

HIV Prevention Plan Addendum Los Angeles County 2003



**County of Los Angeles Department of Health Services
Office of AIDS Programs and Policy**



HIV Prevention Plan Addendum Los Angeles County 2003

**Developed by the
HIV Prevention Planning Committee**
A Select Committee of the Los Angeles County Commission on HIV Health Services

In Partnership with the
County of Los Angeles Department of Health Services
Office of AIDS Programs and Policy

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I. Executive Summary

In 2003 the Los Angeles County HIV Prevention Planning Committee (PPC) commenced the development of a new Comprehensive HIV Prevention Plan for Los Angeles County (2004 – 2008 HIV Prevention Plan). The new Plan will build on the vision introduced by the *Los Angeles County HIV Prevention Plan 2000* (Plan 200), which has directed HIV prevention services in Los Angeles County from 2000 – 2003. The recommendations incorporated in the Plan 2000, including the newly introduced Behavioral Risk Group (BRG) model guided the Office of AIDS Programs and Policy (OAPP) in issuing requests for proposals and funding allocations. The Plan utilizes a comprehensive resource allocation methodology that includes annual estimates of HIV infections to prioritize BRGs. The BRG model represents a critical shift away from a traditional target population model and focuses on behaviors to guide priority populations with an emphasis on communities of color within each BRG. The Plan 2000 further highlights the importance of behavioral theory and intervention research to guide recommendations for best practices.

In 2003, the PPC continued to engage in strategic planning activities to improve the community planning process that contributed to the development of the Plan 2000 and guides services through 2003. As a result of significant changes in federal HIV prevention strategies introduced in 2003, the introduction of a new Community Planning Guidance, new HIV testing technologies, and statewide legislation mandating HIV reporting, the PPC made a decision to develop an addendum to the Plan 2000. By issuing an addendum, the PPC will be able to address current issues not covered in the Plan 2000, provide guidance to the Health Department for the development of the 2003 Centers for Disease Control and Prevention (CDC) HIV Prevention Cooperative Agreement Application, and allow the PPC to engage in a thoughtful process to complete a comprehensive HIV Prevention Plan that addresses these changes. The HIV Prevention Plan 2004 – 2008 is scheduled for completion during the 1st quarter of 2004.

As an addendum, this document is not meant to be viewed as a stand-alone document, but instead, should be reviewed in combination with the Plan 2000. The purpose of this Addendum is to:

1. Provide updated HIV epidemiology data for Los Angeles County.
2. Reiterate the PPC's BRG model for prioritizing populations and allocating resources.
3. Address and provide guidance on issues that have significantly impacted the landscape of HIV prevention in Los Angeles County since publishing the *HIV Prevention Plan 2000*.

Also, the PPC embarked on the development of this addendum to ensure that the community planning process provides the Health Department with guidance for the development of the 2003 CDC HIV prevention application and that prevention efforts remain responsive to the needs of Los Angeles County. The PPC will publish a revised and comprehensive HIV prevention plan in 2004 that includes:

- An epidemiological profile
- Community assessment
- Resource inventory
- Analysis of met and unmet needs
- Recommendations for “Best Practice” intervention strategies
- Prioritized populations and resource allocations
- Recommendations for service integration and linkages
- Program evaluation recommendations
- Goals, objectives and performance indicators
- Identification of technical assistance needs
- A community planning evaluation plan inclusive of quality assurance

Epidemiology

The updated epidemiological data included in the Addendum highlights the disproportionate impact that the HIV/AIDS epidemic is having on people of color within each of the BRGs. A closer look at HIV/AIDS prevalence in Los Angeles County (LAC) shows that as of June 2003, the epidemic continues to be among people of color and predominantly among males, more specifically among men who have sex with men. Local data contrast significantly with overall U.S. trends, where injection drug use, women, and children comprise larger proportions of the national epidemic than they do in Los Angeles County.

Behavioral Risk Group Model

Following an extensive review of risk behavior data collected in Los Angeles County, the PPC voted to continue without *currently* modifying the existing BRG model. However, as the process for developing the Prevention Plan 2004-2008 progresses, the PPC will continue to review the BRG model to examine the trends among currently un-addressed high-risk groups including high-risk heterosexual males and current set-aside populations including Transgenders, American-Indians.

Resource Allocations and Priority Setting

Until data from HIV reporting in the State of California is considered more reliable and complete, the PPC will continue to rely on estimates of HIV infection. Since the last publication of the Prevention Plan 2000, the HIV epidemic in Los Angeles County has changed, impacting the estimates of HIV infection. The PPC is reviewing these new estimates provided by the HIV Epidemiology Program. These new estimates warrant a revision in the funding allocations for the BRGs and other prioritized high-risk populations. The PPC will use the same methodology of applying epidemiologic estimates to the total amount allocated to each BRG and additionally, will examine the geographic estimates of need to determine allocations across each of the eight Service Planning Areas (SPAs). The new recommendations will guide the allocation of any new and renewed prevention funding received by the County.

Current HIV Prevention Issues in Los Angeles County

After considerable discussion regarding the content of this Addendum, the PPC determined that it was important to acknowledge recent changes in key prevention

activities. By critically reviewing the changes and current activities around *HIV Counseling and Testing, Partner Counseling and Referral Services (PCRS), Prevention for HIV Infected Persons, Data/Program Evaluation Improvement, and Perinatal HIV Prevention*, the PPC identified issues that must be addressed for each of these areas. These issues must be addressed to ensure that Los Angeles County develops a response to HIV prevention that meets the needs of persons at high-risk for HIV infection. Also, as the PPC engages in the development of a new HIV Prevention Plan, it must be sensitive to the critical role that these prevention activities will play in implementing the CDC's new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003*.

Conclusion

The creation of a 2003 Addendum to the Los Angeles County HIV Prevention Plan is one of the many milestones of community planning in Los Angeles County. The Addendum provides information regarding the steps and actions that the PPC and the County of Los Angeles are taking in order to meet and exceed CDC prevention standards and provide the best and most effective prevention services for those individuals at risk for HIV infection, and continue to recommend evidence-based prevention strategies for those persons living with HIV.

II. Updated Epidemiology

Los Angeles County and the HIV/AIDS Epidemic

Los Angeles County has almost 10 million residents (9,979,600 million as of January 2003), making it the most populous county in the nation. Spanning 4,084 square miles of land, LAC is the second largest county geographically in the U.S. In 2000-2002, the county's average annual AIDS rate of 16.5 per 100,000 was above the 2001 national rate of 14.7 reported AIDS cases per 100,000.

There are approximately 45,000 persons living with HIV and AIDS (PLWH/A) in Los Angeles County who know their status and thus are in need of care services. There are an additional 9,000 people who do not know their HIV status, are not accessing primary health care, and need to be brought into the system of HIV/AIDS care. Moreover, at least one-third of Ryan White Care Act clients do not qualify for any form of third-party insurance (e.g. Medi-Cal).

In each of the last several years, there has been a decline in the number of new AIDS cases and deaths both in LAC and nationally—attributed primarily to the widespread use and effectiveness of “Highly Active Anti-Retroviral Therapy” (HAART). In addition, the number of persons living with AIDS (PLWA) in LAC has grown from 13,653 in 1994 to 18,089 by the end of June 2003.

In 2003, the Centers for Disease Control and Prevention (CDC) estimated that there were approximately 900,000 PLWH/A in the US, 230,000 of whom do not know they are infected. LAC remains one of the areas in the United States most impacted by HIV/AIDS. Only New York City and four states, including California, have reported more AIDS cases than Los Angeles County.

A closer look at HIV/AIDS prevalence in LAC shows that as of June 2003, the epidemic continues to be predominantly among males (89%), specifically men who have sex with men (70%) and among people of color (62%). These data contrast significantly with overall US trends, where injection drug use, women, and children comprise larger proportions of the national epidemic than they do in LAC.

The most striking change in the local epidemic over the last few years has been in a shift to communities of color. From 1993 to 2002, the proportion of Latinos living with AIDS in the county increased from 28% to 37%. During the same period, African-Americans increased from 20% to 22% of county residents living with AIDS. In contrast, the proportion of Whites living with AIDS decreased from 50% of LAC cases in 1993 to 38% in 2002 and the proportion of Asian/Pacific Islanders remained stable (2%) during the period. This local shift toward communities of color is consistent with changes in the national epidemic. However, the proportion of HIV-infected Latinos in LAC is much higher than in the U.S. as a whole and the AIDS rate among African-Americans in LAC remains much higher than in other racial/ethnic groups.

III. Behavioral Risk Group Model

In 1999, the PPC decided to depart from a resource allocation methodology based on a traditional target population model in favor of a model that focuses on HIV risk behaviors (Behavioral Risk Group Model). However, the PPC determined that three groups, American Indians, Transgenders and persons living with HIV must be included in the priority setting model as populations of special interest. Specifically, the PPC endorsed the inclusion of American Indians and Transgenders as distinct priority populations because epidemiologic data indicated a high seroprevalence rate in these groups, and conceptualizing prevention based on group membership seemed more appropriate for these two groups.

Over the past year, the Evaluation Subcommittee of the PPC reviewed numerous secondary data sources to assess met and unmet HIV prevention needs and evaluate the appropriateness of the current BRG model. Data sources included a recent update of AIDS case data, estimates of HIV infection and surveillance and seroprevalence studies conducted by the Los Angeles County HIV Epidemiology Program. In addition, the Subcommittee reviewed HIV counseling and testing data provided by the Office of AIDS Programs and Policy, and behavioral data collected by local community-based organizations and universities. Following a presentation of the data to the PPC in 2003, the PPC voted to continue without modifying the existing BRG model for the purposes of priority setting, resource allocation and prevention program planning. Additionally, the PPC recognized the continued importance of placing the highest priority for prevention resources on people of color, youth and persons living with HIV within each BRG and special population. The PPC will continue to review behavioral risk data to improve the BRG model.

The methodologies used by the HIV Epidemiology Program to estimate HIV prevalence and incidence (Table 1) is outlined below, including some of the limitations of these methodologies. The six BRGs for which HIV estimates were done include:

- Men who have sex with men (**MSM**)
- Men who have sex with men and women (**MSM/W**)
- Men who have sex with men who are also injection drug users (**MSM/IDU**)
- Heterosexual male injection drug users (**HM/IDU**)
- Female injection drug users (**F/IDU**)
- Women at sexual risk (**WSR**)

BRG categories are mutually exclusive and persons at risk for HIV are counted in only one BRG category. For all BRGs, unprotected sexual intercourse and/or the sharing of injection drug paraphernalia place individuals at risk for HIV infection.

The population size of each BRG and their race/ethnicity breakdown were estimated using a variety of sources—most notably, the 2000 US census, the Los Angeles Health Survey, the HIV/AIDS Reporting System (HARS), OAPP’s HIV counseling and testing database, data from the Alcohol and Drug Program Administration, LAC STD Clinic data, and epidemiological studies performed by the HIV Epidemiology Program.

Certain assumptions were made to inform estimates among populations—for example, it was assumed that the proportion of MSM among the African American and Latino adult male populations is similar to that of White adult males reported in the LA Health Survey. There is a body of evidence that suggests men of color are much less likely to admit to having sex with men compared to White men.

Also, surrogate definitions for certain BRG populations had to be employed. For example, OAPP defines women at high sexual risk as those who, in the last 2 years or since their last HIV test, engaged in anal sex with a male sex partner; engaged in “exchange” sex; had intercourse with a male IDU or MSM or HIV-infected male; had 2 or more male sex partners; had a history of an STD(s); or had sex under the influence of drugs (i.e., crack, amphetamines, cocaine, nitrites/ates, or ecstasy). Using the LA Health Survey, women at sexual risk were defined as that portion of women reporting more than one sex partner, plus 5% of women who reported only one sex partner in the previous 12 months. This combined proportion was then applied to all women ages 15 - 64 years as determined by the 2000 US census.

The number and distribution of persons living with AIDS (PLWA), as well as persons diagnosed with AIDS in 2001, were obtained from HARS. The overall estimated number of person living with HIV (PLWH) was determined by using a modified CDC formula. For every PLWA in LAC, it was estimated that another 1.5 persons are HIV-infected (non-AIDS). To estimate the total number of persons living with HIV and AIDS (PLWHA), these two numbers were added together with a third estimate—that of persons who are HIV-infected but unaware of their HIV status. Nationally, an estimated one out of every four PLWH are not aware of their status.

For estimates of the distribution of PLWH by BRG and race/ethnicity, HARS incident AIDS cases for 2001 were used as a surrogate, as it is a better reflection of the emerging epidemic than that of PLWA. The limitation of this methodology is not knowing the exact relationship between the distribution of PLWH and that of newly diagnosed AIDS cases in HARS.

The number of newly diagnosed HIV infections estimated for LAC this year is based on LAC comprising 5% of the national epidemic. With an estimated 40,000 newly diagnosed cases of HIV infection per year in the U.S., LAC is estimated to have 2,000 new cases.

The distribution of newly diagnosed HIV infections is based on the proportion by BRG, race/ethnicity of persons testing positive at OAPP funded HCT sites, on HARS incident AIDS data, and on the estimated size of the BRG population. Overweighting F/IDU and WSR estimates from HARS data was done to compensate for the under representation of HCT data for the smallest BRGs.

The following table outlines the estimated distribution of persons living with HIV/AIDS and newly diagnosed HIV infections, by Behavioral Risk Group and race/ethnicity in Los Angeles County, 2003.

Table 1. Estimated Distribution of Persons Living with HIV/AIDS

Estimated Distribution of Persons Living with HIV/AIDS and Newly Diagnosed HIV Infections, by BRG and Race/Ethnicity – Los Angeles County, 2003

| BRG | Race/Ethnicity | Percent Estimated PLWH/A* | Percent Total Diagnosed AIDS Cases in 2001** | Percent of Newly Diagnosed HIV Infection** | Estimated Annual No. of Newly Diagnosed HIV Infections |
|-----------------|----------------|---------------------------|--|--|--|
| MSM | White | 22.9% | 19.4% | 15.0% | 301 |
| | Black | 9.2% | 9.2% | 8.4% | 168 |
| | Latino | 19.8% | 19.9% | 27.6% | 552 |
| | Asian/PI | 1.8% | 1.9% | 2.4% | 48 |
| | Other*** | 0.5% | 0.4% | 0.2% | 4 |
| Subtotal | | | | | 1073 |
| MSM/W | White | 2.4% | 2.2% | 1.9% | 38 |
| | Black | 3.6% | 3.8% | 2.9% | 57 |
| | Latino | 5.6% | 5.8% | 6.8% | 137 |
| | Asian/PI | 0.4% | 0.5% | 1.8% | 36 |
| | Other*** | 0.1% | 0.2% | 0.3% | 6 |
| Subtotal | | | | | 274 |
| MSM/IDU | White | 2.6% | 2.5% | 2.1% | 45 |
| | Black | 1.6% | 1.6% | 1.2% | 23 |
| | Latino | 1.6% | 1.6% | 2.1% | 41 |
| | Asian/PI | 0.0% | 0.0% | 0.3% | 6 |
| | Other*** | 0.1% | 0.0% | 0.1% | 2 |
| Subtotal | | | | | 117 |
| HM/IDU | White | 2.6% | 3.0% | 1.7% | 34 |
| | Black | 3.0% | 3.4% | 2.8% | 56 |
| | Latino | 2.3% | 2.4% | 1.5% | 30 |
| | Asian/PI | 0.0% | 0.0% | 0.0% | 0 |
| | Other*** | 0.1% | 0.1% | 0.0% | 0 |
| Subtotal | | | | | 120 |
| F/IDU | White | 1.0% | 1.1% | 0.9% | 19 |
| | Black | 1.3% | 1.4% | 1.3% | 25 |
| | Latino | 0.8% | 0.9% | 0.7% | 14 |
| | Asian/PI | 0.1% | 0.1% | 0.1% | 2 |
| | Other*** | 0.0% | 0.0% | 0.0% | 0 |
| Subtotal | | | | | 60 |
| WSR | White | 1.2% | 1.2% | 1.2% | 25 |
| | Black | 2.8% | 3.0% | 2.9% | 59 |
| | Latino | 3.7% | 4.0% | 3.9% | 78 |
| | Asian/PI | 0.2% | 0.2% | 0.2% | 4 |
| | Other*** | 0.1% | 0.0% | 0.1% | 2 |
| Subtotal | | | | | 168 |

Table 2. Estimated Distribution of Person Living with HIV/AIDS and Newly and Diagnosed HIV Infections by Race/Ethnicity – Los Angeles County, 2003

| Race/Ethnicity | MSM | MSM/W | MSM/IDU | HM/IDU | F/IDU | WSR | Total |
|----------------|-------------|------------|------------|------------|-----------|------------|-------------|
| White | 301 | 38 | 45 | 34 | 19 | 25 | 462 |
| Black | 168 | 57 | 23 | 56 | 25 | 59 | 388 |
| Latino | 552 | 137 | 41 | 30 | 14 | 78 | 852 |
| Asian/PI | 48 | 36 | 6 | 0 | 2 | 4 | 96 |
| Other*** | 4 | 6 | 2 | 0 | 0 | 2 | 14 |
| Total | 1073 | 274 | 117 | 120 | 60 | 168 | 1812 |

* PLWH/A = persons living with HIV and AIDS.

** BRGs account for 91.4% of persons living with HIV/AIDS, 89.8% of all AIDS cases diagnosed in 2001, and 90.4% of estimated new HIV infections; non-BRG exposure groups include heterosexual men, transfusion recipients, pediatric cases, etc.

*** Other race/ethnicity category includes American Indians, Alaska Natives, unknown, and 2 or more races

Priority Populations and Resource Allocations

Background and Rationale

The PPC concluded that since the updated estimates of HIV infections for Los Angeles County are sufficiently different from those in the current plan, it warranted revising the current allocation of prevention funds. Therefore, the PPC will use these new estimates in the priority setting and resource allocation process and include them in the Prevention Plan 2004 - 2008. The new priorities and resource allocations should be used by OAPP in distributing prevention funds that come to Los Angeles County.

The PPC's recently formed Ad Hoc Prevention Plan Subcommittee recommended exploring other issues that may impact priority setting and resource allocations. These issues require more investigation and discussion before finalizing the next priority setting and resource allocations process. These issues include:

1. The current resource allocation model applies countywide race/ethnicity percentages to breakdown BRG populations in each Service Planning Area (SPA). The PPC must explore how it can improve the resource allocation model to ensure that racial/ethnic differences between SPAs are captured and that resources are distributed accordingly.
2. The current resource allocation model uses data that is based on a client's zip code of residence. Efforts must be made to capture data regarding the places where risk behavior takes place and where persons engaging in high-risk behaviors may be accessed. This may be different from the zip code/SPA of residence. The PPC must explore how this data may be captured and considered during priority setting and resource allocation process.
3. The current Plan recommends allocating 25% of all BRG funds for youth. The PPC must revisit this recommendation to ensure its accuracy and proportionality of the percentage to the local epidemic.
4. A thorough examination of the non-population-based set-asides (i.e., *Evaluation, Capacity Building and Technical Assistance, Research and Data Collection, and PPC Support*) in the current allocation recommendations must be completed to ensure that they are reasonable and accurate. The purpose of each item must be clearly spelled out so that the PPC can monitor their actual utilization and effectiveness. In particular, the amounts for *Evaluation* and *Research and Data Collection* need to be re-examined as more funding may be needed or other methods of collecting countywide risk assessment data may be necessary. Also, the PPC and OAPP must review the allocated amount for *PPC Support* to ensure that the PPC can perform all the planning, support, and evaluation activities that are expected of this body.
5. The issue regarding non-injection substance use related to risk for HIV infection should be reviewed more carefully to determine whether it should be included in the allocation formula. Similarly, STD incidence and prevalence data should be

reviewed to determine how they could be used beyond determining resource allocations and geographic estimates of need.

6. There is a need to examine whether incarcerated populations should be considered a separate priority population for distinct resource allocation.
7. To address the CDC guidance that requests that local jurisdictions make HIV positive persons the number one priority, the PPC should consider recommending that a fixed percentage of all BRG funds be allocated for HIV positive persons. This recommendation is similar to the recommendation made in the Plan 2000 for youth, which recommended allocating 25% of all BRG funds for youth.

V. Current Prevention Issues in Los Angeles County

Since publishing the HIV Prevention Plan 2000, significant changes have occurred around HIV prevention that has impacted the landscape of HIV prevention in Los Angeles County. The prevention areas include: *HIV Counseling and Testing, Partner Counseling and Referral Services (PCRS), Prevention for HIV Infected Persons, Data/Program Evaluation Improvement, and Perinatal HIV Prevention*. This section intends to address and provide guidance regarding these changes. The PPC determined that these prevention issues need to be addressed to ensure that Los Angeles County appropriately responded to the CDC's new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003*.

For each prevention topic, background is provided as well as a brief description of current activities. Where possible, issues to be considered and recommendations are made. Addressing these is critical to developing a strategic response to the local HIV epidemic. The PPC and County of Los Angeles should take action based on these issues as they work together to formulate the HIV Prevention Plan 2004 - 2008.

A. HIV Counseling and Testing

Background

HIV Counseling and Testing is one of the most widely utilized prevention strategies in the United States. The goals of HCT include ensuring that HIV-infected persons and persons at high-risk for HIV have access to HIV testing to promote early knowledge of their HIV status; receive high-quality HIV prevention counseling to reduce their risk for transmitting or acquiring HIV; and have access to appropriate medical, preventive, and psychosocial support services. An additional goal of HCT is also to Promote early knowledge of HIV status through HIV testing and ensure that all persons either recommended or receiving HIV testing are provided information regarding transmission, prevention, and the meaning of HIV test results. Los Angeles County continues to place great emphasis on HCT, consistent with the recommendations included in the Centers for Disease Control and Prevention's new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003*.

Current Activities in Los Angeles County

In Los Angeles County, HCT services are organized around the BRG model with the purpose of targeting all HIV prevention services to those at highest risk for infection and/or those living with HIV. Reimbursement for HCT services is based on a fee-for-service system, which offers an incentive for a more targeted approach to providing services. While there has been varied success among HCT providers in Los Angeles County in reaching those at highest risk for HIV, most have shown significant improvement in **targeting** HCT services and have increased the identification of HIV positive individuals and high-risk HIV negative individuals.

Publicly funded HCT is provided in various venues including public health clinics, Alternative Test Sites, community-based organizations, mobile testing units, Los Angeles County Superior Courts, Commercial and Public Sex Environments, drug treatment facilities, Los Angeles County Jails, and HIV/AIDS care and treatment facilities. Significant steps have also been made to integrate co-morbidity screening into prevention services.

Integration of HIV and STD Screening

In response to the syphilis outbreak among MSM in Los Angeles County, OAPP and STD Program are working in partnership to develop a protocol for the integration of HIV and STD testing. To date, STD Program has provided phlebotomy and STD training to OAPP-funded agencies who target MSM and resources have been identified to fund dual testing. In addition, three demonstration projects are currently being implemented to identify co-morbidities. Two agencies provide screening for HIV, STDs (chlamydia, gonorrhea, syphilis) and Hepatitis (A, B, C) and a third agency addresses co-infection with HIV and Hepatitis C among Injection Drug Users. These strategies will shed light on the challenges and opportunities for the provision of more comprehensive HIV and STD integrated services in other community agencies.

Rapid HIV Testing

The advent of rapid HIV testing is poised to play a significant role in Los Angeles County's HIV prevention efforts. Currently, two community sites have implemented rapid testing in Los Angeles County through a CDC project. Several more community sites are expected to offer rapid HIV testing through a California State Office of AIDS project upon the approval of Los Angeles County's CLIA-waiver request.

- Consider the establishment or adoption of rapid testing guidelines to be adhered to by publicly funded HCT providers.
- Develop a strategy for identifying existing or new counselors to be prioritized for rapid testing training.
- Develop a strategy to identify venues that are most appropriate for rapid testing.
- Explore opportunities to provide mental health support for persons providing HCT services including rapid testing.

HIV Non-Names Reporting

On July 1, 2002, HIV became a reportable condition in California. All HCT providers in Los Angeles are required to report new HIV cases to Los Angeles County's HIV Epidemiology Program using a unique identifier system. OAPP is continuing to work with its contracted agencies to ensure that they are aware of their regulatory obligation and to assist the Los Angeles County HIV Epidemiology Program in identifying those HIV cases which have not been reported.

Issues to Consider

The following are key HCT issues that the PPC, in partnership with OAPP and community providers, should consider as the development of the new Los Angeles County HIV prevention plan unfolds:

- Explore mechanisms to increase collaborations with other County agencies that provide services to people at risk for HIV infection (e.g., Alcohol and Drug Programs Administration, family planning sites, etc.)
- Review the fee-for-service system and its impact on HCT services.
- Increase rapid testing training opportunities for select HCT staff throughout Los Angeles County.
- Refine strategies to target those most at risk for HIV and encourage them to seek HCT services.
- Increase return rates for HIV test results by promoting the transition from blood or saliva based HIV testing to rapid HIV testing, where appropriate.
- Increase linked referrals of individuals who test HIV positive to treatment.
- Determine the transaction costs, potential efficiencies and impact on providers associated with combining STD and HIV screening.
- Improve risk behavior data collection at all HCT sites in Los Angeles County and the timely sharing of that data to local stakeholders and community partners.
- Examine pre-test counseling protocols to increase the acceptability of confidential HIV testing and counseling.
- Explore opportunities to pursue mental health support for persons providing counseling and testing services.

B. Partner Counseling and Referral Services (PCRS)

Background

Available evidence suggests that a significant number of new HIV infections originate from HIV infected people who are not yet aware of their infection. This finding emphasizes the need to identify HIV infected persons through HIV-positive, sexual and drug sharing partners and link them to medical, prevention, and other services as soon as possible. One strategy for accomplishing this is voluntary partner counseling and referral services (PCRS), including partner notification (PN).

PCRS provides HIV infected individuals the opportunity to inform sexual and needle sharing partners of possible HIV exposure, testing options, and referrals for clinical care for those testing positive. PCRS trained staff assist HIV positive individuals to explore options and weigh carefully the benefits and challenges associated with disclosure. PCRS is voluntary, confidential and free.

There are four strategies for reaching and informing partners of their potential HIV exposure including:

1. Provider referral – the clinical care provider or health department staff, with permission from the HIV-positive client, informs the partner and refers him or her to counseling, testing, and other support services.
2. Client referral – the HIV infected person accepts full responsibility for informing his or her partners of their possible exposure to HIV and for referring them to HIV counseling and testing services.
3. Contract referral – the infected person has an agreed number of days to notify his or her partners. If by the contract date, the partners have not had a visit for counseling and testing, the health department initiates partner notification services.
4. Dual referral – the HIV infected client and the provider, informs the partner together.

Dual referrals and provider referrals are the easiest and most reliable to document of the four strategies.

Current Activities in Los Angeles County

In LAC, PCRS has traditionally been an arm of HIV Counseling and Testing Services and occurring at an episode shortly after a person learns that he/she is HIV-positive, arguably at a time when persons are less inclined to offer the names of past or recent sexual or drug using partners. As a countywide public health program, PCRS is provided most often by Public Health Investigators trained in partner elicitation and field follow-up and in response to partner notification referrals from medical care providers. In its new approach to PCRS, LAC proposes to significantly, but carefully, expand both the number of trained PCRS personnel, including community-based providers who are experts in delivering prevention with HIV-infected persons (PHIP) services as well as select staff of publicly funded HIV medical outpatient providers. LAC is proposing to take PCRS from a largely single episode intervention to a multiple episode intervention that will occur over the course of a person living with HIV. Finally, LAC recommended modifying existing fee-for-service HIV counseling and testing reimbursement structure to motivate the offering and delivery of PCRS by community-based counselors in publicly funded programs.

Issues to Consider

The following are key *PCRS* issues that the PPC, in partnership with OAPP and community providers, will consider in 2004 as planning for the new Los Angeles County HIV prevention plan unfolds:

- Efforts must be made to clearly define the role of CBOs in PCRS, and determine how they are documenting their activities.
- Continue to assess the effectiveness of PCRS.
- PCRS must be accessible throughout the continuum of HIV/AIDS care and on a constant basis since the individual will always be HIV positive. Examine the integration of PCRS into care.
- The differences and similarities between PCRS for STDs and HIV must be assessed for possible integration.

- Assess differences in PCRS in confidential versus anonymous testing sites.
- Improved marketing of PCRS availability in order to encourage more people to use the services available to them and inform them of their options. There needs to be a greater understanding and awareness of PCRS programs.

C. Prevention for HIV Infected Persons (PHIP)

Background

As previously described, the *Plan 2000* recommends funding allocations based on a BRG model. In addition to the specific BRGs previously outlined, the PPC also identified persons living with HIV as a priority population. While data gathered from the Countywide Risk Assessment Survey (CRAS) indicated that agencies funded to provide traditional HE/RR services for persons most at risk for HIV were also reaching HIV infected individuals, the County of Los Angeles was the recipient of a CDC-funded demonstration project focusing on the prevention needs of people who are HIV-positive.

Current Activities in Los Angeles County

The CDC-funded Prevention for HIV Infected Persons Program (PHIPP) demonstration project focuses on prevention needs for people who are HIV-positive. The Los Angeles County PHIPP offers a multi-level and multi-site approach to prevention with positives, combining outreach, testing and counseling, linkage to prevention and care services, group- and community-level interventions, and health communication and public information services. The following is a list of LAC organizations and the type of PHIPP services they provide as part of the demonstration project:

- *AIDS Healthcare Foundation (AHF)* offers testing, counseling and referrals to partners of HIV-positive individuals at AHF HIV medical clinics.
- *AIDS Project Los Angeles* conducts the POWER (Positive Wellness and Renewal Program). The POWER Program provides prevention case management and individual, group and community level education and support to people living with HIV. Wellness Case Managers and Health Promotion Specialists help clients address relationship issues, disclosure concerns, substance use, individual sexual expression, adherence to HIV medications, and other health and wellness matters.
- *L.A. Gay & Lesbian Center* coordinates the Positive Images Consortium, which incorporates a continuum of services that includes HIV counseling and testing, linkage to prevention and care services, a toll-free telephone chat line, a website and chat room, individual counseling, skills building workshops, community forums, and a social marketing campaign. Positive Images is a collaboration of eleven diverse agencies providing multi-level, multi-site interventions throughout the County of Los Angeles.

- *L.A. Shanti* offers a group level intervention targeting MSM and WSR of diverse communities. The seminar-style intervention focuses on the topics of relationships, dating, disclosure and self-esteem, as a way to equip individuals with the skills to stop the further spread of HIV. The seminar is followed by a series of nine weekly, curriculum driven support sessions that affirm the skills learned during the seminar.
- *Tarzana Treatment Center* provides prevention intensive risk reduction services to individuals who have been HIV positive for less than two years and who are in substance abuse treatment through individual risk reduction counseling, support groups, and workshops.

Issues to Consider

The following are key *Prevention for HIV Infected Persons Program* issues that the PPC, in partnership with OAPP and community providers, will consider in 2004 as planning for the new Los Angeles County HIV prevention plan unfolds:

- Determine the efficacy of interventions for prevention with positives (i.e., Prevention Case Management, Individual, Group and Community Level Interventions).
- Define and clarify the role of mental health in prevention with positives.
- Address the integration of more extensive substance use assessments for clients participating in PHIPP.
- Emphasize and create a better understanding about the importance of discussing sex in interventions for positive persons.
- Increase the visibility and awareness regarding the availability of PHIPP through promotion activities. Effective strategies for engaging and retaining HIV positive persons in PHIPP must be developed.
- Increase focus on co-infection issues including STD, Hepatitis and substance abuse/dependency.
- Explore opportunities to enhance collaborations between and with private medical providers for PHIPP services.
- Address and define the role that Prevention Case Management plays in PHIPP.
- Conduct ongoing assessments of risk behaviors among HIV positive individuals.

D. Data/Program Evaluation Improvement

Background

In July 2001, the LAC OAPP funded AIDS Project Los Angeles (APLA) and the UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) to develop a training project to build capacity among HIV/AIDS service providers, the community planning groups, and OAPP staff in the area of program evaluation. The project goal was to increase the evaluation capacity of the target groups in order to improve HIV prevention and care services in Los Angeles County.

The project began by conducting a Needs Assessment to understand the current capacity of the target groups in program evaluation. It addressed five main research questions. They included:

1. *What is the capacity of respondents in performing evaluation activities?*
2. *What is the level of interest for each of the evaluation topics?*
3. *What evaluation activities do respondents have low capacity and high interest in attending a training on?*
4. *What topics should be addressed in the training program?*
5. *What barriers do staff face in performing evaluation activities?*

The Needs Assessment involved mailing the survey to local HIV/AIDS agencies that currently were contracted with OAPP. The information gathered from the Needs Assessment was used to inform the planning, development, and implementation of the Evaluation Training Program (ETP). A curriculum, trainer's manual, training workbook, and slide presentation were produced to support the ETP. The goal of ETP was to provide participants with a better understanding of the evaluation process and tools to design and implement an effective evaluation of their HIV/AIDS prevention and care services.

Evaluations of the ETP support the need for training in evaluation. Feedback from participants also indicates that there was a high interest among the target groups to receive training. ETP participants are also demonstrating increased knowledge regarding evaluation methods.

Current Activities in Los Angeles County

Systematic evaluation is conducted to:

- 1) Determine the extent to which HIV prevention efforts have contributed to a reduction in HIV transmission.
- 2) Improve HIV prevention services.
- 3) Identify successful interventions.
- 4) Determine characteristics of clients targeted and reached by interventions.
- 5) Measure the effect of interventions on client behavior and HIV transmission.
- 6) Assess community planning.
- 7) Demonstrate accountability to stakeholders.

Using the June 2001 CDC Evaluation Guidance, the following activities are currently included in the evaluation plan and recommended for ongoing implementation.

- Develop and Implement an Evaluation Plan
 - OAPP Research and Evaluation staff in consultation with all OAPP divisions develops and revises an evaluation plan based on all prevention activities and CDC guidelines annually.
 - OAPP Research and Evaluation staff provides initial training and ongoing technical assistance to OAPP program managers and Educational Services

staff to improve the capacity to manage the evaluation components of all service contracts.

- OAPP Research and Evaluation staff collaborates with Information Services staff and Prevention Services staffs on an ongoing basis to ensure that appropriate data collection systems (paper and computer-based) are updated and functional.
- Evaluating HIV Prevention Community Planning
 - PPC Evaluation Subcommittee and OAPP (Research and Evaluation and Planning and Development staff) develop and implement surveys annually to gather demographic information about PPC members and Subcommittee participants.
 - PPC Executive Subcommittee and Planning and Development staff gather quantitative and qualitative data from attendees at forums and break-out sessions quarterly.
- Designing and Evaluating Plans for HIV Prevention Services
 - OAPP Research and Evaluation staff and Prevention Services staff advises on the development of Request for Proposals to ensure clear articulation of program evaluation requirements.
 - OAPP Research and Evaluation staff and Prevention Services staff review proposals recommended for funding for consistency with and linkage to evaluation activities in the HIV Prevention Plan.
- Evaluating the implementation of HIV prevention programs
 - OAPP Prevention Services staff reviews monthly report data for core indicators.
 - OAPP Prevention Services staff conducts annual audits on all OAPP contractors.
 - Contractors submit evaluation plan progress reports annually. OAPP program managers and Research and Evaluation staff review evaluation plan progress reports annually. OAPP Research and Evaluation staff provide technical assistance to both OAPP program managers and agency staff as needed.
 - OAPP staff, PPC participants, related county programs, and academic researchers revise the Countywide Risk Assessment Survey annually. The survey is implemented in the second quarter of the calendar year and analysis and results are disseminated and utilized the following quarter.
- Evaluating linkages among the HIV Prevention Plan, CDC funding application, and allocation of resources
 - PPC members, Planning and Development staff, Prevention Services staff, and Research and Evaluation staff review the CDC funding application for

consistency with and linkages to evaluation components of the HIV Prevention Plan.

- Prevention Services staff review existing service agreements for consistency with and linkages to the evaluation components of the HIV Prevention Plan.
- Prevention Services staff, Planning and Development staff, and Research and Evaluation staff use the Countywide Risk Assessment data, monthly report data, and the priority setting model to evaluate the linkage among the HIV prevention plan, CDC funding application, and allocation of resources during the second quarter.
- Evaluating Core Outcome Indicators of HIV Prevention Programs
 - Workgroup consisting of PPC participants, academic researchers, and OAPP staff will develop standardized outcome indicators by CY 2004.
 - OAPP staff and capacity building contractors will continue to assess the evaluation capacity of service providers.
 - OAPP staff and capacity building contractors will continue to assess the technical assistance needs of providers to improve evaluation capacity.
 - Research and Evaluation staff, Prevention Services staff, and Planning and Development staff will review and update evaluation requirements described in Requests for Proposals.
 - Research and Evaluation staff, Prevention Services staff, and Information Services staff will continue to advise on the development of monthly reports, data collection systems and contract language to ensure that evaluation activities are appropriately integrated.
 - Research and Evaluation staff and capacity building contractors will develop an evaluation manual for service providers by CY 2005.

Issues to Consider

The following are key *Data and Program Evaluation Improvement* issues that the PPC, in partnership with OAPP and community providers, will consider in 2004 as planning for the new Los Angeles County HIV prevention plan unfolds:

- Continue to provide training on basic evaluation concepts to target groups.
- Provide more advanced level training to increase knowledge and skills in specific areas of program evaluation.
- Ongoing technical assistance and capacity building should be provided to service providers in the areas of program evaluation.
- Efforts should continue around evaluation training to ensure building the technical assistance support and resources available to service providers (e.g., network of providers, educational materials).
- Future evaluation activities should focus on the integration and collection of data that measures CDC recommended core outcome indicators.

- A core set of indicators around Knowledge, Attitudes, Beliefs, and Behaviors (KABB) should be identified to facilitate evaluating HE/RR and HCT services on a countywide level.

E. HIV Reporting

Background

The State of California implemented HIV reporting July 1, 2002. Unlike AIDS case reporting which is reported by name, each HIV case is reported using a coded identifier. The identifier contains elements of the last name (Soundex), full date of birth, a one-digit code for gender, and the last four digits of social security number. This is a dual reporting system that requires laboratories to notify the local health officer of positive HIV test results (e.g. Elisa, Western Blot, P-24 antigen, viral load, and viral culture) and mandates that providers report HIV cases within 7 days of receipt of positive laboratory findings. The reporting system is designed to include prevalent HIV cases accessing HIV-related medical services and incident cases tested confidentially. HIV positive cases identified through anonymous HIV counseling and testing services are not reported.

An estimated 25,000 persons are living with non-AIDS HIV disease and receiving health care services in Los Angeles County. At the close of the first year of HIV reporting, 6,083 cases of non-AIDS HIV were reported and over 10,000 potential cases identified through laboratory reporting are pending investigation. Given the magnitude of the task of reporting HIV prevalence and the available resources for conducting HIV surveillance, the growing backlog of HIV prevalent cases pending investigation will not be completed for approximately two years.

Current Activities in Los Angeles County

In July 2004, the Los Angeles County HIV Epidemiology Program will participate in a state-sponsored evaluation of the HIV surveillance system. The evaluation will be designed to assess the validity, reliability and completeness of the reporting system. The evaluation will take 18 months to complete. If the results of the evaluation suggest a sound HIV reporting system, HIV case data will then be used for community planning purposes. In the meantime, the Prevention Planning Committee will rely on AIDS case data and estimates of HIV prevalence.

Issues to Consider

The following are key *HIV Reporting* issues that the PPC, in partnership with OAPP and community providers, will consider in 2004 as planning for the new Los Angeles County HIV prevention plan unfolds:

- Continue to routinely assess the compliance by funded HCT and HIV care providers with State HIV non-names reporting requirements.
- Review strategies and systems that contribute to reporting compliance by public providers and replicate as needed.

F. Perinatal HIV Prevention

Background

The Los Angeles County Perinatal HIV Prevention Program is funded through the State of California Office of AIDS and is part of a national perinatal demonstration project funded by the CDC. The County's program is an integrated effort of existing networks, programs and surveillance activities to reduce perinatal transmission of HIV in Los Angeles County.

Current Activities in Los Angeles County

The *Urban Planning Cluster, Los Angeles Team* (Los Angeles Team) coordinates local efforts by convening meetings composed of prevention, services, and surveillance programs of the Los Angeles County Department of Public Health and the community. The Los Angeles Team represents a partnership among the Los Angeles County OAPP, Maternal Child and Adolescent Health, Pediatric Spectrum of Disease, Pediatric HIV infection Reporting Project, Acute Communicable Disease Control and the LAC-USC Medical Center. Other partners include LAC STD Program, treatment centers and community-based organizations such as the East Los Angeles Women's Center and the Harbor Community Health Center. The Los Angeles Team meets monthly to review strategies among women who are HIV positive and pregnant, hard-to-reach and at risk for perinatal transmission of HIV and in need of prenatal care, HIV/AIDS education, HIV counseling and testing, and early intervention and treatment. The Perinatal HIV Prevention Program components include: 1) social marketing campaign; 2) training of *promotoras* (peer health promoters) and 3) community outreach.

Social Marketing

"Loving Responsibly, A Promise of Love" is a social marketing campaign combined with training of *promotoras* (peer health promoters) and is a community outreach component of the Perinatal HIV Prevention Program. The campaign's specific tasks are to: 1) advertise the State of California AIDS hotline, which provides HIV/AIDS information to the general public; 2) advertise the BABY CAL, which provides information about prenatal care and other State-related programs for pregnant women; 3) advertise the BABY-N-U hotline, which offers County-wide information and referrals about various prenatal health care services to pregnant women; and 4) distribute "Loving Responsibly and A Promise of Love" printed posters, brochures and promotional materials in community settings. Community promotoras, the Harbor Community Health Center and the East Los Angeles Women's Center are trained regarding the social marketing and outreach interventions. Promotoras are the medium through which the social marketing campaign is disseminated since they distribute the brochures, posters and promotional materials during scheduled outreach activities. These interventions are integrated to assure that "hard-to-reach" women gain access to needed services.

Training of Promotoras

The Office of AIDS Programs and Policy entered into a memorandum of understanding with the University of California Los Angeles/Pacific AIDS Education and Training Center (UCLA/PAETC) to develop and provide training to community promotoras who conduct community outreach to pregnant women and women of child bearing age. UCLA/PAETC provides clinical training to physicians, dentists, nurses and pharmacists in the community and disseminates clinical guidelines, resources and information on HIV clinical management. The UCLA/PAETC trains providers to improve their knowledge and skills with:

- Offering HIV testing to all pregnant women
- Discussing HIV test results
- Clinical management of HIV infected women
- Appropriate referral of HIV-infected pregnant women to enhanced case management
- Appropriate referral of HIV-infected pregnant women to treatment centers and related services

The UCLA/PAETC and OAPP are combining their efforts to tailor the training specifically for the promotoras who are bilingual and monolingual Spanish speaking. English only training is also being tailored to multi-ethnic promotoras. UCLA staff and OAPP staff, who are bilingual and bicultural, conduct the training of promotoras in English and Spanish. This training addresses issues related to HIV testing & counseling, outreach methods, treatment of HIV positive pregnant women, and cultural competence issues. UCLA/PAETC staff disseminates a resource kit titled “*A Guide to Clinical Care of Women with HIV*” (Anderson, 2001) for providers serving pregnant women. OAPP staff will disseminate a kit titled “*Protect Yourself and Your Baby from AIDS*”, which includes prenatal HIV counseling and testing guidelines, a flip chart, posters, and pamphlets in English and Spanish produced by Innovative Health Solutions Inc. in conjunction by the California Department of Health Services, Office of AIDS in English and Spanish. OAPP staff also train the promotoras with the project’s protocol to complete client-level data collection surveys of the outreach and social marketing campaign components.

Community Outreach

The HIV Multi-Ethnic Women’s Consortium (HMWC) implements an outreach model designed to train the HMWC’s existing promotoras with the OAPP social marketing campaign in their own communities. Within this context, a “promotora” has a broader meaning than just a peer who promotes health since it incorporates the idea of contributing to the health improvement of the community by actively supporting each of its members. Within this framework, the HMWC trains community **promotoras** as leaders, peer outreach workers and agents of change. These promotoras are members of the target group and live in the communities where the social marketing campaign will be implemented. This outreach model relies on the established trust between the promotoras and the high risk and pregnant women to improve the health of community members by actively supporting and engaging them

in prevention efforts. The promotoras are the conduit through which the social marketing campaign is disseminated and the agents of change that motivate at risk and hard-to-reach women to seek prenatal and HIV care. These approaches combined with the social marketing campaign ensure that hard-to-reach, at risk, and HIV positive pregnant women are linked by a credible peer to a continuum of care that they would otherwise not access or utilize. During outreach, promotoras conduct the following program activities:

- Administer a baseline survey.
- Deliver short educational sessions on the prevention and treatment of HIV, including perinatal transmission to at risk and HIV positive pregnant women.
- Place posters in community settings, distribute brochures, and distribute promotional items (i.e., magnets, bags, pocket cards).
- Motivate at risk and HIV positive pregnant women to test for HIV and seek care.
- Support women while they gain access to and utilize HIV testing.
- Provide appropriate referrals to HIV-infected pregnant women for enhanced case management.
- Provide appropriate referrals to HIV-infected pregnant women for treatment centers and ancillary services.
- Conduct follow-up sessions three months after the baseline and support women who were referred to prenatal care, HIV testing and related services.

Issues to Consider

The following are key HIV perinatal prevention issues that the PPC, in partnership with OAPP and community providers, will consider in 2004 as planning for the new Los Angeles County HIV prevention plan unfolds:

- Assess the effectiveness of “Loving Responsibly” and “Healthy Babies” social marketing campaigns aimed to increase the number of women who are tested for HIV as part of their prenatal care.
- Provide additional training of *promotoras* (peer health educators) and community outreach efforts to increase the number of women who are tested for HIV as part of their prenatal care.
- Implement and evaluate a multi-level intervention that includes individual behavioral sessions, provider training and chart reviews to increase HIV testing among women receiving prenatal care.

VI. Conclusion/Next Steps

Conclusion

The HIV Prevention Planning Committee will continue to use this addendum as a guide towards the development of the CDC grant application until the new 2004 – 2008 prevention plan is completed. Additionally, this addendum will continue to be used as a guide for discussions over issues that need to be considered in order to improve the provision of HIV Health Education and Risk Reduction and HIV Counseling and Testing Services in Los Angeles County.

Next Steps

- Complete the *Los Angeles County HIV Prevention Plan 2004-08* that includes:
 - A SPA and BRG based community assessment,
 - Priority setting and resource allocation process and recommendations,
 - Best practices recommendations for local HCT and HE/RR activities and interventions,
 - Programmatic recommendations for the development of HE/RR, HCT and other prevention program areas that are responsive to the needs of LAC.
- Review the Behavioral Risk Group Model
- Continue with critical and informed discussions over issues that continue to impact the HIV epidemic in Los Angeles County. Specifically, issues that are of recurring concern in multiple areas of prevention planning as mentioned in this Addendum and areas that the CDC suggests to be addressed by prevention providers and prevention grantees including:
 - Substance Use
 - Faith-based Interventions
 - Incarcerated Programs
 - Youth Interventions
 - Integration of Care and Prevention Services
 - HIV Prevention Materials Review
 - Client Level Reporting
 - Quality Management
 - Capacity Building
 - Coordinated Prevention Networks
 - Mental Health of Clients and Providers
 - Integration of STDs, HIV, and Hepatitis Screening and Education
 - Improve Data Collection (Data to enhancing the delivery of services and to monitor program efficacy.)
 - Rapid Testing in clinical and non-Clinical Settings
 - Routine Voluntary HIV Testing as Part of Regular Medical Care
 - Examine Effective Interventions for Persons Living with HIV
 - Establish Standards for the Delivery of Prevention Case Management
