

Chapter 5

Connecticut's Priorities for 2005-2008



Priority Setting in Connecticut

Priority Populations and Interventions for 2005-2008

The Academy for Educational Development (AED) in its priority setting tool, *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*, defines priority setting as a process, which produces a list of ranked priority target populations and interventions proven appropriate and effective. This process ultimately assists the Department of Public Health in appropriating CDC designated and statewide prevention funds to those CPG identified populations most at risk for HIV.

In the CDC's 2003 Guidance for *HIV Prevention Community Planning* a number of goals, guiding principles and objectives are established for the priority setting process:

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population. Priority setting in community planning is based on a review of all existing and new elements prior to decision-making (e.g. epidemiologic profile, community services assessment, previously prioritized target populations, selected set of prevention activities/interventions, and the 2004 Update to Connecticut's Comprehensive HIV Prevention Plan for 2002-2004). The outcome of the CPG priority setting function is that the DPH will have a data-driven process, which it can use in allocating prevention funds to those populations most at risk for HIV.

2002 - 2004 Priority Setting History

In 2001, the Connecticut CPG leadership developed a prioritization process that was designed to meet the guidelines of the 1998 CDC Guidance and take into account the expertise of CPG membership. That prioritization process, grounded in the work of three workgroups (Epidemiological Profile and Priority Setting, Interventions, and Resource Allocation), established Connecticut's priorities (populations and targeted interventions) for the HIV Comprehensive Prevention Plan for 2002 – 2004.

For that process, the CPG used the basic prioritization method described in AED's *Setting HIV Prevention Priorities* and adapted a modified version of the model for use in prioritizing populations, interventions and resources. The CPG eventually settled on 12 populations for prioritization¹, and utilized four quantitative datasets (AIDS prevalence, AIDS incidence, counseling & testing seroprevalence, and STD case rates) and one subjective factor (CPG member knowledge and experience with the populations) in prioritizing populations for the seven CPG regions. Recognizing that different regions of Connecticut faced different epidemics, the priority setting workgroups and CPG leadership felt that setting statewide priorities would not adequately serve populations at-risk. Therefore, populations, interventions, and resources were prioritized or allocated by CPG region.

Following the priority setting process for populations in June 2001, the Connecticut CPG prioritized interventions for all possible priority populations. These prioritized interventions were recommended for the federal HIV prevention funds. Unlike prioritizing populations, interventions

¹ The twelve populations consisted of: White injection drug users (IDUs), Latino/a IDUs, African American IDUs, White men who have sex with men (WMSM), MSM of color (including African American and Latino), White heterosexuals, Latino/a heterosexuals, African American heterosexuals, Youth 13-19 years old; Youth 20-24 years old, HIV-positive individuals, and children infected perinatally.

were examined strictly by population without taking into account the specific regional needs of each population. The CPG decided that the prioritized interventions should serve as guidelines to HIV prevention service providers in each of Connecticut's regions. It was felt that service providers would be more knowledgeable of the priority populations' specific regional needs when developing interventions. To prioritize interventions the CPG used a comparable tool to that which was used for populations, however, the data used to determine intervention priorities differed. In prioritizing interventions, the CPG members wanted to consider not only proven effective interventions based on the literature review, but also the results of the 2001 statewide needs assessment, the findings from the 2002 resource inventory and gap analysis, "cutting edge" interventions, and members' and advisors' experience **about the effectiveness of the interventions for each population. The majority of these** interventions will be used in the establishment of population specific interventions for populations prioritized for 2005-2008.



2004 CPG PRIORITY SETTING PROCESS: Focus on the Future

In April 2003, the CDC announced a new initiative aimed at reducing the number of new HIV infections each year in the United States. This initiative consists of four parts and includes:

- (a) making HIV testing a routine part of medical care,
- (b) creating new models for diagnosing HIV infections outside medical settings,
- (c) preventing new infections by working with people diagnosed with HIV and their partners, and,
- (d) further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests.

This new focus, *Advancing HIV Prevention Initiative*, set the foundation for Connecticut's HIV Prevention Community Planning Priority Setting Process. According to the Community Planning Guidance, CPGs must now consider two major components from the CDC's *HIV Strategic Plan Through 2005*:

- (1) to target populations for which HIV prevention activities will have the greatest impact, and,
- (2) to reduce HIV transmission in populations with highest incidence.

The CDC Guidance clearly states that because of the new initiatives potential to substantially reduce HIV incidence, **CPGs will be required to prioritize HIV-infected persons as the highest priority population for appropriate prevention services**. In addition, uninfected, high-risk populations such as sex or needle-sharing partners of people living with HIV/AIDS (PLWHA) will need to be prioritized based on local epidemiology and community needs. However, as it relates to interventions, the Guidance clearly states that CPGs are no longer required to prioritize interventions for specific populations. As a result, for its 2005-2008 Plan, the Connecticut CPG developed a set or mix of interventions for prioritized target populations (Injection Drug Users, Men who Have Sex with Men, Heterosexual Sex, and HIV-Positives) that will have the potential to prevent the greatest number of new infections. This mix of interventions utilized the prioritized interventions developed for the 2002-2004 Plan, with additional activities included for HIV positive individuals. All interventions are based on behavioral and scientific theory, outcome effectiveness, and/or have been adequately tested with the targeted populations for cultural appropriateness, relevance and acceptability. ***(Additional information related to effective interventions is included in Chapter 4: "What Works in HIV Prevention?")***

Priority Setting Ad Hoc Committee

In February 2003, the CPG formally resumed its priority setting process for the 2005-2008 Connecticut HIV Prevention Comprehensive Plan with the establishment of a Priority Setting Ad Hoc Committee. The Committee was charged with the following:

- **To research and recommend, based on the available literature, a priority setting mechanism to identify priority populations, prevention needs and interventions for the Connecticut HIV Prevention Community Planning Group.**

The committee's related duties consisted of:

- Reviewing available literature on priority setting methods developed by other community planning groups, Ryan White Planning Councils and the Academy for Educational Development (AED).
- Presenting a recommendation for a priority setting mechanism to the CPG for adoption.
- Creating and reviewing the priority setting timeline for workgroup tasks throughout the year.

At the February 2003 Priority Setting Ad Hoc Committee meeting, committee members elected CPG advisor Leif Mitchell as chair and CPG member LeeAnn Marino as co-chair. In June of 2003, resigned from her position as the Priority Setting Ad Hoc Committee co-chair. Brian Goodrich, CPG member and former chair of the Finance and Allocations Committee, was voted in as new committee co-chair at the July 2003 CPG meeting.

Members of the 2003-2004 Priority Setting Ad Hoc committee included: Leif Mitchell, chair; Brian Goodrich, co-chair; Dalia Belliveau, CPG advisor; Ken Carley (DPH) CPG advisor; Debbie Cornman, CPG member; Pat Denardo, CPG advisor; Kathey Fowler, CPG member; Matt Lopes, CPG member; Susan Major (DPH), Dennis O'Neill, CPG member, Richard Spears (DPH), and Albert Young, CPG member. DPH Co-chair Chris Andresen and Community Co-Chairs Brian Libert, Bernadette Brown, and Stephanie Lozada served as ex-officio members. The Parisky Group, as contractor for the CPG, also staffed the priority setting committee (Laura Stone and Barbara Mase).

In April 2003, the committee began the process of reviewing literature and other priority setting mechanisms including:

- Chapter 6 - *Priority Setting in Connecticut* - of the 2002-2004 Comprehensive HIV Prevention Plan;
- NASTAD's HIV decision making tool;
- Mechanisms on priority setting presented at the March 2003 Community Planning Leadership Conference (e.g. Washington, DC and Hawaii);
- Ryan White priority setting matrix from the Title I Planning Council, New Haven/Fairfield County;
- AED's *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*;
- Priority setting models and prioritized population samples from Florida, Pennsylvania, Chicago, and Iowa; and,
- The 2003 Epidemiological Profile of HIV and AIDS in Connecticut.

Discussions and decision-making further ensued which focused on committee timelines and work plans (**See Priority Setting Timeline in Appendix D**), confirmation of a priority setting method, technical assistance and priority-setting committee/CPG trainings, prioritization of populations by risk behavior, further break-out of populations by race (Black, Latino/a, and White), weighting and rating scales, evidence-based and subjective factors, what additional types of data to consider and review for the prioritization process, and incorporation of the priority setting methodology into the CPG bylaws and policy /procedure manual.

Following a lengthy method review, the Priority Setting Committee decided to use the AED model as a basis for the priority setting process and build upon that method. Krista Heybruck, Behavioral and Social Science Volunteer for the CPG, provided five hours per month of training and facilitation for both the Priority Setting Ad Hoc Committee and the CPG regarding the priority setting model and its adaptation to Connecticut's process. Specially designed priority

setting trainings and exercises were conducted with the Priority Setting Ad Hoc Committee, the Executive Committee, and the full CPG membership beginning in August 2003, and, culminated with the prioritization of populations in March 2004.

Beginning in August 2003, mini-Priority Setting 101 Power Point presentations and exercises were implemented during monthly CPG meetings to better acquaint and train CPG members about the various components of priority setting. **(See *Priority Setting 101 PowerPoint samples in Appendix D*).** A 90-minute priority setting workshop was also included in the CPG's annual planning retreat in November 2003 **(See *Dining for Decision training exercise in Appendix D*).**

After reviewing many of the difficulties encountered with the 2001 Priority Setting Process, and also taking into account CPG member evaluation of the process, the Priority Setting Ad Hoc Committee agreed on the following as a foundation for Connecticut's 2004 priority-setting process:

To implement a Priority Setting Process that:

- 1. Is understandable**
- 2. Has a clear purpose**
- 3. Is data-driven**
- 4. Supports allocations that will have the greatest impact**
- 5. Is not based on politics or emotions**

The Priority Setting committee further decided, that unlike the 2001 process, which used a regional model in prioritizing populations, the 2004 process would be focused on setting statewide priorities, thus allowing contractors to determine the most at-risk populations in their region. It was made evident from HIV/AIDS Surveillance data, the 2003 Epi Profile and the 2004 Epi Update, that what drives the epidemic in Connecticut is injection drug use (IDU), followed by men who have sex with men (MSM), and heterosexual sex. AIDS in Connecticut has disproportionately affected specific demographic groups including males (70% of all reported cases), Blacks and Hispanics. Trends in AIDS cases (2002) show an (a) increase in female cases, (b) an increase in Hispanic cases, (c) an increase in heterosexual transmission, (e) and an increase in the age of newly diagnosed cases (e.g. particularly in the 40-49 and 50+ age groups). In 2002, HIV infection in adults became reportable, and, based on the 374 reported HIV cases, it was noted that, in comparison to AIDS cases, HIV cases were more likely to be female (43% HIV vs. 40% AIDS), Hispanic (HIV 40% vs. AIDS 32%), younger (median age of 36 for HIV vs. 41 for AIDS), and were more likely to be initially reported without indicated risk information (48% HIV vs. 35% AIDS). Based on this information, the committee, after much discussion and review, decided to prioritize populations by risk behavior with a further breakout by race. Age and gender were not considered in these population specifics, because it was determined that further breakouts could potentially eliminate populations/groups from consideration. Aspects, such as age and gender, were designated as part of the contractor decision-making process in targeting interventions to specific at risk regional populations.

As a result of the Priority Setting Committee's review of data, the following nine populations, based on behavior, were proposed for prioritization and ranking, with the understanding that HIV-positive individuals would receive highest priority. Because of this priority status, HIV-

positives would not be rated, scored or ranked as the other populations. The nine populations are:

Men Who Have Sex with Men (MSM)	Injection Drug Use (IDU)	Heterosexual Sex
♦ Black	♦ Black	♦ Black
♦ Latino	♦ Latino/a	♦ Latino/a
♦ White	♦ White	♦ White

Datasets Utilized in Priority Setting

The following six evidence-based (driven by data) factors and one subjective factor, which allowed for CPG member preference and experience, were utilized by the CPG in weighting, rating, scoring and ranking the nine populations. Because not all data sets were applicable for each of the populations, the following rationale was developed to support the decision-making (*See Data Sheets in Appendix D*).

Evidence-based Factors

- **AIDS Incidence:** The number of **NEW AIDS** cases diagnosed in a defined population in a specified period (often a year) The number of new cases was available for all populations.
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- **AIDS Prevalence:** The number of people **LIVING WITH AIDS** in a defined population on a specified date, regardless of when they were diagnosed. AIDS prevalence data was available for all populations.

Rationale: AIDS Incidence and AIDS Prevalence data are among the most complete data collected by DPH and can be used as an indicator for HIV prevalence.

- **HIV Incidence:** The number of new HIV cases diagnosed in a defined population in a specific period, usually a year. HIV incidence data was available for all populations.

Rationale: HIV incidence is an important piece of information for planning, but there are some problems: (1) a high percentage of cases (2002) were reported without identified risk (NIR), (2) DPH has only been collecting data since 2002; trends cannot be projected, (3) the system still reports “new reports of HIV infection” meaning some late-testers rather than actual “new infections”, and (4) there is a lag-time in reporting from testing locations. While important data, HIV incidence must be interpreted in the light of the previously mentioned issues.

- **Syphilis Data:** Sexually transmitted diseases are reliable indicators of high-risk behaviors (unprotected sex). Syphilis is the only STD with identified risk behavior information, and also has a higher co-morbidity than either gonorrhea or chlamydia. The data used was reflective of **NEW Syphilis** cases reported in a one-year period. Data was only available for MSM and Heterosexual Sexual behaviors.

Rationale: Although only presenting with a small number of syphilis cases in 2002, the data does indicate a risk behavior among the MSM population. Because no risk behavior is identified for gonorrhea or chlamydia cases, this data will be included as part of the subjective factor (value-based). The presence of gonorrhea and chlamydia cases is an indicator of high-risk behavior among identified populations, but the data alone does not indicate a risk for HIV infection.

Counseling and Testing Data: Both positive and negative test results were reviewed for reported and perceived risk behavior. This data shows is getting tested. **(See Counseling and Testing PowerPoint in Appendix D)**

Rationale: One of the CDC’s new strategies is the focus on HIV testing. Its goal is to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment and ongoing prevention services. In Connecticut, unduplicated CTS reports comprise about 20% of the total HIV reports – a minority percentage of the total HIV tests actually done. While this data only represents a portion of the whole picture, it can provide some insight into identified and perceived risk behaviors.

- DPH Interventions Data Base: **Based on input from the various DPH funded contractors, one can gain a picture of the number of interventions per population as well as the cost and number of people served per intervention.** (See Interventions Database Funding information in Appendix D)

Rationale: With this data, one is able to relate interventions/funding allocations and determine gaps in service. Currently DPH funded interventions by populations break out as follows:

Populations	# of interventions	Funding	# of PLWHA(6/30/03)	Dollars per PLWHA
Heterosexual	204	\$3.1 million	1,291	\$2,401
IDU	95	\$2.1 million	3,094	\$ 679
MSM	57	\$1.0 million	1,221	\$ 819
HIV Positive	19	\$ 450,000	6,476	\$ 69

Subjective Factor:

This value-based factor took into account CPG member preference, experience and expertise, as well as incomplete data that did not cross all populations, but could be considered as indicators of risk behavior for HIV infection. A brainstorming session, facilitated by Behavior Social Science Volunteer (BSSV), Krista Heybruck, regarding barriers to accessing HIV prevention services for the nine at-risk priority populations also provided CPG members and members of the public with an opportunity to provide input on both the perceived and real barriers to services. The additional data component included presentations on the Rapid Assessment, Response and Evaluation (R.A.R.E.) Project in Hartford **(See R.A.R.E. Project Mini-Report in Chapter 3)**, the Youth Risk Behavior Survey (YRBS) and Connecticut School Health Survey, the most recent statewide STD data, and Viral Hepatitis information. **(See**

PowerPoint presentations on youth, STDs, and Viral Hepatitis, as well as the Barriers Discussion in Appendix D).

Weighting, Rating, and Scoring

The dictionary defines prioritization as an arrangement or a dealing with something in order of importance or urgency. In order to facilitate the final ranking of the nine populations, the Priority Setting Committee developed weighting and rating scales to assist in the prioritization process.

- **Weighting** indicates a level of importance or influence for the selected evidence-based factors and subjective factor relative to each targeted population. For the process, the committee developed an “importance weighting scale” of 1-3, with 1 as LOW, 2 as MEDIUM, and 3 as HIGH. Using this weighting scale, the various factors were weighted as follows:

<p><u>Evidence-based factors:</u></p> <ul style="list-style-type: none">• AIDS Incidence: 3• AIDS Prevalence: 3• HIV Incidence: 2• Syphilis Data: 2• Counseling and Testing Data: 1• DPH Interventions Database: 3 <p><u>Subjective Factor: 2</u></p>
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- **Rating** “scores” each factor as a measure within each target populations (e.g. establishes a level of “how much”). The rating scale determined for the evidence-based factors differed from that of the subjective factor on the basis of data-driven information versus value-based. Evidence-based factor rates were calculated using the existing and most recent data available for each population, and then a mathematical formula was applied to compute the rate. For the subjective factor, CPG members were given a total of 50 points to rate the nine populations, with the caveat that the total for the populations must equal 50. Members were permitted to distribute the 50 points among the nine populations based on their experience, knowledge and information received during the subjective factor presentations. Populations could be given similar points, different points or no points. (**See Subjective Factor Rating Sheet in Appendix D**). Once the rate for each evidence-based factor was determined, that number was multiplied by the weight set for that factor (Weight x Rate) to give a population a specific score.
- **Scoring** is the result of multiplying the **Population Factor Weight** by the **Population Factor Rate**. The individual population evidence-based score was then added to the individual population subjective factor score to provide an overall population total score. This resulting population score permitted the final priority ranking of the nine populations. A calculation spreadsheet, which included the nine populations, evidence-based factors, and subjective factor, was developed to assist the Priority Setting Committee in weighting, rating, scoring and ranking the nine populations. A copy of that document with scoring results and ranking is included at the end of this chapter.

Scoring for evidence-based factor was extremely more complicated to calculate than the subjective-factor (**See Priority Setting: It’s Here PowerPoint in Appendix D**).

The following is the process used to determine evidence-based factor and subjective factor scoring:

Evidence-based:

- **AIDS Incidence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of AIDS cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 3 to give a population score.
- **AIDS Prevalence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of AIDS cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 3 to give a population score.
- **HIV Incidence:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of HIV cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 2 to give a population score.
- **Syphilis Data:** Total number of cases in population (only MSM and Heterosexual Sex) was divided by the grand total of Syphilis cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 2 to give a population score. IDUs received a score of "0" because no IDUs tested had tested positive for Syphilis.
- **Counseling and Testing:** Total number of cases in population (e.g. Black MSM) was divided by the grand total of testing cases and resulting number was then multiplied by 100 to provide an indicated strength of the infection in the population. This number was then multiplied by the weight of 1 to give a population score.
- **DPH Interventions Database:** The cost of intervention dollars per PLWA/population was divided by the total cost of intervention dollars per PLWA and the resulting number was then multiplied by 100. The resulting number was multiplied by the weight of 3 and then subtracted from the totals of the five preceding evidence-based factors.

Subjective factor:

Subjective factor scoring, which was more value-based, was accomplished by dividing the specific population score by the grand total subjective factor score (50 points x # of CPG members participating in the process) and then multiplying that number by 100. This number was multiplied by the subjective factor weight of 2 for a final population specific score. The subjective factor population score was then combined with the evidence-based factor population score for a final population specific score.

At the March 2004 Priority Setting Process, CPG members were provided with a final priority setting process presentation (*See Priority Setting: It's Here in Appendix D*), which reviewed the priority setting steps, Connecticut HIV/AIDS statewide information, basic concepts of priority setting (factors, weighting, rating, scoring and ranking), the factors used for decision making and the accompanying rationale, weighting and rating scales, scoring, applicable data used for decision-making, and the process for subjective factor rating. Members were instructed in the use of the Subjective-Factor Population Rating Sheet (*See Rating Sheet in Appendix D*) and then asked to individually rate the nine populations using a pool of 50 points. Member scores were input into a Subjective Factor calculation spreadsheet and the resulting scores were incorporated into the larger Priority-Setting Scoring spreadsheet.

This document was then displayed on a large screen so that CPG members could see the final outcome of the scoring process. Populations were then ranked from high to low.

The ranked results of the Connecticut CPG 2004 Priority Setting process are as follows:

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|-------------------------------|
| HIV-Positive Highest Priority |
| 1. White MSM |
| 2. Latino/a IDU |
| 3. Black IDU |
| 4. White IDU |
| 5. Black Heterosexual |
| 6. Latino/a Heterosexual |
| 7. White Heterosexual |
| 8. Black MSM |
| 9. Latino MSM |

Interventions

The new CDC Guidance for Community Planning indicates that rather than prioritizing interventions for priority target populations as in previous priority setting processes, that CPGs should instead “conceptualize interventions/activities as a set or mix of interventions/activities versus one specific intervention/activity for each target population. Regardless of the mix or set of interventions selected, all interventions, however, must be science-based, proven effective and culturally/ethnically appropriate. For this process, the Connecticut CPG utilized the intervention charts developed during the 2001 Priority Setting Process since all of the interventions included were reflective of the CDC’s *Compendium of HIV Prevention Interventions* (2001) and *Replicating Effective Programs Plus* (REP+). Other interventions, also included in the mix, although not necessarily in the CDC’s list, are research-based and have a positive and significant behavior/health component. (e.g. Needle Exchange Program, Drug Treatment Advocacy and Methadone Maintenance.) The Connecticut CPG has identified injection drug users (IDUs) as a priority population, and has found that based on extensive research syringe exchange programs (SEPs) are an effective, cost-efficient HIV prevention intervention for IDUs. In addition, research also shows that syringe exchange programs have not been associated with increased drug use or initiation of injection drug use. Therefore, the CPG has identified SEPs as an effective HIV prevention intervention for IDUs (**See the CPG Position Statement on Syringe Exchange Programs in Appendix D**)

Based on the CDC’s *Advancing HIV Prevention: New Strategies for a Changing Epidemic*, HIV service and health care providers are also strongly encouraged to include the following concepts/programs within the mix of selected population specific interventions/activities:

- **Incorporation of HIV testing as a routine part of care in traditional medical settings** (e.g. encouraging all health care providers to include HIV testing, when indicated, as part of routine medical care),
- **Implementation of new models for diagnosing HIV infections outside medical settings** (e.g. use of the rapid HIV test),
- **Prevention of new infections by working with people diagnosed with HIV and their partners** (e.g. get HIV positive individuals into care and treatment, provide prevention case management and counseling for people with HIV, promote and institute prevention education and risk reduction activities for people living with HIV, and promote and implement partner counseling and notification),
- **Further decrease mother-to-child HIV transmission** (e.g. promote screening of every pregnant woman for HIV, using the “opt-out” approach, make prenatal screening a routine part of medical care, and promote screening of newborns whose mother’s HIV status is not known).

Given the complexity involved in developing evidence-based interventions as well as trying to understand the social, economic, cultural and individual variables associated with human behavior across Connecticut, designing and assigning interventions which promote positive behavior change can be an enormous challenge. The interventions chosen for the priority populations were selected with a statewide view, thus giving HIV prevention service providers the flexibility to adapt the interventions to the specific population and region wide needs of their service area.

Prevention for Positives

The CDC has identified prevention for HIV-positive individuals as the highest priority for CPGs. Because HIV-positive individuals are living longer and healthier lives, maintaining safer sexual and drug use behaviors can be challenging. The result is AIDS-fatigue, which can lead to dropping out of care, non-adherence to medications, co-infection with STDs and Hepatitis, development of drug-resistant strains of the HIV virus, and exposure to opportunistic infections.²

According to the CDC, although numerous effective prevention interventions have concentrated on HIV-negative populations, only a small number have focused on HIV-positive persons. (e.g. support group/ structured risk-reduction, skills building group, couples or individual-level intervention).

It is crucial in “Prevention for Positives” that individuals both newly and currently diagnosed with HIV be enrolled or referred to medical care. This emphasizes the role of linking prevention and care services into a continuum of care (**See *Integration of Prevention and Care in Chapter 6: Linkages***).

In the 2001 Institute of Medicine’s (IOM) report *No Time to Lose: Getting More from HIV Prevention*,³ the authors emphasize the need for enhanced HIV prevention efforts in the clinical setting as part of the standard of care for HIV-infected persons. Care services have traditionally focused on treatment and support services related to primary care. But according to IOM, health care providers should incorporate effective prevention counseling within their care services. A

² Madhavi Reddy Patt, M.D., M.P.H., Prevention is Treatment: Prevention with Positives in Clinical Care, HRSA CARE ACTION, March 2003.

³ MS Ruiz, AR Gable and EH Kaplan, et al. No Time to Lose: Getting More from HIV Prevention, Washington, D.C.: Institute of Medicine, 2001.

better connect between the two worlds of prevention and care needs to be addressed and measures put into place in order to meet the care and prevention needs of HIV-positive individuals. As part of the CDC's strategic plan, it has developed the SAFE project (Serostatus Approach to Fighting the HIV Epidemic), which calls for efforts to:⁴

1. **Increase the availability of prevention services for people with HIV,**
2. **Teach health care practitioners to perform HIV and sexually transmitted disease (STD) risk assessments in HIV-infected patients, and,**
3. **Increase delivery of prevention messages to HIV-infected patients by health care workers.**

In its *Interim Technical Guidance for Selected Interventions*, the CDC suggests the following ancillary services, obtainable through referrals from a Ryan White Case Manager, for consideration as interventions with HIV-positive persons:

- **Behavioral interventions to reduce risk behavior**
- **Interventions to improve adherence to complex medication schedules**
- **Substance abuse treatment**
- **Mental health treatment**
- **Domestic violence prevention**
- **Family planning services**
- **Housing**

Prevention providers face new challenges in providing prevention interventions for HIV-positive individuals. Not only must consideration be given to getting people into care and maintaining their "in-care status", but providers must also take into account the stigma, barriers, psychological, social, cultural and economic factors that impact PLWHAs and ultimately affect sexual and risk-reduction behaviors.

According to research (*See Working with HIV-Positive Individuals: Risk Behavior and Prevention Strategies in Appendix D*) conducted by Deborah H. Cornman, PhD at the University of Connecticut's Center for Health/HIV Intervention and Prevention (CHIP), current estimates indicate that one out of three individuals who are HIV-positive engages in unsafe sex. A sample of HIV-positive patients in clinical care in Connecticut, indicated that 22% reported unprotected vaginal or anal sex on at least one occasion during a three-month period. Factors associated with risky behavior among HIV-positive individuals include relationship status, economics, emotional states, substance abuse, personality dispositions (e.g. mental health, etc), and perceptions of infectivity. Based on Dr. Cornman's studies, the types of interventions found to be effective with HIV-positive individuals include:

- **Counseling and Testing**
- **Individual counseling**
- **Couples counseling**
- **Single and multi-session group workshops**
- **Prevention case management**

⁴ Carlos del Rio, MD. New Challenges in HIV Care: Prevention Among HIV-Infected Patients. Topics in HIV Medicine, International AIDS Society-USA, Volume 11, Issue 4, July/August 2003.

- **Syringe exchange programs (SEPs)**
- **Drug treatment**
- **Methadone maintenance**

Several other programs exist for HIV-positive persons ranging from less intensive, group-based to intensive individualized interventions. Researchers are currently testing more than ten other interventions. Included in these innovative interventions are social marketing campaigns for gay men, five-session group interventions for HIV-positive women, internet chat rooms, 12-session group workshops for HIV-positive youth, group session workshops for HIV-positive Asian American-Pacific Islander Americans, eight session group interventions for gay male serodiscordant couples and prevention case management programs. In Connecticut, the following four interventions show promise and proven effectiveness in reducing risk behaviors in HIV-positive individuals: **(See *Working with HIV-Positive Individuals: Risk Behavior and Prevention Strategies in Appendix D*)**

- **Four Positive Prevention Interventions** (Developed by Seth Kalichman, Ph.D): Based on the Information-Motivation-Behavior (IMB) Model of Health Behavior Change. A five-session risk reduction intervention.
- The Options/Opciones Project: Clinician-Initiated Risk Reduction Intervention for HIV+ Patients in Clinical Care **(Developed as a collaborative project between researchers at the University of Connecticut and Western Ontario and Yale University)** A collaborative discussion between the clinician and patient in order to assess the patient's risk behaviors, understand the patient's ambivalence about change, elicit strategies for change, and negotiate a behavior change plan of action.
- Project M: A Positive Intervention (Developed by the University of Connecticut and AIDS Project Hartford). A sex-positive approach for risk reduction among HIV+ Gay and Bisexual Men.
- Project Athena (Developed by AIDS Project Hartford). An HIV risk continuum program for HIV-positive women.

Prevention for Positives represents a new and challenging opportunity for prevention providers to make an impact on the epidemic. Additional information regarding effective interventions for HIV-positive persons can also be accessed through the CDC's Replicating Effective Programs (REP) and the Diffusion of Effective Behavioral Interventions (DEBI) projects.

The following charts list the prevention interventions/activities recommended for Connecticut's 2005-2008 priority populations, based on research, literature reviews, the CDC's Compendium and REP, and the CPG's 2001 Priority Setting Process for Interventions.

☑HIV positives

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, couples counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Prevention Case Management (PCM)

Partner Counseling and Referral Services (PCRS)

Community Level Interventions (CLI) -- social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) -- one shot presentations
Community Level Interventions (CLI) -- community wide events, policy interventions, structural interventions

☑ White Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) -- one shot presentations
Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/as Injection Drug Users

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, methadone maintenance, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups
Peer and Non-Peer Outreach
Prevention Case Management (PCM)
Health Communications (HC/PI) -- one shot presentations
Community Level Interventions (CLI) -- social marketing campaigns, community wide events, structural interventions

☑ African American Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing
Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops
Peer and Non-Peer Outreach
Health Communications (HC/PI) -- one shot presentations
Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops

Peer and Non-Peer Outreach

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Men who have Sex with Men

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, couples counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Prevention Case Management (PCM)

Health Communications (HC/PI) – broadcast media, hotlines, one-shot presentations, print and other media

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ African American Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups, single session workshops

Peer and Non-Peer Outreach

Health Communications (HC/PI) -- one shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ Latino/a Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling and couples counseling

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Health Communications (HC/PI) – one-shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

☑ White Heterosexuals

Individual Level Interventions (ILI) -- counseling and testing, individual drug/alcohol counseling, methadone maintenance, peer counseling, motivational interviewing

Group Level Interventions (GLI) – peer and non-peer multiple session workshops, support groups

Peer and Non-Peer Outreach

Partner Counseling and Referral Services

Health Communications (HC/PI) --one-shot presentations

Community Level Interventions (CLI) -- community mobilization, social marketing campaigns, community wide events, policy interventions, structural interventions

Intervention Descriptions – as taken from <i>CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal</i>	Key Elements of Intervention	Examples of Possible Programs under this Intervention
Individual Level Interventions (ILI) – health education and risk-reduction counseling provided to one individual at a time. Individual Level Interventions help clients to make ongoing appraisals of their own behavior, motivate clients to make changes in their behavior, and assist clients in making plans for individual behavior change. These interventions also facilitate linkages to services in both clinic and community settings (e.g. substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV and help clients make plans to obtain these services.	<ul style="list-style-type: none"> • Provided to one individual at a time • Assists clients in making individual behavior change • Facilitates linkages to services in clinic and community settings 	<ul style="list-style-type: none"> • One-to-one peer counseling • Motivational interviewing • Couples Counseling
Group Level Interventions (GLI) – health education and risk reduction counseling (see above) shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education and support. GLIs do not include one-shot education presentations or lectures that do not contain a skills component.	<ul style="list-style-type: none"> • Delivery of service to groups of varying sizes • Use peer and non-peer models 	<ul style="list-style-type: none"> • Multiple session workshops • Single session workshop with skills building component • Self Help/Support Groups
Outreach (peer or non-peer) – HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators (paid person with training on educational interventions) face-to-face with high risk individuals in the clients’ neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits and educational materials.	<ul style="list-style-type: none"> • Face-to-face contact with individuals in the neighborhoods or other areas 	

Intervention Descriptions – as taken from <i>CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal</i>	Key Elements of Intervention	Examples of Possible Programs under this Intervention
<p>Prevention Case Management (PCM) – client centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a combination of HIV risk-reduction counseling and traditional case management that provide intensive ongoing, and individualized prevention counseling, support and service brokerage.</p>	<ul style="list-style-type: none"> • Adoption of HIV risk-reduction behaviors by clients • Combination of HIV risk-reduction counseling and traditional case management 	
<p>Health Communication/ Public Information - (HC/PI) – delivery of prevention messages through one or more channels (broadcast, print, or other media) to target audiences. Messages are intended to build support for safer behaviors, support personal risk reduction efforts, and to tell at-risk individuals how to obtain services.</p>	<ul style="list-style-type: none"> • Delivers prevention messages through media 	<ul style="list-style-type: none"> • Radio, television announcements and broadcasts • Newspapers, magazines, pamphlets and billboards • Hotlines • Clearinghouse • Presentation and lectures (one shot education)
<p>Counseling and Testing – the voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection and given tailored support on how to adapt this information to his/her life. Clients who request testing must be provided with pre-test counseling that enables them to make informed decisions that meet the requirement of the Connecticut HIV Confidentiality Law. through Partner Counseling and Referral Services (PCRS).</p>	<ul style="list-style-type: none"> • Voluntary • Client-centered • Interactive information sharing • Clients who ask for testing must receive pre-test counseling 	
<p>Partner Counseling and Referral Services (PCRS). - Clients should be assisted with notification of sex and needle-sharing partners of their risk and of the availability of HIV counseling and testing services</p>	<ul style="list-style-type: none"> • Partner notification is an option 	

Intervention Descriptions – as taken from <i>CDC Evaluation Guidance and the Connecticut DPH 2002 Request for Proposal</i>	Key Elements of Intervention	Examples of Possible Programs under this Intervention
<p><i>Other Interventions including Community Level Interventions (CLI)</i>—other interventions are interventions that cannot be described by the other types listed above.</p> <p>CLIs seek to improve risk conditions and behaviors in a community by focusing on the community as a whole rather than on individuals or small groups. CLI often attempts to alter social norms, policies, or characteristics of the environment.</p>	<ul style="list-style-type: none"> • CLIs improve risk conditions and behaviors by focusing on the community 	<ul style="list-style-type: none"> • Community mobilization • Social marketing campaigns • Community-wide events • Policy interventions • Structural interventions

Proven effective interventions for Connecticut’s targeted populations as identified by the Connecticut CPG for the 2005-2008 HIV Prevention Comprehensive Plan are included in Appendix D. The table reflects CDC interventions from the 1999 Compendium of HIV Prevention Interventions with Evidence of Effectiveness (updated 2001), as well as those that are non-Compendium, but research-based interventions.

Appendix D: Effective Interventions: Findings from CDC Compendium & Connecticut’s Literature Review.

Key to Cognitive Models and Theories

- HBM: Health Belief Model**
IMB: Information, Motivation, Behavioral Skills Model
TRA: Theory of Reasoned Action Model
TM: Transtheoretical or Stages of Change Model
ARRM: AIDS Risk Reduction Model
SLT: Social Learning Theory
PMT: Protection Motivation Theory
BRP: Behavioral Relapse Prevention Theory

Recommended Federal HIV Prevention Resource Allocation

The HIV Prevention Community Planning Guidance clearly defines the roles and responsibilities of both CPGs and Health Departments. According to the Guidance, the DPH is responsible for supporting the HIV prevention community planning process (via funding, staff and/or consultant/contractor resources, and leadership). The DPH’s role in community planning is to:

- Develop an application to the CDC for federal HIV prevention cooperative agreement funds based on the comprehensive HIV prevention plan, and,
- Allocate, administer and coordinate public funds (including state, federal and local) to prevent HIV transmission and reduce HIV-associated morbidity and mortality.

The latter responsibility includes the awarding of HIV prevention funds to implement the HIV prevention services stated in the comprehensive HIV prevention plan and health department application and to monitor contractor (service provider) activities and document contractor compliance.

HIV Prevention Community Planning Groups are responsible for developing a comprehensive HIV prevention plan and reviewing the health department's application for federal HIV prevention funding for concurrence with the plan. While CPGs are not responsible for determining the allocation of funds for HIV prevention services, it is important for the CPG to know and understand the extent and array of prevention funds that will be allocated as a result of both the health department's and other funders' implementation of the CPG's target population priorities and set of prevention activities/interventions, as described in the Comprehensive HIV Prevention Plan.⁵

With the roll-out of the CDC's new initiatives for advancing HIV prevention, Connecticut HIV prevention contractors have been asked by the DPH to review their currently funded interventions, with a view to increasing or implementing prevention intervention for HIV positive individuals, as well as augmenting expanded counseling and testing opportunities. Federal funding for 2005-2008 will strongly reflect adherence to these new initiatives, but not at the expense of abandonment of funding for interventions targeting HIV-negative individuals. According to CDC Director Julie Gerberding, the CDC is not "abandoning its support for effective programs to prevent infection among HIV negative people, but instead is strengthening existing efforts by encouraging more HIV testing and helping HIV positive people to develop tools to stay healthy and to protect their partners from infection."⁶

For the 2002-2004 Comprehensive HIV Prevention Plan, the CPG's Resource Allocation Workgroup decided that resource allocations should be determined by CPG region since populations had been prioritized by region. Once the CPG allocated specific percentages of federal funding by region, the expectation was that the DPH would award that funding to regional HIV prevention service providers, who in turn would implement the prioritized interventions among the regionally specific prioritized populations. Ten percent (10%) of the state's federal HIV prevention funding was also designated as "set-aside funds" for populations not named in the specific region's top five priority populations or for regional emerging populations.

⁵ 2003-2008 HIV Prevention Community Planning Guidance.

⁶ Gerberding, *Los Angeles Times*, 10/11/03

Table 1 – 2002-2004 Resource Allocation by CPG Region. (Allocation for 2004)

Region	Percent of Federal Funds	Percent of State Funds
Correction	12%	11%
North Central	27%	26%
North East	3%	3%
North West	2%	2%
South Central	29%	27%
South East	5%	4%
South West	22%	20%
DPH Identified Priorities		7%
TOTAL	100%	100%