds will be used to purchase supplies and materials for HIV testing including ELISA test kits, Western blot kits and controls and laboratory supplies including pipettes, gloves, shipping containers, biohazard labels and reagents for off-site testing. Laboratory services will be very much involved in developing protocol and establishing CLIA waivers for this new test.

8) *HIV/AIDS Epidemiologic and Behavioral Surveillance.*

*Complete this section only if requesting program funds to support this activity.*

*Describe any surveillance activities that will be conducted with support provided through this program announcement.*

Respond to the surveillance data needs of prevention program managers and CPGs. The needs include analysis, interpretation, and presentation of surveillance data; preparation of the epidemiologic profiles and other reports for use by KHPAC; and other related activities that directly improve and support the implementation and evaluation of HIV prevention activities. Although the Surveillance Cooperative Agreement provides support to jurisdictions to meet surveillance needs, funds under this announcement may be used to help support unmet HIV/AIDS surveillance activities as described above. CPGs must be involved in the decision-making process. Funds may also be used to address data gaps or unmet state or local needs for supplemental surveillance, HIV incidence surveillance, or behavioral surveillance.

Coordinate with surveillance programs to collect data needed for HIV incidence surveillance efforts.

In areas participating in CDC's National Behavioral Surveillance Program; collaborate with surveillance to assess exposure to, utilization of, and effect of HIV prevention programs.

Collaborate and coordinate with CDC for surveillance activities.

The CDC prevention grant pays for 65% of the surveillance technician position located in HIV/AIDS surveillance. The HIV/AIDS epidemiologist is responsible for the collection, review, analyzing and reporting on incidence and prevalence of HIV infection and AIDS within the state as mandated by law, as a basis for planning, implementation and evaluation of prevention and control programs. The epidemiologist also interacts with other state surveillance programs, local health departments, CDC and private health care community in acquiring information necessary to achieve these purposes. These data are provided to the HIV/AIDS epidemiologist and management staff. The surveillance technician also designs, recommends and implements procedures that produce HIV/AIDS surveillance data for county, state and national epidemiologic analysis of disease trends. This position plays an integral role between surveillance and epidemiologic activities. These duties require this position to be filled in order to ensure that all surveillance and epidemiologic activities can be completed.

The surveillance data collected by the HIV/AIDS surveillance section is analyzed by the epidemiologist and surveillance technician to aid in determining the picture of the epidemic in Kentucky i.e. racial/ethnic groups, risk factors, geographic locations, etc.

This information is then given to the HIV/AIDS prevention office and CPG to aid in

prioritizing where prevention efforts should go. Annually, a presentation is given to KHPAC to assist with this matter. These decisions help to guide efforts for the upcoming year.

*C. Summarize Unmet Needs*

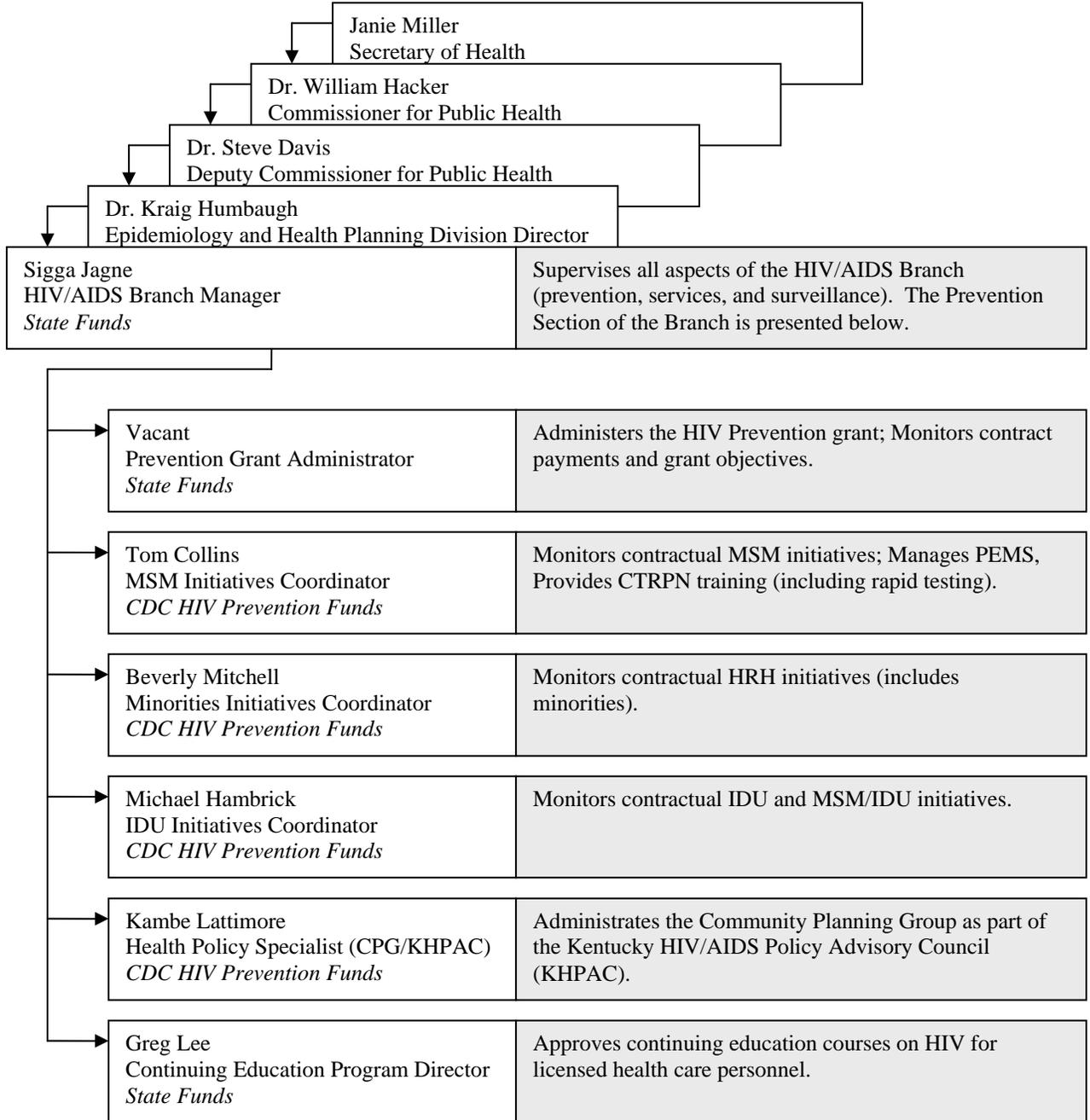
*Summarize any HIV prevention needs that will remain even if the total application is funded. Provide an estimate of funds required to meet these needs.*

The funds requested herein will allow the prevention program to continue; however, in order to adequately address reporting requirements while increasing the timeliness and completion of data a Data Manager would be a beneficial addition to the staff. To secure that position an approximate addition of \$100,000 to cover salary and fringe for that position would be necessary.

*D. Management and Staffing Plan*

*Describe the management and staffing plan to conduct or support the essential components of the comprehensive **HIV prevention program**. Please include an organizational chart that reflects the current management structure and a description of the roles, responsibilities and relationships of all staff in the **program**, regardless of funding source. Identify the positions supported through this cooperative agreement and those funded through other sources, as well as any unfunded staffing needs.*

## Kentucky HIV/AIDS Branch (Prevention) Organizational Structure



### ***Budget Information***

***The budget and budget justification is included as a separate attachment.***