Antelope Valley

Service Planning Area SPA 1

Chapter 1: Overview of HIV Community Planning

Overview

This chapter:

- Provides the Centers for Disease Control and Prevention's (CDC) requirements related to community planning in the United States (U.S.);
- Narrates the history of HIV prevention community planning in Los Angeles County; and
- Describes Los Angeles County's community planning process for the development of the 2009-2013 comprehensive HIV prevention plan.

Community planning and HIV prevention have gone hand in hand since the beginning of the epidemic. Although during the past 26 years there have been amazing advances in medical treatment and HIV is no longer viewed as an acute illness, the need for effective prevention strategies remains paramount. Recent research estimates that persons who are undiagnosed and do not know their HIV status account for between 54% and 70% of new infections in the United States (U.S.) [1]. Thus, the importance of (1) helping people understand how HIV is transmitted, (2) helping them assess their personal risk for acquiring or transmitting HIV, (3) empowering them to learn their status through HIV testing, and (4) giving them the skills and tools necessary to be successful in their efforts to choose life affirming behaviors that promote health and well-being cannot be overstated. Yet, it is the community -- the people of Los Angeles County -- who have their fingers on the pulse of Los Angeles' diverse populations. Thus, community planning is absolutely essential in order to develop effective HIV prevention and testing strategies that will reach those individuals most at risk for acquiring or transmitting HIV.

HIV Prevention Community Planning in the United States

The Centers for Disease Control and Prevention's (CDC) *2003-2008 HIV Prevention Community Planning Guidance* sets forth the national expectations for HIV prevention community planning [2]. This document establishes clear linkages between community planning, the CDC's overarching national goal to reduce the number of new HIV infections by 5% each year in the United States (U.S.) [3], and the CDC's *Advancing HIV Prevention (AHP) Initiative*. It also outlines the congruence needed between local community planning, priority at-risk populations, and HIV prevention programs.

■ CDC's HIV Prevention Community Planning Goals

In its *2003-2008 HIV Prevention Community Planning Guidance,* the CDC outlines three goals and eight implementation objectives for local community planning efforts. These include:

CDC Goal 1: Community planning supports broad-based community participation in HIV prevention planning.

- *Objective A:* Implement an open recruitment process (outreach, nominations, and selection) for Community Planning Group (CPG) membership.

- *Objective B:* Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.

- *Objective C:* Foster a community planning process that encourages inclusion and parity among community planning members.

CDC Goal 2: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

- *Objective D*: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

- *Objective E*: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.

- *Objective F*: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

CDC Goal 3: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

- *Objective G*: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department application for federal HIV prevention funding.

- *Objective H*: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

These goals and objectives provide the framework for local CPGs in their implementation of a community planning and prioritization process. To gauge success of local community planning, the CDC requires that local jurisdictions monitor progress through four program performance indicators; these include:

1. *Proportion of populations most at risk, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of each population;*

2. *Proportion of key attributes of an HIV prevention community planning process that CPG membership agreed have occurred;*

3. *Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan; and*

4. *Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.*

The Los Angeles County Office of AIDS Programs and Policy (OAPP) and the Los Angeles County HIV Prevention Planning Committee (PPC) share the responsibility for monitoring progress towards achieving these goals and objectives, and monitoring the program performance indicators.

The CDC's community planning guidance gives clear direction and expectation for local CPGs as they move into the future. The CDC's *Advancing HIV Prevention Initiative* provides the national direction for HIV prevention in the U.S. and serves as one lens through which Los Angeles County can view and assess its planning efforts.

■ CDC's *Advancing HIV Prevention: New Strategies for a Changing Epidemic*

The CDC's *Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic*[*] was launched in April 2003. It marked a significant refocus of HIV prevention priorities for the United States. This initiative has been aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV and their partners. AHP is based on available evidence that suggests the majority of new infections are caused by persons unaware of their HIV infection. The CDC estimates that 25% of those infected with HIV do not know they are infected. Thus, AHP emphasizes HIV testing, in both medical and non-medical settings, to identify infected persons who are not aware of their own infection and get them into treatment and prevention services as early as possible.

The AHP initiative is intended to complement, expand, and/or strengthen existing HIV prevention efforts; it consists of the following four HIV prevention strategies:

1. Incorporate HIV testing as a routine part of care in traditional medical settings;
2. Implement new models for diagnosing HIV infections outside medical settings;
3. Prevent new infections by working with persons diagnosed with HIV and their partners; and
4. Further decrease mother-to-child HIV transmission.

The CDC further defines the implementation of these strategies through seven activities:

1. Routinely recommend voluntary HIV testing as part of primary medical care services;
2. Offer rapid HIV testing in non-traditional settings;
3. Routinely and voluntarily test inmates in correctional facilities for HIV;

[*] *Advancing HIV Prevention: New Strategies for a Changing Epidemic* – United States, MMWR 2003; 52 (15):329-332.

4. Offer HIV partner counseling and referral services (PCRS);
5. Offer Comprehensive Risk Counseling and Services (CRCS);
6. Offer HIV prevention services in medical care settings; and,
7. Achieve universal HIV testing of pregnant women.

Through the effective implementation of AHP, the CDC expects to achieve the greatest results towards reaching their goal of reducing HIV infections by half in the U.S. AHP places increased emphasis on targeting HIV prevention efforts to persons living with HIV and AIDS (PLWHA) because of the potential to substantially reduce HIV incidence. As a result, local CPGs are now required to prioritize HIV- positive persons as the highest priority population for prevention services. Since the *HIV Prevention Plan 2000,* Los Angeles County has formally prioritized HIV- positive persons, thereby recognizing the benefit of targeting this population more explicitly.

The History of HIV Community Planning in Los Angeles County

As the jurisdiction with the second largest number of PLWHA in the U.S., Los Angeles County has been a pioneer and at the forefront of community planning since the beginning of the epidemic. Community engagement is central to the County's vision and approach in creating a comprehensive continuum of HIV prevention and care services to respond to the epidemic. By active participation of community members including PLWHA, service providers, public health officials, government representatives, faith communities, and other stakeholders, Los Angeles County has established a system of HIV prevention and care services to reach a broad cross-section of its 10 million residents, including an estimated 58,951 PLWHA.

Formal HIV/AIDS planning began in Los Angeles County in 1988 with the release of the *Comprehensive Service Plan*, prepared by Peat, Marwick & Company. Building on this initial plan, a group of community activists formed the County/Community Planning Council in 1990. Staff members of HIV/AIDS community service providers, Los Angeles County HIV prevention planning staff, and other stakeholders comprised the membership of this planning council, predating the CDC's national directive for locally-based community planning in 1993. The County/Community Planning Council collaborated with the County's AIDS Program Office (now known as the Office of AIDS Programs and Policy) to prepare the first Los Angeles County HIV Strategic Plan. The plan guided both HIV prevention and care services for the three-year period from July 1990 through June 1993.

In early 1994, the Planning Council approved the 1993-1996 HIV Strategic Plan. The community planning process became more robust as the Planning Council fostered broader community input and participation through public hearings, focus groups, subcommittees and task forces, with support of the Department of Health Services, and the HIV Epidemiology Program. During this period, the County also completed a full needs assessment regarding HIV education, counseling and testing, and care services, with HIV prevention services comprising a relatively small portion of the overall plan.

In 1995, the Los Angeles County Board of Supervisors passed a new County ordinance and created the Los Angeles County Commission on HIV Health Services (Commission). The Commission replaced the former Planning Council and remains the primary community planning group for care services. To better address HIV prevention needs, the Commission established the

PPC as a select committee of the Commission. The purpose of the PPC was to serve as the CDC-required CPG with responsibility for making recommendations regarding targeted HIV risk groups and the full complement of prevention interventions in Los Angeles County.

In May 2005, a County ordinance was subsequently approved by the Board of Supervisors that restructured the local Ryan White CARE Act Title I planning body and reorganized its reporting hierarchy. This structural change established two distinct planning bodies with no formal reporting linkage (the PPC had been a select committee of the Commission since its inception in 1994). While the PPC forwards recommendations to the local administrative agency (OAPP) for HIV prevention activities, the renamed Commission on HIV (COH) forwards directives to the administrative agency for care-related services. PPC members are appointed by the Director of OAPP. COH members are appointed by the Board of Supervisors, and the Commission office is organized within Executive Office of the Board. Despite the separation, both the PPC and COH have been committed to participating in ongoing joint meetings and to work collaboratively to address critical local HIV prevention and HIV care integration issues.

Building upon the 1993-1996 HIV Strategic Plan, the PPC completed a second needs assessment to develop the Los Angeles County HIV Prevention Plan updates for the period July 1996 through June 1999. This plan continued to guide HIV prevention services and resource allocations in Los Angeles County through 1999. In early 1999, as the new millennium approached, the PPC embarked upon its next comprehensive community planning process up to then.

Los Angeles County's *HIV Prevention Plan 2000* and subsequent *HIV Prevention Plan 2004-2008* have guided HIV prevention planning, service provision, and resource allocation since 2000. During this eight-year period, the PPC implemented a behaviorally-based planning model for prioritizing individuals most at risk for HIV infection. In 2000, the PPC identified and prioritized six behavioral risk groups (BRGs) that provided the foundation for services during this eight year period. The PPC expanded the initial six BRGs to seven BRGs that guided services between 2004-2008. The seven BRGs are:

- Men who have sex with men (MSM);
- Men who have sex with men and women (MSM/W);
- Men who have sex with men and use injection drugs (MSM/IDU);
- Heterosexual male injection drug users (HM/IDU);
- Female injection drug users (F/IDU);
- Women at sexual risk (WSR) and their partners; and
- Transgenders at sexual risk/Transgender injection drug users (TSR/TIDU) and their partners.

Further, the PPC recommended in 2004 that funding allocations for HIV positive individuals and youth intersect with all BRG categories. The PPC also identified two populations at elevated risk for HIV and prioritized them to receive dedicated funding to ensure they did not fall through the cracks of service delivery. They were:

- American Indians/Alaskan Natives; and
- Incarcerated Population.

Community involvement in the development and implementation of the last two comprehensive HIV prevention plans was tremendous. Hundreds of community members participated, responding to surveys, collaborating at community forums and focus groups, and offering their voices to the planning process. This highly participatory process became the benchmark in preparing for Los Angeles County's 2009-2013 HIV prevention community planning process.

Los Angeles County HIV Prevention Community Planning: 2009-2013

Los Angeles County entered its 18th year of HIV community planning in 2007 with the intent of developing a new, five-year comprehensive HIV prevention plan. The PPC is the local group responsible for HIV prevention community planning within the County. Together with OAPP, the PPC is responsible for conducting needs assessments, identifying prevention priorities, and ensuring that funding is allocated in a manner to address community needs.

■ PPC Mission, Vision, and Purpose

As the PPC began planning for the new HIV prevention plan, they reaffirmed their mission, vision, and purpose:

MISSION

To engage in an ongoing process to develop and update a comprehensive HIV prevention plan for the diverse population of Los Angeles County.

VISION

To identify and support methods and programs that are effective in preventing transmission of HIV, thus reducing the incidence of HIV infection in Los Angeles County.

PURPOSE

The PPC assists in completing several vital tasks within the County, including:

- Compiling an epidemic profile of HIV, AIDS, and other health indicators in Los Angeles County;
- Assessing the needs of populations at risk for HIV infection and transmission;
- Reviewing the prevention resources available in Los Angeles County;
- Analyzing and addressing the gaps in services;
- Identifying effective strategies and interventions to prevent new infections; and
- Prioritizing prevention needs.

■ PPC Subcommittees

The PPC has standing subcommittees and creates ad hoc subcommittees as needed to accomplish its mission. Subcommittees report the progress of their work to the PPC at regular meetings. The PPC encourages non-PPC members to attend these subcommittees to further garner community input. Currently, the PPC has five standing subcommittees:

❖ *EXECUTIVE*

The Executive Subcommittee includes the PPC Co-Chairs and the Chairs of each standing subcommittee. This subcommittee is responsible for setting the agenda for all PPC meetings and for ensuring that the PPC accomplishes its goals and objectives as stated in the comprehensive HIV prevention plan. Each year, this subcommittee ensures that Los Angeles County's application for CDC prevention funding, prepared by OAPP, is reviewed by the PPC. This review ensures that the application submitted is in concurrence with the HIV prevention plan. The Executive Subcommittee also guides the development of social marketing strategies and helps obtain community input in the content development process.

❖ *EVALUATION*

This subcommittee evaluates the HIV prevention application process, assists in the planning and collection of needs assessment data, assists in the review of secondary data for prevention resource prioritization and allocation, and participates in the development of tools to evaluate the community planning process.

❖ *JOINT PUBLIC POLICY*

As of 2007, this is a joint subcommittee of the PPC and the Commission on HIV. The mission of the Joint Public Policy (JPP) Committee is to address public policy issues at every level of government that impact efforts to implement an HIV service delivery plan for Los Angeles County, in accordance with the annual comprehensive care and prevention plans. The Joint Public Policy committee also originates policy initiatives in accordance with HIV care service and prevention interests and provides education and access to public policy arenas for various stakeholders (planning group members, service consumers, providers, and other residents of Los Angeles County). This committee also facilitates communication between government and legislative officials and the planning bodies in Los Angeles. Recommending policy positions to the planning bodies (PPC & COH) and the Los Angeles County Board of Supervisors is also a responsibility of the Joint Public Policy Committee.

❖ *OPERATIONS*

This subcommittee maintains clear and consistent policies and procedures for efficient operation of the PPC. This subcommittee ensures that policies and procedures reflect current operations by monitoring membership needs, making needed revisions to the *Policies & Procedures* biannually, and facilitating the training and development of PPC members. The subcommittee acts as the nominating body that reviews applications for membership and makes recommendations for PPC membership selection to the Executive Subcommittee. The Operations Subcommittee assures that new member orientations take place throughout the year as needed, coordinates the PPC Annual Planning Meeting, reviews PPC member attendance and reports to the PPC Co-chairs regarding membership attendance and participation, and reviews gaps in the PPC membership, making all necessary efforts to recommend nominees to cover those gaps.

❖ *STANDARDS & BEST PRACTICES*

This subcommittee is responsible for identifying and prioritizing strategies to assist HIV intervention implementation consistent with the Los Angeles County HIV Prevention Plan, identifying effective interventions for each of the prioritized risk groups, and facilitating and promoting the standardization of intervention protocols and implementation.

In addition to the five standing subcommittees, the PPC forms specific ad hoc work groups/task forces to address key tasks. Ad hoc groups are usually comprised of PPC members as well as other key stakeholders in the community who have an interest in the specific work at hand. The most recent ad hoc groups are:

❖ ***HIV COUNSELING AND TESTING (HCT) WORK GROUP***

The mission of this work group is to enhance HCT services in Los Angeles County. The HCT work group is an ongoing working body under the Standards and Best Practices Subcommittee, and meets monthly. The HCT work group reports to the PPC through the Standards and Best Practices Subcommittee in a standing report.

❖ ***PREVENTION PLAN WORK GROUP***

The Prevention Plan Work Group of the PPC was an ad hoc work group that was charged with developing the comprehensive Los Angeles County HIV Prevention Plan 2009-2013. There were 31 regular participants on the Prevention Plan Work Group. Approximately 57% were community stakeholders and 43% were PPC members. The work group made recommendations to the Executive Subcommittee and PPC for funding and allocation of HIV prevention services in Los Angeles County with input from PPC subcommittees. The work group organized the different work products developed by the Evaluation, Standards and Best Practices, and Operations subcommittees and incorporated them into this new plan.

Other ad hoc groups in the past have been formed to address a specific purpose or need, or other emerging issues. In the past few years, the PPC formed a number of ad hoc groups, including the Crystal Methamphetamine Task Force, the Venue Based Task Force, the African American Men Who Have Sex with Men Task Force, and the Public Policy Ad Hoc Committee. In August 2007, the Public Policy Ad Hoc Committee became a joint standing subcommittee of the PPC and the Los Angeles Commission on HIV as described previously.

■ PPC Membership

The PPC is comprised of 20 to 30 members on average, who are chosen to reflect the characteristics of the current HIV/AIDS epidemic in Los Angeles County as described in the most recent epidemiologic profile. As of December 2007, there are 26 PPC members. Although the current membership goal is 30 participants, there is no limit. The membership reflects the HIV epidemic in terms of age, gender, race/ethnicity, geographic distribution by service planning area (SPA), and risk for HIV infection.

Members make knowledgeable contributions towards the understanding of the specific HIV prevention needs of the populations they represent. At the same time, they participate as group members in objectively weighing the overall priority prevention needs of all of Los Angeles County.

The PPC seeks membership from:

- Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., sexually transmitted diseases program, alcohol and drug program, tuberculosis program, substance abuse prevention and treatment, mental health services, housing services/homeless shelters, HIV care and social services) to persons with or at risk for HIV infection.

- Experts in epidemiology, behavioral and social sciences, program evaluation, and health planning.
- Staff of state and local health departments, including the HIV prevention and STD treatment programs; staff of state and local education agencies; and staff of other relevant governmental agencies (e.g., substance abuse, mental health, corrections).
- Representatives of key non-governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities).

The PPC has an open nomination/membership solicitation process. All interested members of the community may submit a membership application to OAPP at any time. Upon receipt, OAPP staff review and then forward all applications to the Operations Subcommittee of the PPC for consideration. The Operations subcommittee acts as the nominating body that reviews applications for PPC membership and makes recommendations to the Executive Subcommittee for appointment. The Operations Subcommittee reviews the current local HIV/AIDS epidemic to ensure parity, inclusion, and representation, considers gaps in PPC membership, and recommends nominees accordingly to fill gaps. To ensure a clear and concise method for nominating and selecting new PPC members, the Operations Subcommittee follows the membership procedures outlined in the *PPC Policies and Procedures*.

After the review process, the Operations Subcommittee votes to either forward an application to the Executive Subcommittee or to keep it on file for future consideration.

The Executive Subcommittee, which is comprised of all of the subcommittee chairs, PPC community co-chairs, and governmental co-chairs, reviews the membership recommendations presented by the Operations Subcommittee. The Executive Subcommittee reviews and approves nominations to be presented to the full PPC for a vote. Upon approval, the PPC forwards nominations to the OAPP Director for endorsement and final appointment.

■ The 2009-2013 Comprehensive HIV Prevention Planning Process

❖ *STRUCTURE*

The PPC approved the formation of an ad hoc Prevention Plan Work Group during its April 2007 meeting to launch work on the *Los Angeles County HIV Prevention Plan 2009-2013*. During its first meeting in May 2007, the Prevention Plan Work Group created a set of guidelines regarding participation and voting. They also created an aggressive timeline with a detailed work plan that outlined the steps needed to complete all aspects of the prevention plan by the end of December 2007. The work group incorporated the various tasks of the PPC subcommittees into their proposed work plan. They reviewed and utilized work products from the following three PPC subcommittees:

1. Operations – responsible for compiling the resource inventory;
2. Standards and Best Practices – responsible for the focus groups and key informant interviews, gathering information on interventions, HCT recommendations; and
3. Evaluation – responsible for updating the epidemiologic profile and developing the Los Angeles Coordinated HIV Needs Assessment.

The brevity of these descriptions provides only a glimpse of the tremendous effort made by all to complete the work of Los Angeles County's 2009-2013 HIV prevention plan. For example, the

PPC's Standards and Best Practices Subcommittee was responsible for identifying available evidence based interventions, compiling a database of those interventions, and making recommendations to the Prevention Plan Work Group and the PPC regarding effective interventions in Los Angeles County. Their work spanned a review of existing published interventions available through the CDC and other government organizations, as well as those being developed by various HIV interventionists across the country, including the array of locally developed interventions (LDIs) that have shown promise in Los Angeles County. Literally hundreds of hours of the community's time and dedication went into what has been an intense, inclusive, and comprehensive HIV prevention planning process.

Complementing the work of these subcommittees during this same period OAPP, the PPC, and the Commission on HIV collaborated on the development and implementation of Los Angeles County's first, coordinated needs assessment process referred to as the *Los Angeles Coordinated HIV/AIDS Needs Assessment* (LACHNA). This assessment process was designed to assess both the care-related needs of persons living with HIV and AIDS (PLWHA) in Los Angeles County as well as the HIV prevention needs of individuals at risk for acquiring or transmitting HIV. LACHNA replaced Los Angeles County's previous HIV prevention needs assessment – the *Countywide Risk Assessment Survey* (CRAS).

The Prevention Plan Work Group was responsible for prioritizing populations at greatest risk of acquiring and transmitting HIV. The process used is detailed more fully in *Chapter 4: Priority Populations*.

Participation in the Prevention Plan Work Group was open to the public, and included representatives from the PPC, OAPP, representatives from the County's eight service provider networks (SPNs), and other community members. The group elected a Chairperson and Deputy Chairperson to lead the meetings. The Prevention Plan Work Group reviewed and approved work of various PPC subcommittees that related to the HIV Prevention Plan (e.g., Standards and Best Practices Subcommittee identified evidence-based interventions to be included in the plan). OAPP engaged the services of an external consultant to assist in facilitating the prioritization process as well as to write the final version of the plan.

❖ *PROCESS*

The Prevention Plan Work Group met as needed and held twenty-two (22) meetings from April to November 2007. Participation was open to the public. In its early meetings, work group members approved using a simple majority voting process for its decision-making. However, in order to maintain a meeting that was open to the public, the Prevention Plan Work Group determined that in any given meeting, to participate in voting, a member had to attend three consecutive meetings. This voting eligibility requirement allowed for an open participatory process, while ensuring that an individual would not impede the progress that had been made by individuals who were able to regularly attend the meetings. At the same time, it was the intent of the work group to reach consensus on specific issues before moving to a vote. The purpose was to promote inclusion of all members and ensure that everyone had an opportunity to speak. If a decision could not be reached through consensus, a work group member would make a motion, according to Roberts Rules of Order, that would result in a vote.

In July 2007, OAPP and the Prevention Plan Work Group engaged the services of an external consultant to assist with the writing of the plan but also to assist the work group as needed through their priority setting process. During the next few meetings, the work group voted to use

a formal consensus decision-making process for priority setting. Members understood that a true consensus-based approach would likely take longer than utilizing a voting process. They determined that it was of utmost importance that they maximize community participation during priority setting and that utilizing a formal consensus decision-making model would enhance their deliberations. However, understanding that time was also important, they approved utilizing a super majority (67%) voting procedure for decisions when 100% consensus could not be reached. During the formal consensus process, if consensus was not reached, the consultant or other facilitators asked to hear from the members who expressed concerns. They were asked to state their concern and offer a possible solution that would address that concern. After this process, if consensus was still not reached, the Prevention Plan Work Group took a vote of eligible voting members (based upon the three meeting attendance requirement). For all decisions related to priority setting, the vote had to equal or exceed a super majority.

Average community participation ranged from 30 to 50 community members attending all scheduled meetings at any given time. In terms of race/ethnicity, participants represented the diversity of Los Angeles County's epidemic. Approximately 37% of work group members were Latino or Hispanic, 30% African American or Black, 3% Asian or Pacific Islander, and 20% White. 10% of the work group self-reported multiple races/ethnicities or other race/ethnicity. Of the 31 regularly attending members, 43% were male; 50% female; and 7% transgender individuals. Approximately 16% of participants were HIV- positive; 81% HIV negative; and 3% did not declare their HIV status or it was unknown. Of the consistent members, 43% were also PPC members and 57% were interested community stakeholders.

The dedication and commitment of all participants cannot be overstated. In September, the Prevention Plan Work Group convened a three-day Data Summit to review all the available epidemiologic and other data on the HIV epidemic in Los Angeles County to drive an evidence-based decision-making process for priority-setting. As deadlines drew nearer, the Prevention Plan Work Group scheduled additional meetings to complete the work. During September and October 2007, the group met almost weekly. The level of community participation and engagement in this process exceeded previous planning cycles. Thus, it is with great pride and ownership that the community of Los Angeles County presents the *Los Angeles County HIV Prevention Plan 2009-2013* as its most current comprehensive HIV Prevention Plan.

❖ *NEXT STEPS*

Community planning is not a onetime only process. Although the immediate work of the Prevention Plan Work Group is now complete, there is important work that will continue moving forward. First, now that new priority populations have been established, a more comprehensive data analysis of LACHNA findings will be completed. Second, although there are many lessons to be learned through Los Angeles County's first systematic resource inventory process, OAPP and the PPC will assess the initial work completed and determine the next steps for gathering additional information regarding available resources in the County. Third, OAPP and the PPC are working together to complete a more thorough gap analysis regarding HIV prevention and testing services. Lastly, as with the previous plan, OAPP and the PPC expect that new issues will emerge over the next five years that will require immediate attention. As these new issues emerge, the PPC will continue to form special ad hoc work groups to gather the information necessary to address them. This is part of a continuous and ongoing process. As information is updated, the PPC and OAPP will update the current plan or create an addendum to this plan as needed. In fact, the design of the current plan, creating each section so that it can stand alone, including the pagination, is intentional. It allows for updates to specific sections within the plan

to be easily inserted without revising the entire plan. This style embraces the view of both OAPP and the PPC that Los Angeles County's *2009-2013 HIV Prevention Plan* is a living, breathing document promoting rapid and thoughtful responses to changes that occur within the epidemic in both the near and long-term.

Chapter References

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