HIV/STI PREVENTION SERVICE STANDARDS

Approved by COH on 4/11/24.

INTRODUCTION

Service standards outline the elements and expectations a service provider follows when implementing a specific service category. Service standards set the minimum level of care agencies should offer to clients. The Standards are intended to help agencies meet the needs of their clients. Providers are encouraged to exceed these standards. The Los Angeles County Commission on HIV (COH) developed the Prevention Service Standards to reflect current guidelines from federal and national agencies on HIV and Sexually Transmitted Infection (STI) prevention, and to establish the minimum standards of service delivery necessary to achieve optimal health among people with increased risk of HIV and STIs, regardless of where services are received in the County. Since there are many different types of organizations that may provide prevention services, not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STI testing only, will not necessarily be expected to provide adherence services for clients who are accessing pre-exposure prophylaxis (PrEP).

The development of the Standards includes guidance from service providers, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP), and members of the Los Angeles County COH, Standards and Best Practices Committee and the COH Prevention Planning Workgroup (2022-2023).

SERVICE DESCRIPTION

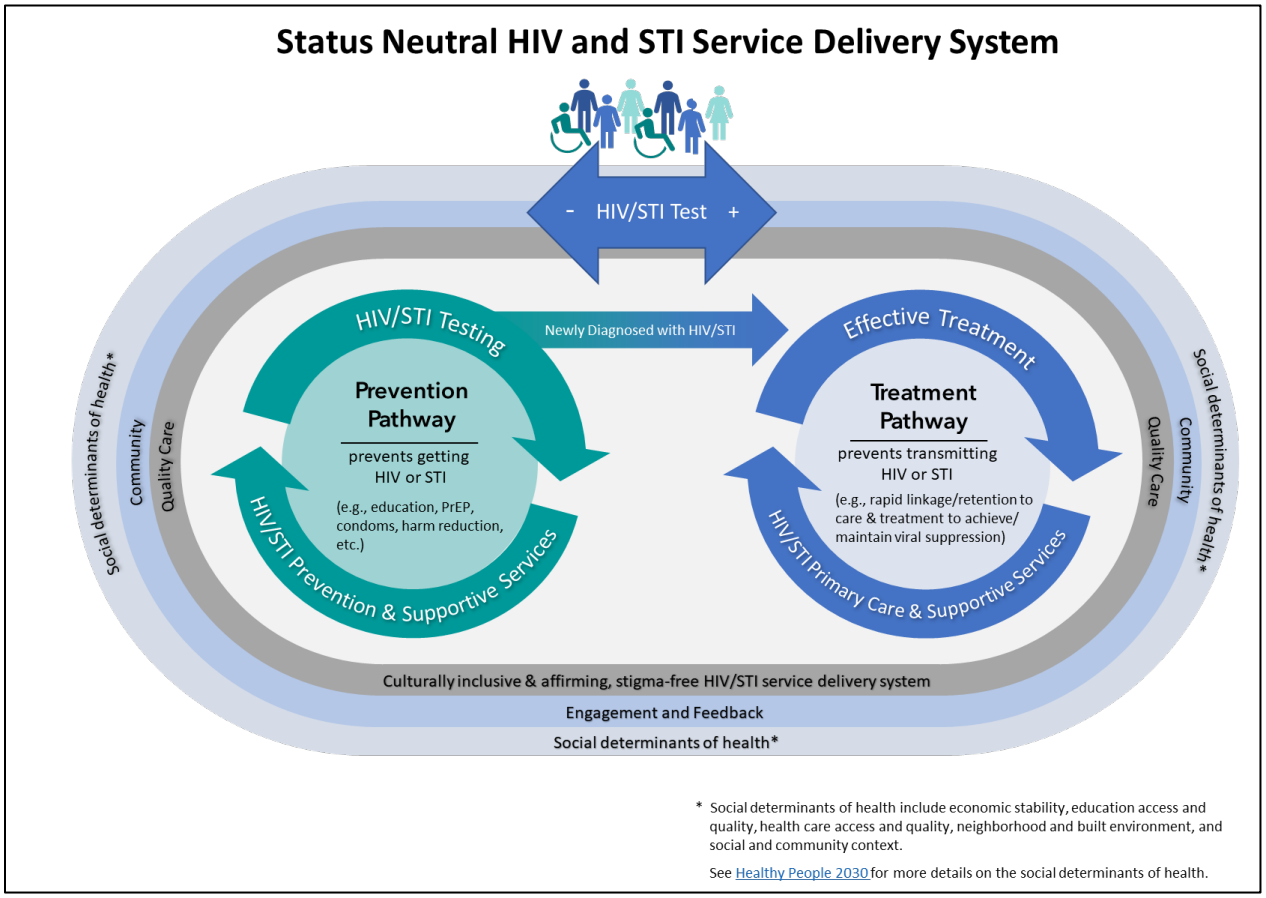
Prevention Services are those services used alone or in combination to prevent the transmission of HIV and STIs. The early diagnosis and treatment of STIs is vital to interrupting transmission of STIs as well as HIV. Prevention Services include HIV and STI screening, biomedical interventions, non-biomedical/behavioral interventions, social services, harm reduction, and medical interventions.

The Los Angeles County COH's *Status Neutral HIV and STI Service Delivery System Framework,* depicted in Figure 1 below, was used to guide the development of the Prevention Service Standards. The *Status Neutral HIV and STI Service Delivery System Framework* was developed in 2023 and adapted from the Centers for Disease Control and Prevention Status Neutral HIV Prevention and Care framework. This framework functions to provide an overview of the comprehensive support and care critical to addressing the social determinants of health that create disparities, especially as they relate to HIV and STIs. Continuous preventive, medical care and supportive services are highlighted as part of an ongoing effort by patient and provider to maintain engagement in clinical preventive care or treatment. A status-neutral approach to HIV care and prevention means that all people, regardless of HIV status, are treated in the same way. Engagement in the status neutral HIV and STI service delivery system starts with an HIV and/or STI test. Any result, positive or negative, initiates further engagement with the service delivery system leading to a common goal where HIV and STIs are neither acquired nor transmitted. The result is a dynamic trajectory into and through the continuum depending on test results. The figure emphasizes the continuous return of HIV negative persons to HIV/STI testing and linkage and engagement in care of persons diagnosed with HIV or STIs. When done

effectively, rapidly linking newly diagnosed persons to HIV/STI treatment and those who test negative to ongoing prevention services will result in the decrease of new HIV and STI infections. It will also support people with diagnosed HIV (PLWH) to thrive with and beyond HIV, and for those with diagnosed STIs to receive treatment and access to prevention strategies.

Figure 1 - Status Neutral HIV and STI Service Delivery System Framework

(Framework adapted from the Centers for Disease Control and Prevention Status Neutral HIV Prevention and Care framework)



The status neutral framework reaches beyond established HIV and STI prevention & care systems and works to create pathways to vital medical and supportive services that meet the needs of clients regardless of their HIV or STI status and is not centered solely around meeting disease-specific needs. The benefits of a status neutral approach include a reduction in institutionalized stigma for people with HIV (PWH), a reduction in stigma associated with STIs, increased efficiencies that improves resource utilization, and gained knowledge/insight from various service deliveries.

BACKGROUND

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

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV and STI infection. Therefore, a multitude of strategies (e.g., housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV and STIs. Since it is not feasible to create standards for every potential prevention service, the HIV and STI Prevention Service Standards described in this document focus on ensuring that every individual at risk of acquiring or transmitting HIV infection and/or STIs is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time. Additionally, given there are many different types of organizations that may provide prevention services, not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STI testing only, will not necessarily be expected to provide adherence services for clients who are accessing PrEP or Doxy PEP.

DEFINITION OF HIV AND STI PREVENTION SERVICES: HIV and STI Prevention Services are those services used alone or in combination to prevent the transmission of HIV and STIs. Prevention services may include:

- **Biomedical** HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among HIV-negative individuals (via PrEP and PEP). Additionally, biomedical STI prevention refers to prevention methods that use antibiotics (DoxyPEP) and vaccination to decrease the risk of STIs.
- **Non-biomedical** HIV and STI prevention refers to strategies that aim to alter behaviors that make individuals more vulnerable to HIV and/or STI acquisition.
- **Harm Reduction** refers to a set of strategies that reduce the harms associated with substance use. These strategies can reduce behaviors resulting in elevated risk of HIV infection among injecting and non-injecting drug users.

SUMMARY OF CORE PREVENTION SERVICE COMPONENTS: The HIV and STI Prevention Service Standards seek to ensure the provision of a core set of integrated HIV and STI prevention services aimed at preventing the acquisition and transmission of HIV and STIs. The Core Prevention Service Components are Screening and Assessments, Biomedical Prevention, Harm Reduction (drugs, alcohol use and sexual activity), and Non-biomedical/Behavioral Prevention. These Core Prevention Service Components are complementary and should be used collectively to maximize prevention efforts.

UNIVERSAL STANDARDS FOR HIV AND STI PREVENTION SERVICES

UNIVERSAL STANDARDS FOR HIV AND STI PREVENTION SERVICES: In order to achieve the goal of reducing new HIV and STI infections, prevention services in Los Angeles County must include the following universal standards:

- Staff members meet the minimum qualifications for their job position and have the knowledge, skills, and ability to effectively fulfill their role and the communities served. If a position requires licensed staff, staff must maintain licensure to provide services.
- Staff participation in trainings appropriate to their job description and program including, but not limited to partnering with LGBTQ+/Transgender community, HIV Navigation Services (HNS), STI transmission and treatment, trauma-informed care, Narcan/naloxone use, fentanyl testing, cultural competence, and implicit bias.
- Provide services that are accessible and non-discriminatory to all people with a focus on highly impacted populations.
- Educate staff and clients on the importance of screening, biomedical prevention, non-biomedical prevention, and harm reduction to reduce the risk of HIV and STI transmission.
- Protect client rights and ensure quality of services.
- Provide client-centered, gender-affirming, age appropriate, culturally, and linguistically competent service delivery.
- Provide high quality services through experienced and trained staff.
- Meet federal, state, and county requirements regarding safety, sanitation, access, and public health.
- Guarantee client confidentiality and protect the right of client autonomy.
- Prevent information technology security risks and protect patient information and records.
- Inform clients of services and collect information through an intake process.
- Effectively assess client needs and encourage informed and active participation.
- Address client needs through coordination of care and referrals to needed services.
- Ensure that the quality of service and materials given to patients during telehealth encounter is similar with in-person visits.
- Attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.
- Address the social determinants of health such as economic and social conditions that influence the health of individuals and communities.
- Use a strength-based approach to service design and seek to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life.
- Ensure a sex positive environment and interaction with clients.
- Adopt trauma-informed approaches to interacting with patients.

Screening and Assessments

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Intake	Initiate a client record at first clinic visit or client interaction.	Intake tool in client file to include (at minimum): • Documentation of HIV/STI status (if applicable) • Proof of LA County residency or Affidavit of Homelessness • Verification of program and financial eligibility (if applicable) • Date of intake • Client name (lived name if applicable), pronouns, home address, mailing address and telephone number • Emergency and/or next of kin contact name, home address and telephone number • Signed and dated Release of Information, Limits of Confidentiality, Consent, Client Rights and Responsibilities
Assessment	Comprehensive assessments are completed in a cooperative process between staff and the client during first visit/appointment. Alternatively, clients may complete online assessments prior to their first visit. Comprehensive assessment is conducted to determine the: • Client's needs for prevention and medical services, and support services including housing and food needs • Client's current capacity to meet those	Comprehensive assessment on file in client chart to include: • Date of assessment • Signature and title of staff person conducting assessment • Completed assessment form Client strengths, needs and available resources in the following areas: • Medical/physical healthcare • Medications and Adherence issues

	needs/identify barriers that address needs • Client's medical home • Ability of the client's social support network to help meet client needs • Extent to which other agencies are involved in client's care	• Mental health • Substance use and/or substance use • HCV/HIV dual diagnosis, if applicable • Nutrition/food • Housing and living situation • Family and dependent care issues • Gender Affirming Care including access to hormone replacement therapy, gender affirming surgical procedures, name change/gender change clinics and other related services. • Transportation • Language/literacy skills • Religious/spiritual support • Social support system • Relationship history • Domestic violence/Intimate Partner Violence (DV/IPV) • History of physical or emotional trauma • Financial resources • Employment and Education • Legal issues/incarceration history • Knowledge/beliefs about HIV/STIs/Hepatitis • Agencies that serve the client and/or household
	Staff will conduct reassessments with the client as needed.	• Date of reassessment • Signature and title of staff person conducting reassessment

		• Completed reassessment form
HIV Testing	Staff will conduct appropriate HIV and/or STI tests based on sexual health history or client request.	Documentation of HIV/STI testing in client file and data management system.
	HIV/STI testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge/written consent.	Documentation of patient consent as required or appropriate.
	Provide immediate and, if necessary, repeated, linkage services to persons with a preliminary positive HIV test result or a confirmed HIV diagnosis.	Documentation of linkage to care.
Testing and Treatment of STIs	Assess patients risk for STI acquisition.	STI risk assessments on file.
	Provide or partner with agencies that provide treatment for patients to test positive for an STI	Documentation of STI treatment plan and medication prescriptions. If referring to other agency, Memorandum of Understanding (MOU) on file.
	Ensure client is linked to services that cover the cost of treatment.	Documentation of linkage to services.
	Conduct follow up testing 3 months after positive test to ensure STI has been treated appropriately.	Documentation of follow-up.
	Provide or partner with agencies that provide vaccination for HPV and Hepatitis B, as recommended.	Vaccination record.

BIOMEDICAL PREVENTION

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Treatment as Prevention (for PLWH)	Provide antiretroviral treatment (ART) to persons with diagnosed HIV within 3 days of diagnosis.	Documentation of treatment and prescription orders on file.
	For patients who choose to postpone treatment, periodically reoffer ART after informing them of the benefits and risk of currently recommended regimens.	Documentation of care follow-up and timeline.
	Enroll patients in health insurance or medical assistance programs that provide HIV care or cover costs of care.	Documentation of referrals or appointments with benefits specialists.
	Offer navigation assistance and support to encourage active participation in care.	Documentation of navigation assistance and/or referral.
	Establish procedures to identify patients at risk for lapses in care or services that support their continued care.	Documentation of chart reviews and internal procedures for maintaining engagement in care.
PrEP/PEP	Assess a client's risk of HIV acquisition.	Risk assessments on file.
	Provide clients with a PrEP/PEP Navigator/Navigation Services	Documentation of service in client files.
	Provide PrEP prescription that addresses the specific needs of the client.	Documentation of service in client files.
DoxyPEP	Assess a client's risk of STI acquisition.	STI risk assessments on file.
	Provide DoxyPEP prescription to clients at risk of STI acquisition.	Documentation of STI treatment plan and medication prescriptions.
Partner Services	Identify client's recent sexual and/or injection drug use partner(s).	Documentation of partner services offer.
	Notify partner(s) of potential exposure to HIV and/or STI.	Documentation of partner notification.
	Offer appropriate HIV and/or STI treatment and care plan to partner(s).	Documentation of treatment provided to partners.
	Conduct follow up to ensure partner(s) adherence to treatment/care.	Documentation of follow-up.

	Refer clients to expedited partner services, as needed.	Documentation of referral.

HARM REDUCTION (drugs, alcohol use and sexual activity)

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Narcan/Naloxone	Partner with agencies/organizations to provide training to clients on how to use nasal Narcan and/or injectable naloxone.	Documentation of training.
	Partner with agencies/organizations to provide free or low-cost Narcan and/or naloxone to clients.	Documentation of Narcan/naloxone distributed.
Fentanyl Test Strips and Other Substance Testing Kits	Partner with agencies/organizations to provide training to clients on how to use fentanyl test strips, and other substance testing kits.	Documentation of training.
	Partner with agencies/organizations to provide free or low-cost fentanyl test strips and other substance testing kits.	Documentation of test strips distributed.
Syringe Services Programs	Partner with agencies/organizations to provide syringe services that include: • Needle exchange • Safe disposal • Nasal spray Narcan • Injectable naloxone • Condoms • Wound care kit • Safer smoking supplies (e.g. pipes, mouthpieces, cleaning supplies)	Documentation of items collected and/or distributed.
Peer Support	Provide referrals and assist with linkage to peer support as related to substance use disorder.	Documentation of referral.
Contingency Management	Provide referrals and assist with linkage to Contingency Management programs for stimulant use disorder.	Documentation of referral.
Mobile/Street Medicine	Provide mobile and/or street medicine to clients, where feasible.	Documentation of schedules, services provided/used, etc.

Medication Assisted Treatment (MAT)	Provide MAT for clients identified with substance use disorder, as appropriate per provider assessments.	Documentation of treatment provided.

NON-BIOMEDICAL/BEHAVIORAL PREVENTION

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Education/Counseling	Provide HIV and STI education. Sessions will focus on Health Education/Risk Reduction Prevention, Behavior Change Skills Building and increasing knowledge of access to care services based on the client's risk assessment. Sessions can be provided on a one-to-one basis or group setting depending on the client's preference, need and/or environment. Sessions can be conducted on an ongoing basis, depending on need, and can be from 1 to 3 weekly or semi-monthly sessions.	Documentation of program manuals and curricula.
	Provide PrEP/PEP education and counseling for clients at risk of HIV acquisition.	Documentation of program manuals and curricula.
	Provide DoxyPEP education and counseling for clients at risk of STI acquisition.	Documentation of program manuals and curricula.
	Provide education for PLWH on the importance of maintaining an undetectable viral load, the importance of adhering to care, and increase their capacity to engage their own care.	Documentation of program manuals and curricula.
	Offer free or low cost internal and external condoms and dental dams.	Documentation of safer sex supplies provided client.
Supportive Services	Assess the client's need for supportive services.	Completed assessment on file.
	Provide referrals and assist with linkage to supportive services. Services may include:	Documentation of referrals.

	• syringe exchange • housing services • mental health services • substance abuse services • food and nutrition support • employment services • unemployment financial assistance • drug assistance programs • health insurance navigation • childcare • legal assistance • other services, as identified and needed • health literacy education • peer support Referrals should be to local facilities, clinics, and service providers in the area of the client minimizing transportation barriers.	
Social Marketing and Outreach	Outreach to potential clients/families and providers.	Outreach plan on file.
	Collaborate with community partners and health care providers to promote services.	Documentation of partnerships.
Navigation Services	Provide navigation assistance for linkage to supportive services.	Documentation of services offered.
	Health Navigators will canvas the target areas to identify and document all available service providers that can be used as referral sources for clients.	Activity logs on file.
	Health Navigators will become familiar with the access, referral, and intake process to educate clients of this process when providing referral for services.	Training or resources identified by staff on file.
	Follow up session should be conducted to reassess clients' current situation and need for additional services.	Documentation of reassessment.