Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Health Services
800 NE Oregon Street
Portland, OR 97232-2162
(971)673-0153
(971)673-0178 Fax

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TO: CLHO-Executive Committee
Local Health Department Administrators

FROM: Loreen Nichols, Chair
CLHO-HIV Committee

Mitchell Zahn, HIV Prevention Manager
DHS HIV/STD/TB Program

RE: HIV Prevention Funding Formula

CLHO-HIV requests your consideration of a new funding formula to support HIV counseling, testing, and referral; and other HIV prevention services. The new formula combines three funding areas into single funding stream. Local health department and state HIV Prevention Program staff will work together to determine the HIV prevention services available in each community.

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 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.

CLHO-HIV made it's first big step towards meeting this federal mandate with an HIV Prevention formula change in late 2004, and has endeavored for over the last year to further retarget resources for HIV counseling, testing, and referral services and other prevention services. Early in 2005, the CLHO-Executive Committee approved and adopted a one-year interim formula for IDU outreach services.

As CLHO-HIV began to focus on finalizing the IDU Outreach formula, it discovered adjustments to the two other funding streams were also necessary in order to maintain an overall prevention funding package that is consistent with local epidemiology. The large minimum funding base in the IDU Outreach formula resulted in some lower-incidence counties receiving much higher funding than some higher-incidence counties. Furthermore, it was noted that the amount of funds and efforts expended on IDU outreach is disproportionate to Oregon's risk profile, with men who have sex with men accounting for nearly 70% of new HIV infections, and injectors

(including MSM/IDU) less than 20%. Funding for IDU Outreach currently exceeds one-third of the proportion of total funds available for targeted interventions, while less resources are being directed to MSM. Resources for the HIV Prevention Block and Intervention Grants have decreased over the past two years, while funding for IDU Outreach has been maintained at $360,000 per year.

Another consideration is that the federal government, through the Program Evaluation and Monitoring System (PEMS) under development at CDC, will require financial reporting by program model. Since program models could conceivably cross funding streams, it was important to develop a single funding stream to facilitate financial reporting.

Finally, Oregon has higher quality information about HIV incidence after it established HIV name-to-code reporting in 2001. HIV diagnoses are a more definitive marker about the nature of HIV transmission than prevalence, and the Committee and consulting epidemiologists felt that incidence should be used to a greater degree than in the past. Further, while the formula's reliance on high-risk testing does provide indication of a county's efforts to test high-risk persons for HIV, improved incidence data shows increased high-risk testing does not necessarily result in finding new HIV positive cases, which is the outcome sought.

CURRENT HIV PREVENTION FORMULA: The HIV Prevention Program currently distributes funding to local health departments through three funding streams, the *Prevention Block Grant*, the *Intervention Grant*, and the *IDU Outreach Grant*. These funds are distributed as follows:

1. Prevention Block Grant Funds primarily HIV counseling, testing, and referral services. All local health departments are eligible for this funding. The formula is:

- **Prevalence (60%)**
- **High-Risk Testing (30%)**
- **County Population (10%)**

Minimum funding amounts are provided based on two-year average number of high-risk tests conducted.

2. Intervention Grant Funds HIV prevention services that target specific high-risk populations above and beyond HIV counseling, testing and referral services. Counties with 1.15% of the population living with HIV/AIDS (at time of diagnosis) are eligible for this funding stream.[1] The formula is:

- **Prevalence (80%)**
- **Minority Population (20%)**

There are no minimum funding levels.

3. IDU Outreach Grant Funds nine counties for intensive services to injection drug users. Eligibility for funding was based on anecdotal assumptions about drug use on the I-5 corridor, infrastructure, and county ability to reach injection drug users. Seven of the nine counties

[1] In the current year, nine counties were eligible for *Intervention Grant* funding, including Clackamas, Deschutes, Douglas, Jackson, Josephine, Lane, Marion, Multnomah, and Washington Counties.

funded provide needle exchange and other services.[2] The two counties that do not provide needle exchange conduct intensive outreach and structural policy work. The current one-year interim formula provides a base for supply costs for counties providing needle exchange services, plus:

- **Prevalence of individuals with an IDU history (45%)**
- **IDU Testing History (45%)**
- **Population (10%)**

PROPOSED FORMULA: The Committee is recommending the *Prevention Block Grant*, the *Intervention Grant*, and the *IDU Outreach Grant* be combined into a single HIV Prevention funding stream, and distributed according to the following formula:

Funding would be restricted to counties with an average of one new case over the prior three-year period.

- **Incidence (55%):** 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.
- **Prevalence (30%):** The number of people living with HIV infection and AIDS residing in a county, based on residency at the time of diagnosis. For FY 2006-07, prevalence is measured on December 31, 2004.
- **High-Risk Testing (15%):** The latest two-year average of public sector HIV tests conducted to MSM, IDU, and MSM/IDU in a county.

DELIBERATIONS: 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 and joined the committee. Members agreed upon the following principles:

- The purpose of HIV prevention funding is to avert new infections and find new positives.
- Not all counties need be eligible for funding, including HIV counseling, testing, and referral services.
- Establish a single formula for a single funding stream for all HIV prevention services.

The following questions were posed to help guide the discussion:

- What is our goal?
- Who receives funding? Should eligibility differ for counseling and testing and for targeted prevention programs?
- What's the mechanism for determining which populations to target? Should there be a mechanism to assist in determining appropriate interventions for those target populations?
- Should funded counties receive a minimum funding amount?
- Should the formula treat Multnomah County differently than other counties?
- Should related co-morbidities, such as syphilis or hepatitis C, be considered?

[2] IDU Outreach services are funded in Benton, Douglas, Jackson, Josephine, Lane, Marion, Multnomah, Tillamook, and Washington Counties.

Members also thoroughly reviewed data elements in the current formula, and derived at the following rationale for selecting and removing the various elements in this proposal:

- Incidence - Added to the formula because it is the best marker of current infections.
- Prevalence – Provides a marker of pool of infection in the community. Because incident cases are already included in this number, it should therefore be weighted lower.
- High-risk testing – Has provided an incentive to local public health departments to target testing for several years. Support for this indicator was mixed, and its inclusion at 15% is a compromise between members who thought it should represent a higher percentage, and those who thought it should be removed entirely. Increased high-risk testing does not necessarily yield a greater number of new infections. However, during this transition it seems appropriate to continue to reward counties that have worked hard to implement strategies to locate those at highest risk for HIV infection.
- Population - was not considered an important factor in the formula, since it is not a marker for HIV transmission.
- Ethinic minorities – African Americans and Hispanic/Latinos are disproportionately affected by HIV in Oregon, however, because the formula and programmatic needs are not linked, the committee felt this should be removed. State staff will work with local health departments, if needed, to help reach these populations.

Numerous other scenarios were considered, including:

- those involving different weightings of formula elements;
- the current formulae condensed into a single funding stream;
- formulae with varying amounts for a financial base;
- an incidence-only funding stream; and
- consideration of a “request for proposal” process.

The proposed formula represents a compromise between committee members, who agreed on the data elements but differed on the weightings. Significant concern was expressed by Douglas County that this proposal removes too much capacity from Southern Oregon, and threatens to close of that region’s last remaining AIDS service organization. Southern Oregon in particular has benefited from base funding in the IDU Outreach Program (other HIV Prevention funding streams did not include a large base.) Additionally, other IDU outreach programs in lower-incidence areas may lose all or part of their funding support.

CONSEQUENCES: The elimination of minimum funding levels in exchange for a formula based principally on HIV incidence redirects funding away from Southern Oregon and some other counties. This mainly occurs in counties currently funded for IDU Outreach services. However, it was felt by some members of CLHO-HIV that this is a necessary correction, and not a flaw in the proposed formula, which more closely equalizes funding with HIV incidence. As several areas will be substantially affected, CLHO-HIV is currently considering a one-year transition plan.

ACTION REQUESTED: CLHO-HIV requests that CLHO-Executive Committee consider and adopt this proposal at its next scheduled meeting in January. CLHO-HIV members and state staff are available at any time for questions.