



**Strategic and Operational Plan for HIV Prevention
in King County**

Public Health – Seattle & King County HIV/AIDS Program

October 26, 2007

Executive Summary

The HIV/AIDS Program for Public Health – Seattle & King County has been a leader in working to reduce the impact of HIV and AIDS in our community through prevention and treatment services. Far too many have suffered from HIV/AIDS epidemic across the world and in our community, but with the help of many community partners we have been effective in reducing its local impact. Examples of this include:

- Holding new infections steady at between 350 and 400 per year, despite an increasing number of people living with HIV,
- Having one of the lowest percentages nationally of people with HIV in the country who are not receiving regular care (17.9%),
- Maintaining one of the lowest HIV infection rates among injection drug users, 2-3%, in major urban centers

We have made these accomplishments in a declining funding environment. In real dollars, HIV prevention programming funds have decreased 18% in the past ten years. Using our available funds most efficiently, we have continually adjusted our approaches to track the changing face of the epidemic.

While we have made a difference in curbing the spread of this epidemic locally, we can do better. In this document --the Strategic and Operational Plan for HIV Prevention in King County-- we are establishing a new, community goal for reducing the number of HIV cases and setting a strategy for how we can achieve it.

Our goal is to reduce new HIV infections in King County by 25%, from the current 370 to 280 cases per year, by 2015. This is a significant but achievable challenge for our community. To accomplish this goal, it will take new resources to reverse the downward trend in funding, and we will need to continue evolving in our approach. We will reprioritize and refocus our programs on areas where they will do the most good and address the current challenges. This strategy will also require a greater role for our governmental and community-based partners in testing, education and HIV-related health issues.

Not everyone is at the same risk for acquiring HIV, and our plan puts the greatest emphasis on those who are most likely to acquire and transmit the infection. As of June 30, 2007, 6,188 persons in King County are reported to be living with HIV or AIDS. Most affected are men who have sex with men (MSM), MSM who also inject drugs (MSM/IDU), other injection drug users (IDU), and foreign-born Blacks. Together, they make up 86% of all reported cases of HIV in King County.

To reduce HIV infections, our efforts will focus on two primary prevention goals that focus on those most at-risk.

The first goal is to identify new HIV cases among men who have sex with men (MSM), injection drug users, and foreign-born blacks. Identifying new cases is critically important to our strategy, because once people know their HIV status, they are much more likely to reduce their risk taking behaviors – by an average of 60% -- which will help to prevent the spread of the disease to others. It will also link HIV-positive people to life saving monitoring and treatments.

This goal will be accomplished by redoubling our efforts to provide HIV counseling and testing to the people at highest risk. We will intensify our case finding efforts and linkage to HIV treatment through enhanced testing technologies. We will also promote routine testing and advocate for policy changes that will support all of these efforts.

HIV testing is important, but is not a comprehensive solution to the epidemic. Some people act in ways that put others at risk, often driven by drug and alcohol use. Because of the gap in time from infection to testing and diagnosis, people with previous HIV negative tests may be at risk for transmitting new infections.

Our second prevention goal addresses the behaviors that sustain HIV transmission by promoting behavior change among high-risk populations. By increasing the visibility of HIV in the highest risk communities, we will help people understand the danger and act to protect the health of themselves and their partners. We will increase targeted interventions to at-risk populations and make drug treatment options more available, as drug use significantly increases the risks for contracting HIV. HIV-positive persons will also be linked to care and antiviral treatment that may reduce their infectiousness and prolong their lives.

This plan builds on the efforts and achievements of our program and our partners over many years to reduce the devastating toll of HIV and AIDS on individuals, families and the community. Through this plan, we are taking the next step in our efforts to lower levels of HIV infection in King County. This is an ambitious goal, and it will require new resources, an evolution in our approach and a commitment from across our community to create a healthier future.

HIV/AIDS Program Operational Plan for 2008-2015

The Public Health HIV/AIDS Program Strategic and Operational Plan for HIV Prevention in King County will guide HIV prevention funding decisions for the next seven years.

The ultimate goal of this plan is to reduce new HIV infections in King County by 25% by 2015. The plan fully incorporates the following:

- our most recent HIV prevention planning processes which are contract requirements for the majority of our HIV prevention funding
- the findings and recommendations of the Board of Health HIV/AIDS Committee, including their recommendation to set numeric goals and outcome indicators; and
- new strategic directions proposed by the Centers for Disease Control

Review of HIV Prevention Planning Processes

Two important planning processes inform the development of HIV/AIDS Program activities. First, the HIV/AIDS Program leads an annual process with the participation of current fund recipients and Prevention Division Leadership to determine allocation of about \$2.7 million of Omnibus and CDC funds to internal Public Health programs. This “internal” process generally begins in late winter and funding recommendations are made for Director approval in time for the annual King County budget process. Prior to the 2007 process, at the suggestion of HIV/AIDS Program leadership, the HIV prevention planners developed a long term planning process and convened an expert staff committee which began meeting in December 2006. This committee developed the **“HIV Prevention Strategic Plan for Internal Funding”** (Attachment A). This plan clearly identifies guiding principles and strategic direction for internal HIV prevention activities, i.e. those funded directly within Public Health. The committee’s process included a systematic review of the local HIV epidemiology and trends; a review of HIV prevention programs currently in place; reviews of the literature on HIV prevention for high-risk populations; a survey of other comparable health departments; and these experts’ determination of HIV prevention internal funding goals, outcome and process objectives, and priorities. Although this more comprehensive plan was initiated before the April 2007 Board of Health draft report, this plan has subsequently been modified to better address the Board of Health Committee draft report and recommendations. Following changes to address the Board of Health report, the revised plan was vetted again with the expert staff committee (July 2007).

The second regular planning process is the bi-annual community prevention planning process. Every other year, as required by CDC and Washington State DOH, the Seattle HIV/AIDS Planning Council convenes a Prevention Prioritization Committee to develop a two-year HIV prevention plan. This plan directs use of 100% of CDC HIV prevention funds and 50% of AIDS Omnibus funds. The Council develops and approves a plan which specifies and prioritizes up to 10 distinct priority populations in need of HIV prevention; it also specifies the kinds of prevention interventions which can be funded

for these populations. The HIV/AIDS Program uses this plan to develop a competitive request for proposals process for community-based agencies. Successful applicants are awarded two-year contracts.

In spring 2007 the Council developed and approved its **2008-2009 King County HIV Prevention Plan** (Attachment B), and the HIV/AIDS Program is now in the process of carrying out the plan. Public Health will announce funding awards for programs serving priority populations with priority interventions in fall 2007, with contracts beginning on January 1, 2008.

The two plans described above guide the **HIV/AIDS Program Operational Plan for 2008-2015**. The Operational Plan establishes specific program goals, measurable objectives with numeric targets and program activities. This plan's seven-year span is in alignment with the Board of Health subcommittee's recommendation that we establish five to seven year community-wide goals.

Epidemiology of HIV/AIDS in Seattle-King County

As of June 30, 2007, 6,188 King County residents were reported living with HIV or AIDS. "Reported" cases are those that have been diagnosed in King County and reported to Public Health. This is lower than the number of people estimated to be living with HIV or AIDS (most recent estimate, 7200 to 7800) because 1) some people are unaware of their infection because they have not tested or not received their HIV-positive test result, 2) some have tested anonymously and not been reported; and 3) some have not yet been recorded in the HIV surveillance system. As of August 2007, King County epidemiologists believe that 10 – 20% of all HIV-infected persons in King County (720 to 1560) are unaware of their diagnosis or unreported at this time. The following discussion of the epidemiology in King County uses reported cases rather than the estimated number of people who are infected with HIV. We use reported cases because the *actual* number of cases is unknown and likely varies by sub-population. We do not have enough information about these variances to provide accurate subpopulation estimates. The case report data, on the other hand, are very reliable.

In accordance with the CDC Community Planning Guidance, the Seattle HIV/AIDS Planning Council, in collaboration with HIV/AIDS Program staff, prioritized the top populations for which HIV prevention services could have the greatest impact to reduce new infections. The **2008-09 King County Prevention Plan** prioritizes 8 populations: HIV+ persons, White MSM, foreign-born Blacks, Latino MSM, Black MSM, MSM/IDU, IDU, and young MSM (see Table 1). The prioritized populations, excluding the HIV+ category, address at least 86% of all reported cases of HIV in King County. The average reported prevalence in these populations is 7.5% compared to an average reported prevalence of 0.4% for King County as a whole. Clearly, the Prevention Plan captures the populations most impacted by HIV in King County.

The King County epidemic is concentrated in the MSM population, with five of the eight priority populations focusing on MSM. White MSM is the category with the greatest

number of living cases (3,032 or 49% of all reported HIV+ cases), while the remaining priority populations each comprise between 5% and 9% of the total.

- *Incidence:* White MSM also have the highest annual incidence, with an average of 151 new cases reported between 2003-05. Foreign-born Blacks, the only priority population with an increasing share of all people living with HIV, have the next highest average annual incidence with 31 new cases. The average number of new infections in the remaining populations ranges between 19 and 29 new cases.
- *Prevalence:* HIV prevalence is highest among MSM/IDU. Public Health estimates that 16.8% of MSM/IDU are infected with HIV with an even higher prevalence, approximately 35%, for those MSM who inject crystal methamphetamine. The prevalence in the remaining priority populations are, in descending order: Black MSM (15.8%), Latino MSM (14.7%), White MSM (12.6%), young MSM 15 - 24 (7.9%), IDU (2.5%), and foreign-born Blacks (1.8%).
- *Late diagnoses:* Thirty-three percent of newly diagnosed HIV+ persons receive an AIDS diagnosis within 12 months of being diagnosed with HIV. Within the priority populations, a racial disparity exists in late diagnosis, with 48% of foreign-born Black cases and 46% of Latino MSM cases receiving a late diagnosis. White MSM and MSM/IDU are less likely to receive a late diagnosis. (Young MSM are also less likely to receive a late diagnosis, but we believe this is more a function of their age than of special case finding efforts or testing behaviors in this population.)
- *Health disparities:* HIV/AIDS disproportionately impacts some communities of color in King County, especially foreign-born Blacks, Latino MSM and Black MSM. Blacks overall have the highest per capita rate of HIV infection of any racial group in King County at about twice the white rate. Within the increasing numbers of cases amongst Blacks, we have recently identified and begun to describe an emerging epidemic within a rapidly growing population of foreign-born immigrants, primarily from Sub-Saharan Africa, where HIV and AIDS exists in staggering numbers. King County Latinos and Native Americans also have higher rates of HIV infection than whites, but Asians and Pacific Islanders so far have much lower rates of infection than whites.

Table 1
Epidemiologic Indicators for the Eight Priority Populations

POPULATION (in priority order)	Reported number living w/HIV 6/30/07	Percent of total number of HIV+ persons	Average annual number of newly diagnosed cases, 2001-05	Estimated population size	Estimated prevalence of reported cases	Average number (and %) of late diagnosis 2001-05
HIV+ (all reported cases)	6,188	100%	357	n/a	100.0%	119 (33%)
White MSM, age 24-69	3,032	49%	151	24,044	12.6%	43 (28%)*
Foreign Born Black, age 15-69	293	5%	31	16,153	1.8%	15 (48%)*
Latino MSM, age 24-69	328	5%	22	2,077	14.7%	10 (46%)*
Black MSM, age 24-69	299	5%	19	1,783	15.8%	8 (39%)
MSM/IDU, age 15-69	529	9%	29	3,000	16.8%	6 (20%)*
IDU, age 15-69	360	6%	22	14,249	2.5%	9 (39%)
Young MSM, age 15-24	461	7%	20	5,842	7.9%	3 (14%*)

NOTES:

1. All age groups are based upon age at diagnosis of HIV.
2. Only reported cases are included in this analysis.
3. Population estimates distributed according to the 2004 American Community Survey.
4. Percent late diagnosis is defined as percent diagnosed with AIDS within 12 months of HIV diagnosis, among 1,738 cases diagnosed with HIV 2001-2005.

*Statistically significant difference compared to percentage for all HIV+.

The Current Funding Picture

Over the past 13 years, Public Health's state and federal HIV prevention funding has declined by 18.1% when adjusted for inflation (City and County revenues for HIV prevention fluctuate annually and are generally earmarked for specific services). In order to increase the effectiveness of these declining revenues, the HIV/AIDS Program has routinely adjusted its allocations toward more highly effective prevention services for the highest risk populations. These services are listed in priority order:

- *Case finding among MSM and MSM/IDU:* The HIV/AIDS Program has consistently funded HIV counseling and testing services (HIV C/T) at Public Health's Harborview STD Clinic. In addition to HIV C/T for high- and moderate-risk clients at the clinic, the STD Clinic funds have included outreach testing in bathhouses and sex clubs and a peer referral HIV testing program for MSM/IDU called Project Unite. The STD Clinic tests more MSM than any other single venue within Public Health and finds approximately 75 newly identified cases of HIV each year, more than any other single site. The clinic is also one of Public Health's primary sources of behavioral surveillance data, and is currently conducting a pilot program to provide a health promotion intervention to provide intensified counseling and encourage more frequent testing for the highest risk MSM who use the clinic.

Case-finding dollars have also funded community-based testing for MSM and MSM/IDU, first through the Seattle Gay Clinic and more recently through Gay City Health Project. In 2006, Gay City tested 1,624 MSM and found 27 newly identified cases of HIV infection. In order to reduce inter-test interval among highest risk MSM and MSM/IDU, the HIV/AIDS Program is conducting a pilot program through Gay City. This program focuses on actively encouraging the highest-risk MSM to test every three months and bringing in MSM who haven't tested in the last two years, and learning why MSM are not testing more frequently.

- *Early identification of new infections:* Beginning in 2003, Public Health began performing nucleic acid amplification testing (NAAT) on all blood specimens taken from men who have sex with men seeking testing at the STD Clinic and Gay City. Through NAAT testing, Public Health identifies approximately 11 new cases of HIV per year, providing early identification of cases that would not have been discovered through standard HIV testing. Early identification is important because it allows people who are newly infected with HIV to know their HIV status, engage in appropriate medical care, and change their behaviors when they are in an acutely and most highly infectious stage of their disease. The HIV/AIDS program is increasing funding for NAAT testing in 2008.
- *Case finding among foreign-born Blacks:* Since foreign-born Blacks first emerged as a population at higher risk for HIV infection, the HIV/AIDS Program has implemented several pilot programs to increase testing in this population. In 2004 and 2005, we organized a soccer tournament ("Kick Away HIV") that brought together soccer teams from various African and Caribbean communities and promoted HIV C/T to the teams and spectators. While a very popular event, the soccer tournaments did

not yield an increase in testing or case finding sufficient to justify the cost. In 2006, we shifted our effort to work with the International Clinic at Harborview to institute routine HIV C/T for the clinic population, which has a large caseload of African immigrants. This proved difficult to implement and also did not yield adequate testing or case finding.

In our continuing effort to increase HIV C/T among foreign-born Blacks, we are funding a pilot program through the Center for MultiCultural Health (CMCH) to provide outreach testing to African immigrant communities. CMCH has provided HIV prevention services to this population for three years and has established connections with community groups, businesses, and mutual associations. The agency will use these relationships to promote HIV C/T to members of the communities and provide confidential testing at the Urban League building and through outreach to specific venues. Continued funding will be contingent upon the agency's demonstrated ability to reach the populations with C/T services.

- Partner Counseling and Referral Services (PCRS): Over the last two years, the HIV/AIDS Program has increased its attention to and funding for PCRS (formerly known as partner notification services). Current PCRS services find seven new cases of HIV per year. In 2008, the STD Clinic, which conducts PCRS, will more widely implement the service in order to find more cases. We are also working with the AIDSNET Council and DOH on a PCRS Improvement Plan, which among other things will advocate for changes to the Washington Administrative Codes to make PCRS for HIV more routinely applied, more timely, and more effective.
- Syringe exchange: Public Health manages syringe exchange and currently operates six sites in King County: four within the City of Seattle and two in south King County. The program exchanges 1.8 to 2 million syringes and provides 50,000 individual encounters to an estimated 6,000-7,000 unduplicated IDU per year. In addition to providing new sterile syringes in exchange for used ones, the program provides a range of clinical and educational harm-reduction services including screening and counseling for HIV, hepatitis, syphilis, other blood-borne infections and tuberculosis. An overwhelming and consistent body of research supports the efficacy of syringe exchange in reducing HIV transmission by injection drug users without encouraging or increasing drug use. HIV infection rates among injection drug users have been shown to decrease 5.8% per year on average in cities with syringe exchange programs, whereas infection rates increased 5.9% in cities without syringe exchange programs. IDU incidence in King County has been stable at 2 – 3% for the last twenty years. The HIV/AIDS Program also helped change laws to enable pharmacists to sell sterile injection equipment to IDUs who may not access needle exchange programs.
- Case finding among IDUs: The HIV/AIDS Program began funding increased HIV testing at the King County Jail and the Regional Justice Center in 1998. The program has provided testing mostly for injection drug users. Because of low case finding rates, funding for this program will be reduced in 2008 providing fewer HIV tests and increasing the emphasis on surveillance and providing prevention

counseling for HIV+ inmates. This will free up resources to be used for case finding in higher risk populations.

- *Behavioral interventions:* Behavioral interventions are planned health promotion interventions designed to help high-risk populations cease or reduce high-risk sexual and drug-using behaviors. Locally, we have offered behavioral interventions since the epidemic was first identified in 1983. The HIV/AIDS Program has always emphasized community involvement in population prioritization and intervention development and delivery. With the 1993 advent of the CDC Community Planning Guidance, the HIV/AIDS Program has worked with the Seattle HIV/AIDS Planning Council, our local community planning body, to shift funding toward interventions for high-risk populations. For example, funding for lower-risk heterosexual populations has decreased dramatically over time. In 2002, we allocated 17% of the community funding pool to heterosexual populations. In 2008, we will allocate 10% to the highest risk heterosexual population, foreign-born Blacks.

Most behavioral interventions are currently provided by community-based providers. We currently fund five individual level, two street and community outreach, five community level and two mass media/Internet interventions. The individual level interventions (prevention case management and risk reduction counseling) all target the highest risk groups, men who have sex with men and/or HIV-positive persons. A competitive Request-For-Proposal (RFP) process, based on the **2008-09 Prevention Plan** (Attachment B), will direct 2008-09 funding for community-based prevention education services to the populations most at risk for acquiring or transmitting HIV. In order to focus the applications to better address the HIV/AIDS Program goals, the RFP now requires agencies to develop measurable objectives for at least one Public Health-defined goal and it prioritizes intervention types that we believe will have the best chance of reducing new HIV infections. A non-conflicted review panel will evaluate proposals in early September 2007, with awards being announced by the end of September.

- *Routine HIV testing:* In response to the September 2006 CDC guidance promoting routine testing to find previously undiagnosed cases of HIV, the HIV/AIDS Program is currently piloting a provider outreach campaign targeting community clinics. We have begun work with Harborview and will work with selected community and PH clinics to identify barriers to routine testing and provide technical assistance. We have already obtained from the support of the King County Medical Society for routine HIV screening by County providers, and we have worked with DOH to develop informational materials to facilitate this effort.

The ultimate goal of the HIV/AIDS Program's prevention programming is to prevent the transmission and acquisition of HIV. Over the last decade, the number of newly diagnosed infections has consistently remained between 350 and 400 cases. In the face of declining resources, and an increasing population of HIV-infected people who are living longer with the disease and able to transmit it to those who are uninfected, this represents a success for our current HIV prevention efforts. Without any additional

funding or major changes to our programming, we expect to be able to maintain a stable level of new infections in spite of the growing population of HIV-infected individuals.

How Can We DECREASE New Infections in King County?

KING COUNTY HIV PREVENTION GOAL	Year	Target
By 2015, decrease the annual number of new HIV infections (HIV incidence) in King County by 25%.	2015	280
	2013	305
	2011	330
	2009	350
	2007	Baseline = 370*

* 352 cases per year is the average number of *newly diagnosed* reported infections for years 2003-2005. Because some new infections are undiagnosed, the baseline is higher than this average. These targets will be adjusted for local population increases or decreases.

Data: Epi HIV-AIDS Reporting System (HARS, surveillance)

The HIV/AIDS Program has undertaken this strategic planning process to more efficiently allocate our resources in order to reduce new infections below the current level of 350-400 per year. To focus our efforts, we have adopted a set of goals and outcome objectives to guide our decision making. We have set a community-wide goal of reducing the annual number of new HIV infections by 25% by 2015. Using the most recent years for which we have complete surveillance data (2003-05), the average number of newly *diagnosed* infections in King County stands at 352. To create a baseline, we've adjusted the figure upward to 370 to account for the new infections that are occurring but not being diagnosed or reported. Using a baseline of 370 cases, we seek to decrease the annual number of new infections to 280 by 2015.

Reaching a 25% reduction in new infections will require three necessary conditions. First, and at very least, we must preserve our current level of funding. If real dollars continue to decrease, we may not even be able to sustain a stable rate of new infections much less reduce new infections. Second, the allocation of existing funds must change to focus even more on providing effective and cost-effective interventions to high-risk populations. Reprogramming our current resources, however, can only carry us part of the way toward our goal. The third necessary factor is additional funding. The set of new initiatives necessary to meet the goal will require new funding.

Specific Goals and Outcome Objectives:

In order to reach the community-wide goal of a 25% reduction in new HIV infections, the HIV/AIDS Program has developed specific goals and measurable outcome objectives that form the basis of our seven-year operational plan. The goals and objectives represent the changes that we believe must occur in order to reduce the spread of HIV infection in King County. They will provide a lens through which program staff will make funding decisions, both for internal Public Health programs and for the community-based organizations that are our partners in HIV prevention. The goals focus on identification of new HIV cases and reducing the sexual and drug-using risk behaviors in high-risk populations that lead to the spread of HIV.

Goal 1: To identify new HIV cases, especially among MSM, IDU and foreign-born Blacks.

The outcome objectives and numeric targets for our goal of identifying new HIV cases are found in Table One below. Because all infections do not reside within one population, Goal One requires a mix of testing efforts geared to the populations we know are at highest risk (MSM, MSM/IDU, and IDU), those that are emerging populations (foreign-born Blacks), and the moderate-risk and general populations in which HIV-positive people may remain unaware of their infections for many years. The outcome objectives work synergistically so that progress toward one objective will provide progress toward other objectives as well. For example, increasing testing (and case finding) within the foreign-born Black population (Objective 1.4) will reduce the racial disparities in late diagnoses (Objective 1.2). Paradoxically, success in achieving Goal One may actually result in an increase in newly diagnosed infections that are reported through the surveillance system in the first few years, while the reductions won't be seen until later. We are confident that we can make strong progress toward the outcome objectives in Goal One. Expanding access to HIV testing and removing barriers to testing are much less complicated than motivating people to change their sex and drug-using behaviors.

Goal 2: To reduce sexual and drug risk behaviors among HIV-negative and HIV-positive men who have sex with men, injection drug users and foreign born black heterosexuals.

Table 2, also below, shows the outcome objectives and numeric targets for the goal of reducing sexual and drug risk behaviors in at-risk populations. This behavior change goal focuses specifically on those most at risk, rather than moderate-risk or low-risk populations, because a reduction of risk behaviors in the high-risk populations will have a greater impact on HIV incidence. Behavioral interventions are especially critical for HIV positive persons. As HIV positive persons live longer and feel healthier, some are more sexually active and are at greater risk for transmitting HIV and/or acquiring other STD.

Goal 1: To identify new HIV cases, especially among MSM, IDU and foreign-born Blacks.

Outcome Objectives	2007	2009	2011	2013	2015
Objective 1.1: By 2015, increase the proportion of persons newly diagnosed with HIV who are interviewed for partner notification services from 50% to 75%. <i>Data: Harborview STD Clinic and HARS</i>	50%	56%	62%	68%	75%
Objective 1.2: By 2015, decrease the percentage of people who receive an AIDS diagnoses within 12 months of being diagnosed with HIV from 33% to 25%, with an emphasis on eliminating the disparities among racial and ethnic groups. <i>Data: HARS</i>	33%	31%	29%	27%	25%
Objective 1.3a: By 2015, decrease the median test interval from last test among previously tested MSM with newly diagnosed HIV from 12 to 6 months. <i>Data: HARS</i>	12	10	8	7	6
Objective 1.3b: By 2015, decrease the proportion of MSM newly diagnosed with HIV who have never tested from 12% to 6%. <i>Data: HARS</i>	12%	10%	8%	7%	6%
Objective 1.4: By 2015, increase the number of foreign-born Blacks (FBB) who have tested since moving to the United States from x to y (baseline and targets to be determined). <i>Data: PH Clinics - pending</i>	Determine baseline	tbd	tbd	tbd	tbd
Objective 1.5: By 2015, increase the percentage of health care settings with threshold HIV prevalence of 0.1% that routinely provide HIV testing from the current 0% to 30%. <i>Data: Survey random sample of providers every two years</i>	0%	5%	15%	25%	30%

Goal 2: To reduce sexual and drug risk behaviors among HIV-negative and HIV-positive men who have sex with men, injection drug users and foreign born black heterosexuals.

Goal 2: Outcome Objectives*	2007	2009	2011	2013	2015
Objective 2.1a: By 2015, decrease the proportion of HIV-positive persons who engage in unprotected anal or vaginal intercourse with non-concordant partners in the last 12 months from 25% to 20%. <i>Data: Harborview Madison Clinic; Future sources: NBHS, STD Clinic</i>	25%	24%	23%	21%	20%
Objective 2.1b: By 2015, decrease the proportion of HIV-negative MSM who engage in unprotected anal or vaginal intercourse with non-concordant partners in the last 12 months from 14% to 10%. <i>Data: Harborview STD Clinic; Future sources: NBHS</i>	14%	13%	12%	11%	10%
Objective 2.2a: By 2015, decrease the proportion of HIV-positive MSM who report methamphetamine use in the last 12 months from 22% to 18%. <i>Data: Harborview STD Clinic</i>	22%	21%	20%	19%	18%
Objective 2.2b: By 2015, decrease the proportion of HIV-negative MSM who report methamphetamine use in the last 12 months from 9% to 7%. <i>Data: Harborview STD Clinic</i>	9%	8.5%	8%	7.5%	7%
Objective 2.3a: By 2015, increase the proportion of IDU who obtain at least 75% of their syringes from pharmacies or syringe exchange in the last three months from x to y (baseline and targets to be determined). <i>Data: Jail surveillance</i>	Determine baseline	tbd	tbd	tbd	tbd
Objective 2.3b: By 2015, increase the proportion of IDU who report <u>not</u> sharing with more than 1 partner in the last three months from x to y (baseline and targets to be determined). <i>Data – Jail surveillance</i>	Determine baseline	tbd	tbd	tbd	tbd

Limitations of HIV Prevention Efforts

The declining resources for HIV prevention efforts, discussed above, impose one barrier on reducing the spread of HIV. Another important barrier is the state of the scientific advances that could help us reach this goal. Absent a vaccine, which could eliminate or at least substantially reduce the acquisition of the virus, HIV prevention relies on two main sets of interventions: HIV testing and behavior change. Investing in HIV testing services makes sense. It is estimated that over half of new infections result from persons unaware of their infection.^{1,2} Once people learn of their HIV infection, they reduce their risk behaviors an average of 60% in the 12 months following their diagnosis.^{3,4,5,6,7} Additionally, testing services link newly diagnosed HIV-infected persons to life-saving monitoring and treatment. Medical treatment that reduces viral load also decreases the transmission of HIV at least at a population level, further enhancing the prevention benefit of case finding.⁸ Thus, we are confident that our prior and continued efforts at increasing investments in HIV testing will help us make progress toward our community-wide goal.

HIV testing, however, is not a comprehensive solution to the epidemic. Even with NAAT testing, there is a lag between infection, testing, and diagnosis. Therefore, people with a recent HIV-negative test or those who have not been tested must remain motivated to continue to practice safer sex and injection practices. Also, some people who know that they are HIV-positive continue to engage in behaviors that put their sex and drug-using partners at risk. Drug and alcohol use by both HIV-positive and HIV-negative individuals clouds judgment and increases the likelihood of engaging in risky behaviors. Behavioral interventions attempt to educate people about their risk and help them change their behaviors. Given the complexity of sex and drug-using behaviors, however, these interventions can only be partially successful at best. The research on effective behavior change interventions for MSM tends to come from the pre-HAART era and little recent research exists. This is especially true for interventions serving

¹ Marks G, Crepaz N, Senterfitt JW, et al. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. *J Acquir Immune Defic Syndr*. 2005;39:446-453.

² Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*. 2006;20:1447-1450.

³ Doll LS, O'Malley PM, Pershing AL, Darrow WW, Hessel NA, Lifson AR. High-risk sexual behavior and knowledge of HIV antibody status in the San Francisco City Clinic Cohort. *Health Psychol* 1990;9:253--65.

⁴ Cleary PD, Van Devanter N, Rogers TF, et al. Behavior changes after notification of HIV infection. *Am J Pub Health* 1991;81:1586--90.

⁵ Fox R, Odaka NJ, Brookmeyer R, Polk BF. Effect of HIV antibody disclosure on subsequent sexual activity in homosexual men. *AIDS* 1987;1:241--6.

⁶ van Griensven GJP, de Vroome EMM, Tielman RAP, et al. Effect of human immunodeficiency virus (HIV) antibody knowledge on high-risk sexual behavior with steady and nonsteady sexual partners among homosexual men. *Am J Epidemiol* 1989;129:596--603.

⁷ Coates TJ, Morin SF, McKusick L. Behavioral consequences of AIDS antibody testing among gay men [Letter]. *JAMA* 1987;258:1889.

⁸ Quinn TC, Wawer MJ, Sewankambo N, et al. Viral load and heterosexual transmission of human immunodeficiency virus type 1. *N Engl J Med* 2000;342:921--9.

MSM of color and MSM who use methamphetamines. While we base all behavioral programs on evidence-based models and/or behavioral theory, we do not have a strong set of proven effective interventions serving the priority populations with the highest incidence and prevalence in King County. Unlike medicine's ability to substitute methadone and other opiate replacements for heroin addiction, there is no treatment for methamphetamine use which has proven to be highly effective. Yet, locally at this point methamphetamine use is likely contributing more to HIV transmission than heroin use. We cannot discontinue funding behavioral interventions, but we have less confidence that we can strongly impact the sex and drug-using behaviors of those who are at highest risk. More prevention intervention research is needed.

Implications for Existing Funding

The HIV/AIDS Program will continue prioritizing use of HIV prevention funds for case finding efforts and behavioral interventions focused on the highest risk populations, with special efforts directed toward those initiatives that most directly address the outcome objectives.

- Because MSM continue to be the most impacted, this plan dictates a shift of resources toward more services for this population.
- Because we have a growing population of HIV positive persons who are feeling healthier and may be more sexually active, we must assure that services are in place to help them maintain safer behaviors.
- In 2008, Public Health has set aside funds to promote HIV awareness and testing messages for high-risk MSM.
- Foreign-born Blacks are an emerging population in which incidence and prevalence rates continue to increase, and late diagnoses are common. This plan requires shifting more resources into testing for this population.
- The greatest change this plan proposes for testing resources will impact services for moderate-risk populations. These services currently take up almost a quarter of our internal HIV/AIDS Program spending and will need to be reduced to free up resources to better target higher risk populations.
- This plan should directly inform the allocation percentages set during the community planning process. Public Health must work closely with the community planning body to assure that resources are distributed in accordance with this plan.
- General populations: In September 2006, the CDC recommended that every person, age 13-64 be tested at least once for HIV in the process of routine care. It will take several years to successfully implement routine HIV testing in most clinic, hospital, and emergency rooms. CDC's goal in making its recommendation was to ask the help of the larger medical community and of the health insurance industry to find unaware cases of HIV infection. Nevertheless, Public Health will need to model this routine testing, and do extra work with the private health care sector, so some resources are being devoted to this new initiative. However, we want to reserve the bulk of HIV prevention funding for efforts targeting populations at greatest risk

Many of the new testing initiatives, especially those around routine testing and PCRS, will require enabling changes to the Washington Administrative Code. In order to remove existing barriers to testing and effective and efficient PCRS, the HIV/AIDS Program believes that:

- the code should explicitly allow for HIV testing to be covered by the general consent for care
- providers should have no prescriptive requirements to screen for or address risk behavior
- Public Health should not need specific permission from providers to outreach to cases for PCRS, and
- PCRS records should be maintained indefinitely, as is the case for other sexually transmitted infections.

We will continue to work with the Washington State Department of Health, the AIDSNET Council, and the Washington State Association of Local Public Health Officers to promote these changes.

Allocation of Additional Funds

As part of our strategic planning effort, the HIV/AIDS Program has identified and prioritized new initiatives for each goal that will enhance our ability to reduce the number of new infections occurring in King County. While limited progress toward implementing the interventions may be achieved through reallocating existing funding, full implementation of these initiatives will require new funding.

Table 4

New initiatives to improve case finding (Goal 1)

Priority	Activity	Description
1	Expansion of NAAT Testing	Expand NAAT testing to include private providers who see large panels of MSM. <i>Estimated annual cost: \$136,000</i>
2	Formative Research – foreign-born Blacks	Continue formative work to identify appropriate HIV testing sites for foreign-born Blacks (and pilot programs to assess effectiveness). <i>Estimated cost range: \$50,000 - \$100,000</i>
3	Needs Assessment –	Conduct a needs assessment among MSM who have not tested in last two years. A needs assessment will help us

	Late Diagnoses	<p>identify the specific barriers to testing and how to overcome those barriers.</p> <p><i>Estimated cost: \$75,000</i></p> <p>Validate the HARS data on time of HIV acquisition. “Late diagnoses” are determined by comparing time of acquisition to time of AIDS diagnosis which may be wrong if persons tested anonymously, or in other regions.</p> <p><i>Estimated cost: 0, restructuring existing allocations unless surveillance funds are reduced.</i></p>
--	----------------	--

New initiatives to improve case finding (Goal 1)—*continued*

Priority	Activity	Description
4	Promotion of Routine Testing	<p>Develop, implement and monitor structured provider outreach campaign to assure implementation of routine testing for moderate-risk and general populations. This will include working with the King County Medical Society and the State DOH to actively promote routine HIV testing for persons age 13-64.</p> <p><i>Estimated cost: \$50,000</i></p>

Table 5

New initiatives to reduce risk behaviors (Goal 2)

Priority	Activity	Description
1	Reduction of Crystal Meth Use Among MSM	<p>Increase support of drug treatment and /or contingency management activities to reduce crystal methamphetamine use among MSM. Consider New Champions approach and expanding contingency management.</p> <p><i>Estimated annual cost: \$200,000</i></p>
2	Behavioral Interventions for HIV-positive Persons	<p>Increase support for effective behavioral interventions for HIV-positive persons such Comprehensive Risk Counseling and Services and individual counseling. The increased support should be accompanied by increased</p>

		evaluation support so we can assure that the intervention effect remains. <i>Estimated annual cost \$150,000</i>
3	Behavioral Interventions for HIV-negative MSM	Increase behavioral intervention capacity within the public health and community based agency sites that serve the greatest number of men who have sex with men. <i>Estimated annual cost \$50,000</i>

Assuring Adequate Surveillance

Setting long-term goals and outcome objectives requires a set of measurements that can be repeated over the course of the next seven years. While this may sound obvious, it presents its own challenges. Surveillance costs money, the CDC has been the sole source of HIV surveillance efforts, and CDC resources for surveillance are declining. Technological changes also impact measurement. For example, in the past, Public Health has been able to conduct population-based surveys of MSM households using random digit dial technology. The population's increasing reliance on cell phones as their sole telephone service has cast considerable doubt on the future reliability of this survey method. Other methods must be developed and tested; this will require new resources.

In order to measure progress toward our outcome objectives, the HIV/AIDS Program will use currently available data sources that we know will continue to be available in the years to come. We will rely heavily on core surveillance data collection (HARS, the HIV/AIDS Reporting System) which has sufficient funding to continue to be a primary source of data well into the future. We will also rely on data collected at sentinel testing and HIV care service sites (such as the STD Clinic and Jail testing sites). Sentinel sites are able to provide valuable information over time. For example, the STD Clinic captures a wealth of data from each testing encounter, including risk behavior. While the clinic may not be representative of the population as whole, it is able to collect data on individuals who are at higher risk than members of the general population. In this sense, it provides a better picture of the at-risk people who we seek to reach with the HIV testing and behavioral interventions that we fund. Where necessary, we will divert funds for prevention efforts to the collection of data that we cannot obtain through surveillance or sentinel sites.

Attachment A

Public Health HIV/AIDS Program **HIV Prevention Strategic Plan for Internal Funding**

1. Summary

HIV prevention in a large urban community depends on three critical components: individuals' timely awareness of their HIV status, knowledge and skills to reduce risk behaviors, and an environment and community actively promoting behavior change. Local public health, in conjunction with community and private sector providers, must assure that it funds and promotes the best balance of programs that address these components.

Every year, the Public Health – Seattle & King County HIV/AIDS Program allocates approximately \$2,800,000 to programs within Public Health primarily for HIV prevention services (less than 10% of these dollars are used for care services). We want to assure that we are making optimal use of internal prevention resources and that our decision making is driven by local data, scientific literature and staff and community input. This is particularly important in light of expected decreases in both CDC Prevention and Washington State Omnibus.

In late 2006, HIV/AIDS Prevention Planning staff convened a small group of HIV/AIDS program leaders for a comprehensive strategic planning process. The group reviewed HIV data and prevention literature, and made specific recommendations for population and activity funding priorities. Subsequently, the Board of Health HIV/AIDS Committee issued recommendations to the Board of Health. We recognize that these recommendations are an important source of input to our internal planning and have incorporated them throughout the document.

The outcome of this process was a seven year strategic and operational plan which will be updated annually with new information and annual funding priorities.

2. Description of Process

The HIV Prevention Planning Team developed the strategic planning process. We recruited an expert committee who agreed to seven meetings over a two-month period:

Gary Goldbaum, Chief Epidemiologist, HIV/AIDS Program
Matthew Golden, Medical Director, STD Control Program
Bob Wood, Director, HIV/AIDS Control Program
Karen Hartfield, HIV Prevention Planner
Barb Gamble, HIV Prevention Planner
Frank Chaffee, HIV Program Manager

Barbara Krekeler, STD Program Manager
Robert Marks, STD Program Supervisor
Michael Hanrahan, HIV Education Team Supervisor
David Bibus, Deputy Manager, Prevention Division

Over the course of the seven meetings, the committee accomplished the following tasks:

- Reviewed HIV/AIDS Prevention Program mission, vision, goals and objectives
- Reviewed local epidemiology data and trends
- Reviewed HIV prevention scientific literature
- Reviewed currently funded programs
- Conducted survey of comparable local health departments to determine program activities and structures
- Determined internal funding goals, outcome and process objectives and funding priorities

We devoted five meetings to these key focus areas: HIV Counseling and Testing, PCRS and other C/T related programs, Prevention Interventions for Injection Drug Users, Prevention Interventions for Men Who Have Sex with Men, Health Education and Technical Assistance, and Infrastructure. For each program area, we addressed the following questions:

- What are the most effective program models?
- What is the cost effectiveness of programs?
- What should our programmatic direction be?
- What subpopulations should we focus on?
- What is the ideal mix of programs within the health department?
- What is the impact of the new CDC CTR guidelines on this program area? Should our priorities shift? How should this impact our work with community providers?
- What should the mix be between short term and long term investments? Should we make long-term investments like community-level interventions where change may take a long time, or only/mostly invest in immediate outcome interventions such as counseling and testing?

We spent the final meetings prioritizing program activities and populations for internal funding. We prioritized strategies within the following populations:

Men who have sex with men
Injection Drug Users
Foreign-Born Black Heterosexuals
Moderate Risk Populations
General Populations

While we did not specifically prioritize strategies for HIV-positive Persons, we did discuss Public Health and community based organization roles with this population, and whether we are directing adequate resources.

Meeting minutes and background activities may be found in Appendix A.

The committee then reviewed the final plan and made recommendations for target allocation ranges for the priority populations. Using this information, the prevention planning staff developed a set of recommendations for 2008 prevention funding. The final plan is intended to be in place for five years, but we will reassess the plan each year before distributing internal prevention dollars.

While the plan details new program priorities, budget shifts are necessarily gradual and full implementation of the plan will occur over time.

3. Guiding principles for internal program activities

The committee reviewed a variety of background materials prior to and during its deliberations. These included the HIV/AIDS Program vision and mission statements, specific prevention and care goals, currently funded programs and scientific literature. We determined that the following principles should guide our internal program activities:

A. Public Health and community HIV programs should prevent the largest number of new HIV infections.

While this principle seems straightforward, it represents a shift in our thinking. We believe that we should prioritize program activities that are likely to have the greatest impact on the epidemic in terms of numbers of cases prevented.

It necessarily follows that selection of target populations should be based on the best available epidemiologic data such as incidence and prevalence, population size, trends and the likelihood that any given intervention will have an impact on the population. We are fortunate to have a strong HIV/AIDS epidemiology program and we must maintain that capacity. In addition, all staff need to be well versed in local epidemiologic data and trends.

B. Program activities should be based on empirical evidence and/or behavioral theory.

The committee reviewed the most current intervention literature addressing our highest risk populations (see Appendix B). This literature, combined with our collective experience, strongly suggests that the foundation of all activities should be tested program models or theories. In particular, health behavior theories including the Health Belief Model, Theory of Reasoned Action, Social Learning Theory and Transtheoretical Model, should be reflected in intervention design. Health education programs should be informed by health literacy models.

C. Cost effective strategies should be prioritized particularly in the absence of strong empirical evidence.

The committee reviewed cost effectiveness literature, particularly related to HIV counseling and testing and IDU intervention strategies.

D. Selection of program activities should reflect the ecologic model of disease prevention (see Appendix C).

The ecologic model identifies five spheres of influence on health behaviors: individual, interpersonal, institutional, community and social structures/policy. The work of the HIV/AIDS Program seeks to address all spheres of influence.

E. When possible, HIV/AIDS Program activities should include a productive partnership with the impacted communities

It is our belief that most public health programs are strengthened by meaningful community involvement from the impacted populations. When appropriate, we strive to include communities in program development and delivery.

F. The continuum of prevention activities must fulfill the mandates of the Washington State AIDS Omnibus Act and the Centers for Disease Control HIV Prevention Initiative.

The bulk of our prevention funds come from two funding sources with clear mandates and priorities. While we strive to have a comprehensive continuum of prevention activities, our program activities must be consistent with the requirements of our funders.

4. Goals, Objectives and Priority Activities for Internal Funding

Community-wide goal

By 2015, decrease the annual number of new HIV infections (HIV incidence) in King County by 25%.

In addition to the community-wide goal, we have identified four major sub-goals for HIV prevention. The first two sub-goals are associated with measurable outcome objectives that, if met, greatly increase the likelihood of achieving the community-wide goal of decreased transmission. Our operational plan details activities associated with each of the four sub-goals.

Because all citizens of King County are not at equal risk for acquiring or transmitting HIV infection, we have defined three population categories:

- High-risk populations: Men who have sex with men, injection drug users and foreign born black heterosexuals, HIV-positive persons and their identifiable sex partners
- Moderate-Risk Populations: Persons seeking services at STD clinics (excluding MSM, IDU and FBB) and African Americans (excluding MSM and IDU)
- General Populations: Persons who are not members of any high or moderate-risk population

The bulk of our internal activities, and all of our contracted activities, are targeted toward high-risk populations.

Goal 1: To identify new HIV cases, especially among MSM, IDU and foreign-born Blacks.

Outcome Objectives

By 2015, increase the proportion of persons newly diagnosed with HIV who are interviewed for partner notification services from 50% to 75%.

By 2015, decrease the percentage of people who receive an AIDS diagnoses within 12 months of being diagnosed with HIV from 33% to 25%, with an emphasis on eliminating the disparities among racial and ethnic groups.

By 2015, decrease the median test interval from last test among previously HIV-tested MSM with newly diagnosed HIV from 12 months to 6 months.

By 2015, decrease the proportion of MSM newly diagnosed with HIV who have never tested from 12% to 6%.

By 2015, increase the number of foreign-born Blacks (FBB) who have tested since moving to the United States from x to y.

By 2015, increase the percentage of health care settings with threshold HIV prevalence of 0.1% that routinely provide HIV testing from the current 0% to 30%.

Public Health Priority Activities:

- Deliver best practice **HIV testing services**, and counseling as appropriate, for high-risk populations.
- Deliver best practice **partner counseling and referral services**
- Facilitate **routine HIV testing** and surveillance among moderate-risk and general populations through WAC revisions and improved cost effectiveness.
- Mobilize MSM, and African American communities to **implement grassroots efforts** to prevent HIV

Goal 2: To reduce sexual and drug risk behaviors among HIV-negative and HIV-positive men who have sex with men, injection drug users and foreign born black heterosexuals.

Outcome Objectives –

By 2015, decrease the proportion of HIV-positive persons who engage in unprotected anal or vaginal intercourse with non-concordant partners in the last 12 months from 25% to 20%.

By 2015, decrease the proportion of HIV-negative MSM who engage in unprotected anal intercourse with non-concordant partners in the last 12 months from 14% to 10%.

By 2015, decrease the proportion of HIV-positive MSM who report methamphetamine use in the last 12 months from 22% to 18%.

By 2015, decrease the proportion of HIV-negative MSM who report methamphetamine use in the last 12 months from 9% to 7%.

By 2015, increase the proportion of IDU who obtain at least 75% of their syringes from pharmacies or syringe exchange in the last three months from x to y (baseline and targets to be determined).

By 2015, increase the proportion of IDU who report not sharing with more than 1 partner in the last three months from x to y (baseline and targets to be determined)

Public Health Priority Activities:

- Deliver effective behavioral interventions to highest risk populations
- Mobilize highest risk communities to implement grassroots efforts to prevent HIV
- Promote single use of sterile syringes and injection equipment.
- Provide visible public health leadership on HIV and AIDS.

Goal 3: Assure adequate surveillance mechanisms to measure outcome indicators.

Public Health Priority Activities

- Maintain the current surveillance system which adequately informs deployment of best practice HIV testing services and other prevention strategies, including IDU surveillance.
- Develop a consensus on additional surveillance measures to put in place.

Goal 4: Assure provision of HIV information and referral services to King County community

Public Health Priority Activities:

- Deliver **current HIV/AIDS information** to the general population and providers.

5. Infrastructure/Systems Planning Priorities

The goal of the HIV/AIDS Program infrastructure group is *to improve the HIV/AIDS Program's capacity to achieve its overall goal of preventing the largest number of new HIV infections in King County. Our outcome objective is to develop, implement and monitor HIV prevention programs within Public Health and community-based organizations and assure cost-effectiveness in program activities*

The infrastructure group includes the program manager, Education Team manager, contract monitoring staff, prevention planning staff, Ryan White Title I Planning Council staff and administrative support staff. The organizational chart may be found in Appendix E.

The strategic planning process included a discussion of how infrastructure might be restructured to increase efficiency and effectiveness. The group acknowledged that it is difficult to reduce infrastructure in the face of growing demands for program and fiscal accountability. However, the group recommended doing an analysis of restructuring within the planning and administrative support teams. Priority activities include:

- Analysis of the impact of lengthening planning cycles and contracting cycles
- Analysis of the impact of consolidating administrative support functions within HIV/AIDS and HIV/AIDS Epidemiology
- Analysis of potential new fund sources for HIV prevention activities (in collaboration with the Public Health Grants Manager)

6. Evaluation Plan/Performance Measures

There are a number of performance measures already in place. The extent to which we are meeting our process objectives and implementing strategies can be measured through existing data collection methods. The Washington State SHARE system can be used for all high-risk intervention process data. The federal PEMS system will be used to track HIV counseling and testing. Each funded program (excluding infrastructure) will be required to establish and report quarterly on process measures and summary reports will be produced semi-annually.

Our primary outcome objectives are to identify new HIV cases and to reduce sexual and drug risk behaviors among HIV-negative and positive populations. Outcome indicators, targets and data sources are detailed in the operational plan component. We have relied heavily on random digit dial surveys to provide population based data, but the validity of this approach is threatened by the population's increased reliance on cellular telephones. Many households no longer have local area network lines. We will work closely with University of Washington demographers to assure that we are implementing the most reliable data collection methods.

7. Funding Priorities

The HIV/AIDS Program will review and update this plan annually, and clearly identify annual internal funding priorities accordingly. Funding priorities for 2008 may be found in Appendix F.

Attachment B

2008-09 Prevention Plan

Approved by the Seattle HIV/AIDS Planning Council April 2007.

NOTES AND OVERALL CAVEATS:

- \$10,000 (in 2008) was taken “off the top” to conduct a needs assessment regarding crack use among MSM, with special attention to crack use in Black MSM.
- Subpopulations listed under each population category are NOT listed in priority order. Unless noted, it is not required that all populations be funded.
- Interventions are NOT listed in priority order. Unless noted, it is not required that all interventions be funded.
- HIV Counseling and Testing is a priority intervention across all sub-populations, except HIV+. It is prioritized with the understanding that Public Health will fund this service. Community-based counseling and testing programs are not eligible to apply under this funding pool. However, HIV Counseling and Testing is an acceptable component of a Community-Level Intervention for Foreign-born Blacks.
- Partner Counseling and Referral Services (PCRS) is a priority intervention for all sub-populations, as those contacted may or may not be HIV+; it is prioritized with the understanding that Public Health will fund this service.
- All interventions should address the wide range of co-morbidities including but not limited to homelessness, incarceration, mental illness, etc. where applicable.
- All interventions should focus on those persons engaging in higher risk sex and/or drug using behaviors.
- It should be noted that the HIV+ population includes only those persons who know their HIV status.
- Substance Use Treatment includes, but is not limited to, Opiate Replacement Therapy.
- Street and Community Outreach includes Internet outreach for MSM populations.

#1 HIV+
(15% of the available funding pool)

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> • Foreign-born black heterosexuals • MSM Crystal users • MSM 	Prevention Case Management
	Individual-Level Intervention
	Group-Level Intervention
	Substance Use Treatment
	Partner Counseling & Referral

#2 White MSM, age 25-69
(12% of the available funding pool)

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> ▪ Public, commercial or anonymous sex venues, especially bathhouses/sex clubs ▪ Crystal-using non-injectors 	Prevention Case Management
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

* For MSM populations, street and community outreach includes internet outreach.

#3 Foreign-born Blacks, ages 15-69

(10% of the available funding pool)

Caveat: Applicants must show how they will work through established community venues and address issues of stigma and confidentiality.

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> No Sub-populations 	Community-Level Intervention*
	HIV Counseling and Testing
	Partner Counseling & Referral

* For this population, a CLI could include HIV counseling and testing.

#4 Latino MSM, 25+

(12% of the available funding pool)

Caveats for Latino MSM programs:

*Caveat: Any intervention targeting Latino MSM must be culturally and linguistically sensitive to both foreign-born and native-born Latinos.

*Caveat: All programs targeting Latino MSM must address the issues of heterosexually-identified MSM.

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> No sub-populations 	Prevention Case Management
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

* For MSM populations, street and community outreach includes internet outreach.

#5 Black MSM, 25+

(12% of the available funding pool)

Caveats for Black MSM programs:

**Caveat: All programs targeting Black MSM must address the issues of heterosexually-identified MSM.*

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> No sub-populations 	Prevention Case Management
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

* For MSM populations, street and community outreach includes internet outreach.

#6 MSM/IDU, age 15-69

(13% of the available funding pool)

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> Crystal injectors 	Prevention Case Management
	Substance Use Treatment
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral
	Syringe exchange

#7 Injection Drug Users (IDU), age 15-69

(11% of the available funding pool)

Caveats for IDU programs:

*Caveat: Programs must address both sexual and injection-related risks.

Priority Subpopulations	Priority Interventions
<ul style="list-style-type: none"> No sub-populations 	Syringe exchange
	Street and Community Outreach
	Substance Use Treatment
	HIV Counseling and Testing
	Partner Counseling and Referral

#8 Young MSM, age 15-24

(7% of the available funding pool)

Subpopulations	Priority Interventions
<ul style="list-style-type: none"> MSM trading sex for money, drugs or shelter 	Prevention Case Management
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

* For MSM populations, street and community outreach includes internet outreach.

Special Set Aside for an Innovative Program (8% of the available funding pool)

Innovative Program Requirements

Funding: The Prioritization Committee sets aside 8% of the funds in the community pool for an “innovative program” focusing on MSM, regardless of HIV status.

Eligibility: The following eligibility criteria apply:

- Applicants must propose a program to deliver services to the MSM populations that have been identified in the prevention plan (HIV+, White, Latino, Black, MSM/IDU, and Young MSM). Proposals may address any or all of these populations.
- Applications that propose to implement interventions identified by the Centers for Disease Control’s Diffusion of Effective Behavioral Interventions (DEBI) project are NOT eligible for this funding. Proposals using DEBI interventions must compete in the population-based funding categories.
- Applications that seek to maintain or expand programs previously funded by Public Health will not be eligible for funding. However, proposals that seek to adapt innovative programs from other cities are eligible to apply.
- Only non-profit, community-based agencies are eligible for funding in this category. Universities and Public Health programs are not eligible to apply for this funding.

Program Requirements: The program must be theory or evidence-based. The program must have a strong evaluation component and preference will be given to those proposals that use outside evaluators.

Contracting: The Prioritization Committee instructs Public Health to consider this a pilot program. Therefore, to the greatest extent possible, Public Health should ensure that the program has a reasonable start-up period for program planning and implementation, contractual goals that recognize that new programs need time to build a client base, and the flexibility to adjust program goals if the original implementation plan falls short of the contracted service units.