Oregon

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TO: CLHO-Executive Committee
Local Health Department Administrators

FROM: Loreen Nichols, Chair
CLHO-HIV Committee

RE: HIV Prevention Funding Formula

CLHO-HIV requests your consideration of a new funding formula to support HIV Conseling, Testing, and Referral; and other HIV prevention services.

The new formula is a single funding stream and will rely on local health department and state HIV Prevention Program staff working together to determine the package of HIV prevention services available in each community.

The recommended formula is:

Number of new infections diagnosed in community over three years: 55%
Source: HIV/AIDS Reporting System
Time Period: Funding for FY 2006-07 will rely on data from CY 2002-04.

Number of persons living with HIV and AIDS: 30%
Source: HIV/AIDS Reporting System
Time Period: Funding for FY 2006-07 will rely on number of persons living in the county jurisdiction on December 31, 2004. As a result of data limitations, persons living with HIV and AIDS are defined as where they lived at the time of diagnosis. Those passing away are removed from the counts.

High-risk testing conducted by LHD over two years: 15%
Source: HIV Testing Database

Time Period: Funding for FY 2006-07 will rely on testing data from CY 2003-04.

BACKGROUND: The Centers for Disease Control and Prevention issued the Advancing HIV Prevention Initiative in 2003. CDC's goal is to reduce by half the number of new infections nationally annually from 40,000 in 2003 to 20,000 in 2008. A major strategy it proposes in meeting this mandate is to find persons living with HIV who are unaware of their positive HIV status, to increase resources to HIV testing sites most likely to find persons who are HIV positive and to target primary prevention services to persons living with HIV and AIDS to minimize opportunities for further HIV transmission.

Additionally, early in 2005, the CLHO-Executive Committee approved and adopted a one-year interim formula for IDU outreach services. At that time, eight of nine counties eligible for IDU outreach funding were receiving $35,000 each and Multnomah County was receiving $80,000. The one-year interim formula was based on a supply costs base for counties providing needle exchange services, plus a formula that looked at number of persons living with HIV or AIDS in the county with an IDU history (45%); two-year average of tests of persons with an IDU history (45%); and population (10%). Local health departments funded for IDU outreach services through the HIV Prevention Program were not to lose or gain more than 50% of funding during this interim year.

Against this backdrop, CLHO-HIV has endeavored for over one year to retarget resources for HIV counseling, testing, and referral services and other prevention services in order to meet the federal mandate and program needs.

PROCESS: Finalizing a formula that each of the CLHO-HIV committee members could "live with" required considerable discussion over more than one year. During this time, several members left the committee and several members joined the committee. At the start of the process, committee members agreed on several public health concepts, which helped guide the discussions. These concepts included the following:

1. **What is our goal—avert new infections, finding new HIV positives, increase number of individuals with knowledge of their serostatus, raise awareness, build capacity, maintain capacity, etc.?** CLHO-HIV members agreed that the purpose of HIV prevention funding is to avert new infections and find new positives.

2. **Which counties should be eligible for HIV prevention funding? Should eligibility for funding differ for counseling and testing and for targeted**

prevention programs? It was agreed that not all counties need be eligible for HIV prevention funding, including HIV counseling, testing, and referral services. Although there was near agreement that funding should come through a single funding stream to minimize some of the difficulty in filing quarterly expense reports for programs that cross the funding streams, there was ambiguity on whether that meant within the funding stream could there be separate components. Ultimately, the Committee chose a single formula for a single funding stream.

3. **For counties receiving support for targeted prevention, should there be a mechanism to determine which populations to target? Should there be a mechanism to assist in determining appropriate interventions for those target populations?** There was agreement that each local health department would work with the state program to determine appropriate targeted populations, based on local epidemiology, and interventions based on funding level for the county.

4. **If funded for HIV prevention services, should there be a minimum funding amount?** No minimum funding amounts are included in the formula approved by the committee.

5. **How do we support structural interventions or policy work?** Local health departments would work with the state program to determine how to support their structural work in respect to HIV prevention. An example of this would be a county interested in establishing a needle-exchange program who is working with other collaborators and the police in developing the program.

6. **Should the formula treat Multnomah County differently than other counties?** The argument to treat Multnomah County differently is based on an incidence model. More than 50% of HIV infections in Oregon are reported in Multnomah County, indicating a need to focus resources in the metropolitan area. As the Committee is recommending an incidence-based formula to CLHO, there is no need to treat Multnomah County differently in the formula.

7. **Should related co-morbidities, such as syphilis or Hepatitis C, be considered in the formula?** Programs already are required to provide information about related co-morbidities in HIV CTRS. Most programs serving MSM and other populations provide information about syphilis and most programs serving IDU provide information about Hepatitis C. There

was agreement that these do not belong in the funding formula, but may be programmatic considerations in the delivery of services.

8. **Should public support be made available to all AIDS-service organizations in the state?** This was suggested by one community partner. Committee members rejected this consideration in the establishment of appropriate funding levels for local public health.

Majority Report: Given these considerations, the Committee is recommending the following formula to be adopted by CLHO:

1. **Incidence:** The number of people newly diagnosed over the most recent three-year calendar year period who live in the county. For FY 2006-07, data from calendar years 2002-2004 will be used. Incidence provides the most reliable indicator of populations and regions most recently affected by the epidemic. CLHO-HIV recommends that this indicator be weighted at 55%.

2. **Prevalence:** The number of people living with HIV infection and AIDS residing in a county. Due to data limitations, we must use residency at the time of diagnosis. For FY 2006-07, prevalence is measured on December 31, 2004. Prevalence provides a marker of pool of infection in the community. CLHO-HIV recommends that this indicator be weighted at 30%. Please note that incident cases are included in this number and therefore it is weighted lower than incidence.

3. **High-Risk Testing:** Although incidence and prevalence are considered outcome indicators for targeting testing resources, the HIV Prevention Program has provided an incentive to local public health departments to target testing for several years. Support for continuing use of this indicator was mixed and providing a weight of 15% for this data element was a compromise between members who thought it should be removed entirely from the formula to those who thought it should represent a higher percentage in the formula. In some counties, where testing is targeted few new cases of HIV are found and in other counties where it does not seem testing is targeted yield a large number of new infections. However, during this transition it seems appropriate to continue to reward counties that implemented strategies to locate those who are at highest risk of HIV infection.

Minority Report: As indicated above, the recommended formula represents a compromise between committee members. Some felt that the recommended

formula removed too much capacity from Southern Oregon, which had benefited from base funding in the IDU Outreach Program. (Other HIV Prevention funding streams for did not include a generous base like the IDU Outreach Program.) Additionally, other IDU outreach programs in lower-incidence areas may lose all or part of their funding support. Some members felt that high-risk testing should have received a greater weight in the formula. In order to gain support for the compromise formula, it was agreed that this narrative would include this Minority Report section.

Transition Plan: As several areas will be substantially affected by this change in formula, CLHO-HIV members recommend a one-year transition period to the new formula. During the transition year, local health departments losing funding under the new formula will only lose 50% of what they would lose under full implementation of the formula. Local health departments that gain funding under the new formula will only receive 50% of what they would gain under full implementation of the formula.

Action Requested: CLHO-HIV requests that CLHO-Executive Committee consider this formula for a single funding stream for HIV prevention services and adopt it at its next scheduled meeting in January. CLHO-HIV members and state staff are available at any time for questions.