Seattle HIV/AIDS Planning Council

2008-09 Prevention Plan

Approved by the Council on April 9, 2007.

NOTES AND OVERALL CAVEATS:

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

#1 HIV+

(15% of the available funding pool)

Subpopulations	Priority Interventions
• **Foreign-born black heterosexuals** • **MSM Crystal users** • **MSM**	**Prevention Case Management**
	Individual-Level Intervention
	Group-Level Intervention
	Substance Use Treatment
	Partner Counseling & Referral

#2 White MSM, age 25-69

(12% of the available funding pool)

Subpopulations	Priority Interventions
▪ **Public, commercial or anonymous sex venues, especially bathhouses/ sex clubs** ▪ **Crystal-using non-injectors**	**Prevention Case Management**
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

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

#3 Foreign Born Blacks, ages 15-69

(10% of the available funding pool)

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

Subpopulations	Priority Interventions
• **No Sub-populations**	**Community-Level Intervention***
	HIV Counseling and Testing
	Partner Counseling & Referral

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

#4 Latino MSM, 25+

(12% of the available funding pool)

Caveats for Latino MSM programs:

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

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

Subpopulations	Priority Interventions
• **No sub-populations**	**Prevention Case Management**
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

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

#5 Black MSM, 25+

(12% of the available funding pool)

Caveats for Black MSM programs:

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

Subpopulations	Priority Interventions
• **No sub-populations**	**Prevention Case Management**
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

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

#6 MSM/IDU, age 15-69

(13% of the available funding pool)

Subpopulations	Priority Interventions
• **Crystal injectors**	**Prevention Case Management**
	Substance Use Treatment
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral
	Needle Exchange

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

(11% of the available funding pool)

Caveats for IDU programs:

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

Priority Subpopulations	Priority Interventions
• **No sub-populations**	**Needle Exchange**
	Street and Community Outreach
	Substance Use Treatment
	HIV Counseling and Testing
	Partner Counseling and Referral

#8 Young MSM, age 15-24

(7% of the available funding pool)

Subpopulations	Priority Interventions
• **MSM trading sex for money, drugs or shelter**	**Prevention Case Management**
	Substance Use Treatment
	Street and Community Outreach*
	Community-Level Intervention
	Group-Level Intervention
	HIV Counseling and Testing
	Partner Counseling & Referral

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

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

Innovative Program Requirements

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

Eligibility: The following eligibility criteria apply:

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

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

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

Committee Decision-Making Rationale and Background

Background:

- The interventions listed in this plan, and intervention-related caveats were approved by the Council on February 12, 2007. Therefore the Council will be voting on the rest of the plan completed by the prioritization and allocation (P & A) committee.
- The interventions committee also recommended that the P & A committee set aside funding for an innovative program for MSM. The P & A committee accepted this recommendation, and it is reflected in the plan.
- The prioritization and allocation committee met seven times between January 19th and March 16th, 2007. Their job was to finalize the Top Populations identified by Public Health's Epidemiologists, identify sub-populations, if needed, within the Top Populations, rank order the populations, and allocate percentages of the community funding pot to each.
- Due to cuts from the state, it is anticipated that the funding pool will be smaller than it was two years ago, approximately $3,100,000 for two years, rather than the $3,200,000 for the 2006-2007 period.

RATIONALE FOR MAJOR DECISIONS:

- **Accepting the Top Populations:** The committee considered other populations not included by the epidemiologists, but found that none had high enough numbers or rates to be included. For the 2006-2007 plan, epidemiologists had identified an additional population, MSM Testing for STDs, using STD Clinic data to identify this population. However, the previous committee struggled with the overlap between this population and the other MSM populations. For 2008-2009, the epidemiologists used only HIV/AIDS surveillance data to create the list of Top Populations at the request of the Prioritization Steering Committee.

- **Creating Sub-Populations and/or caveats:** The committee wanted to limit the number of identified sub-populations, as it would be impossible to fund separate programs for each. Instead, sub-populations were listed only in places where a specific population could be seen as having increased risk of getting or spreading HIV, based on the available quantitative and qualitative data. Additionally, caveats were included in some populations to ensure that some issues (such as heterosexually identified Latino and Black MSM, and Foreign Born Latino MSM) would be addressed by any program applying for the funds.

- **Ranking of Top Populations:** The committee considered each of these factors in order to determine the rank order of the Top Populations:
  1. **CDC Guidance requires that HIV+ be the #1 population**.
  2. **Incidence Number for 2003-2005.** The group felt this was the best indication of where the epidemic was going, especially for White MSM and Foreign Born Blacks, who have significantly higher incidence than the other populations. This resulted in the following ranking: 1. HIV+; 2. White MSM; 3 Foreign Born Black; 4. MSM/IDU; 5.

Latino MSM; 6. Black MSM; 7. Young MSM and 8. IDU. Note: 4 through 8 have very similar incidence.

3. **Trend.** The group felt that trend was the next most important factor, solidifying Foreign Born Blacks in the number 3 position. The much larger incidence among White MSM overrode that population's downward trend. No ranking change.
4. **Late Diagnosis.** Two populations had a greater than average level of late diagnosis, Foreign Born Blacks and Latino MSM. Because Foreign Born Black was already at #3, it was not moved, but Latino MSM was moved up to #4. MSM/IDU, Young MSM and White MSM had a significantly lower rate of late diagnosis. White MSM was not moved due incidence, but MSM/IDU and Young MSM were moved to 7 and 8 respectively. This changed the ranking to 1. HIV+; 2. White MSM; 3. Foreign Born Black; **4. Latino MSM**; 5. Black MSM; 6. IDU; **7. MSM/IDU; 8. Young MSM**.
5. **Prevalence Rate.** The highest prevalence rate was among MSM/IDU. Because the prevalence rate was not dissimilar to Latino and Black MSM, MSM/IDU, was moved up to #6, right after Black MSM. This made the ranking: 1. HIV+; 2. White MSM; 3. Foreign Born Black; 4. Latino MSM; 5. Black MSM; **6. MSM/IDU;** 7. IDU; 8. Young MSM.
6. **Population Size.** The larger population size of IDU in comparison with Young MSM, caused the group leave IDU at #7. No ranking change.

- **Prevention Needs Assessment:** The committee determined that there should be one prevention needs assessment, taking place in 2008, which would look at crack use in MSM, with special attention given to crack use in the Black MSM population. The issue of crack use came up during discussions of sub-priorities and caveats. The group felt that there was insufficient data to justify a caveat or sub-priority, but that this should be the focus of the needs assessment. STD Clinic data indicated higher rates of crack use among Black MSM, but this did not appear to translate into higher rates among HIV infected persons. Additionally, anecdotal reports indicate that providers are seeing increased crack use in MSM. It was determined that there should be only one needs assessment during the two-year period, as the second year (2009) is the one in which the prioritization process takes place. The group set aside $10,000 for the assessment (the same as was set aside in previous years for assessment) which will cover the cost of incentives, transportation and a research assistant.

- **Removal of the Counseling and Testing Set-Aside in Black and Latino MSM Categories:** For 2006-2007, $100,000 was set aside ($50,000 from Latino MSM, $50,000 from Black MSM) to fund community-based counseling and testing. Previous to that prioritization, counseling and testing was funded solely from other Public Health funds, and (in the same way as needle exchange), there was a caveat to that effect. For 2008-2009 the committee determined that counseling and testing should not be done with these dollars (except as part of an overall community-level intervention for Foreign Born Blacks) because they wanted this funding pool to be reserved for other types of behavioral interventions.

- **Creating (and Funding at 8%) an Innovative Program for MSM Category:** The rationale for this was developed by the Interventions Committee, and received a positive response at the Council and the Prioritization Committee. The reasons for creating this category include:
    - The number of new HIV infections has remained constant at about 400 per year, indicating some success, but also a continuing problem that has yet to be fully addressed
    - Over 60% of these new infections are in MSM
    - Agencies are more likely to apply for on-going programs which have a track record, as these are likely to score higher in the grant review process
    - Creating a program in which ONLY new programs would be considered seemed the best way to address the issue

- **Setting Allocation Percentages for the Top Populations:** The plan for ranking the Top Populations (above) served as the basis for allocation funds. Additionally, the group looked at the previous funding levels, other funding sources, and additional data related to factors such as the ease/difficulty of reaching a population in setting allocations. Here are more specifics:

    1. **HIV+: 15%**. Decreased from 2006-2007 allocation by 3%. The committee reduced funding for this population, despite an anticipated loss of an external program for two reasons. First, and most importantly, this population was seen as easy to identify and target. Secondly, care providers are required to provide prevention messages as part of Case Management and Ambulatory/Outpatient Medical Care. However, the group funded this population at a greater rate than any other populations because members felt that care providers were not able to address the need. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.
    2. **White MSM 25-69: 12%.** Increase from 2006-2007 allocation by 2%. The committee increased funding to this category due to the incidence and prevalence in the population. White MSM account for nearly half of prevalent cases, and over 41% of incident cases in the last 3 years. The committee was concerned about non-injection crystal use in this population and other risky behaviors. The committee did not raise the funding higher because significant resources go to this population from internal Public Health funds, and because of a downward trend in this population over time. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.
    3. **Foreign Born Blacks 15-69: 10%.** Increase from 2006-2007 allocation by 4%. This population is the only one with an increasing trend. This, coupled with the multiple cultures and languages spoken by the various populations, led the committee to make a significant increase in funding for Foreign Born Blacks. The committee chose not to increase funding further due to a new externally funded program. However, this program has a narrower target (East African women and youth) and has a broader focus (substance abuse and HIV prevention) and therefore the committee was uncertain about what impact of this program would be.

4. **Latino MSM 25-69: 12%.** Decrease from 2006-2007 allocation by 1%. The committee noted that the highest rate of late diagnosis was in this population, although the overall population is small. Because of this, paired with the language and cultural issues, the group determined that this population should have the same amount of resources targeted to it as the much larger White MSM population. Note: In the previous plan $50,000 from this pot was set aside for a community-based testing and counseling program, this is no longer the case. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.
5. **Black MSM 25-69: 12%.** Decrease from 2006-2007 allocation by 2%. The committee noted that the second highest prevalence rate was among this population. At the same time, the group does not have a higher late diagnosis rate, and is a small overall population. These factors, along with being a population in which many MSM do not identify as such led the group to allocate 12% of the funding to it. Note: In the previous plan $50,000 from this pot was set aside for a community-based testing and counseling program, this is no longer the case. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.
6. **MSM/IDU 15-69: 13%.** Same allocation as in 2006-2007. This population has the highest prevalence rate of any population, although there is no increasing trend. Additionally, this population has access to needle exchange, which is funded through other Public Health dollars. Members of the committee were concerned about the high risk behavior in this population, and therefore maintained 13% funding. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.
7. **IDU 15-69: 11%.** Decrease from 2006-2007 allocation by 3%. This population has the lowest prevalence rate of any of the top populations, and the population has access to needle exchange and methadone vouchers both of which are funded through other Public Health resources. These factors led the group to decrease the allocation to this population.
8. **Young MSM 15-24: 7%.** Increase from 2006-2007 allocation by 1%. The committee agreed that no population should receive less than 7%. The group discussed adding another percentage point for this population (to bring it to 8%), but decided that they did not want to take that percentage point from any other population, and that the additional 1% would not be enough to created an additional program. For all populations which include MSM, the 8% set aside for an innovative program was a consideration, although members were aware that it was not certain which populations would be targeted by this program.