

# 2011 Priority Setting Process

Chicago HIV Prevention Planning Group  
Wednesday, April 27, 2011



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# Why do we do it?

- Maximize limited prevention funds targeted to populations most at risk
- Reduce the number of HIV infections in Chicago
- Respond to changes in the epidemic
  - Cycle of three years (2012-2015)
- To develop and refine the City's Comprehensive HIV Prevention Plan



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# How do we do it?

- Review previous priority setting outcomes
- Convene 3 committees
  - **Populations (POP) Committee**
  - **Evaluation/Quality Management (EQM) Committee**
- Review & discuss the data
- Develop scoring materials and tools (when applicable)
- Discuss committee recommendations
- Vote on recommendations
- Submit recommendations to the Executive (Finishing) Committee for final approval



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# What does the **Populations Committee** do?

- Monitor populations
  - Continually review which populations are most at risk
  - Discover and analyze geographic ‘hot spots’
  - Utilize all potential data sources, including, but not limited to, HIV/AIDS case data, population co-factor data, and other epidemiological data
- Continually inform the body of ‘Special Concerns Populations’ that may need particular attention
- *Needs Assessment*: Continually seek to identify other populations with special concerns and develop reports and/or presentations on notable findings



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# What does the **Evaluation/Quality Management Committee** do?

- Evaluate the effectiveness of the community planning process
- Identify intervention best practices
  - Monitor effective interventions
  - Review science-based interventions (DEBI's, compendium, etc.)
  - Utilize all potential data sources
- Evaluate the outcomes of prevention projects
- Needs Assessment: Identify gaps in prevention services taking any notable findings from populations committee into consideration as appropriate and provide/analyze research related to interventions



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# What are the outcomes?

- Prioritized Populations and geographic areas (POP)
- Recommended Interventions that reduce HIV transmission (EQM)
- Recommended percentages of resource allocations to CDPH for the next RFP process



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# What did the committees do to prepare?

- Attend meetings (show up): Full Body, Committee, etc.
- Review materials (especially data/presentations)
- Conduct your own research & literature reviews
- Ask questions & share information
- Make suggestions
- Actively participate in committees



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# POPULATIONS 2011



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# 2011 Population Committee Membership

- William Tutol, Co-Chair
- Juan Lopez, Co-Chair Elect
- Sanford Gaylord
- Hector Salgado
- Anthony Sullivan
- Paris Willis
- James Belanger
- Darius Mayfield
- Mawiyah Coates
- Teffany Anderson
- Amy Wong
- Maurice Chapman
- Dianna Manjarrez
- Mary Brewster



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# 2011 Populations Committee

- Charged with the following:
  - Identify populations groups with the highest HIV incidence rates and HIV/AIDS prevalence rates;
  - Identify science-based interventions that are most effective at reducing HIV transmission among high-risk HIV-negative and HIV-positive populations group(s); and
  - Identify geographic areas with the highest HIV-incidence rates (“hot spots” or clusters)



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# 2011 Recommendation #1

- Retain all 2008 population committee priority setting recommendations with some amendments as stated in the 2010-2011 Chicago Comprehensive HIV Prevention Plan



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# Review POPULATIONS 2008



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# 2008 Recommendation # 1

## Recommendation # 1 – Populations

- Accept the existing cluster model A, B and C



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# 2008 Cluster Model Defined

- Rationale: Clusters
  - Regional areas comprised of zip codes and community areas with high HIV incidence rates above the city average of 69.1 per 100,000 cases.



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# 2008 Funding for Citywide and Cluster Programs

- Cluster: Delegate agencies are funded to provide HIV prevention services within a specific geographic area (cluster A, B or C).
- Citywide: Delegate agencies are funded to serve populations from two or more clusters.



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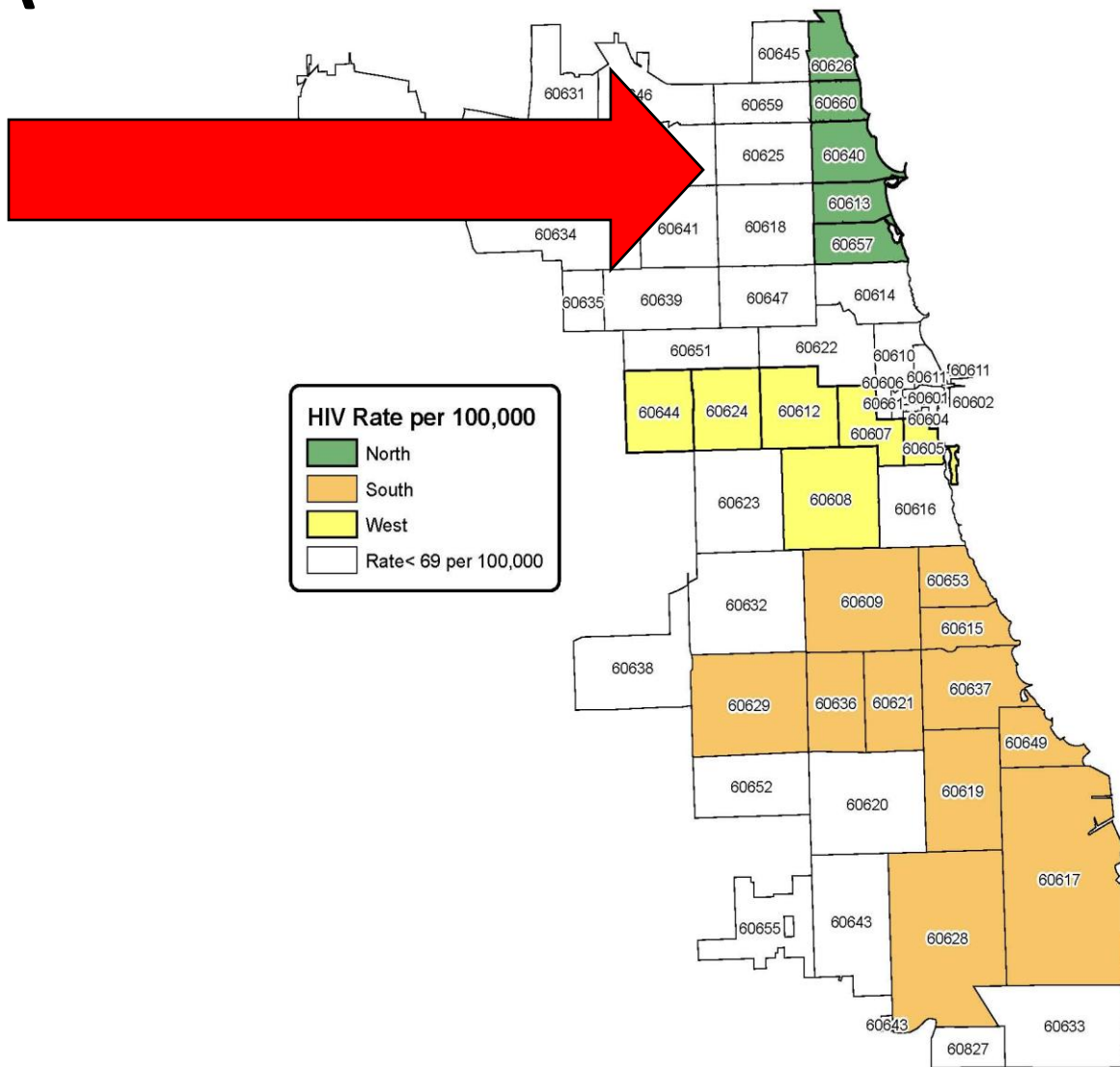
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# CLUSTER A

Average Annual HIV(not AIDS) Rate > 69.1 per 100,000\*  
by Zipcode, Chicago 2006-2007, as of 6/08

**Zip Codes**  
**60613**  
**60625**  
**60626**  
**60640**  
**60657**  
**60660**



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\*Includes 3 zipcodes with rate < 69.1 that had a significant rate increase from 2002-2003  
 Chicago Department of Public Health  
 Office of HIV/AIDS Surveillance, September 2008

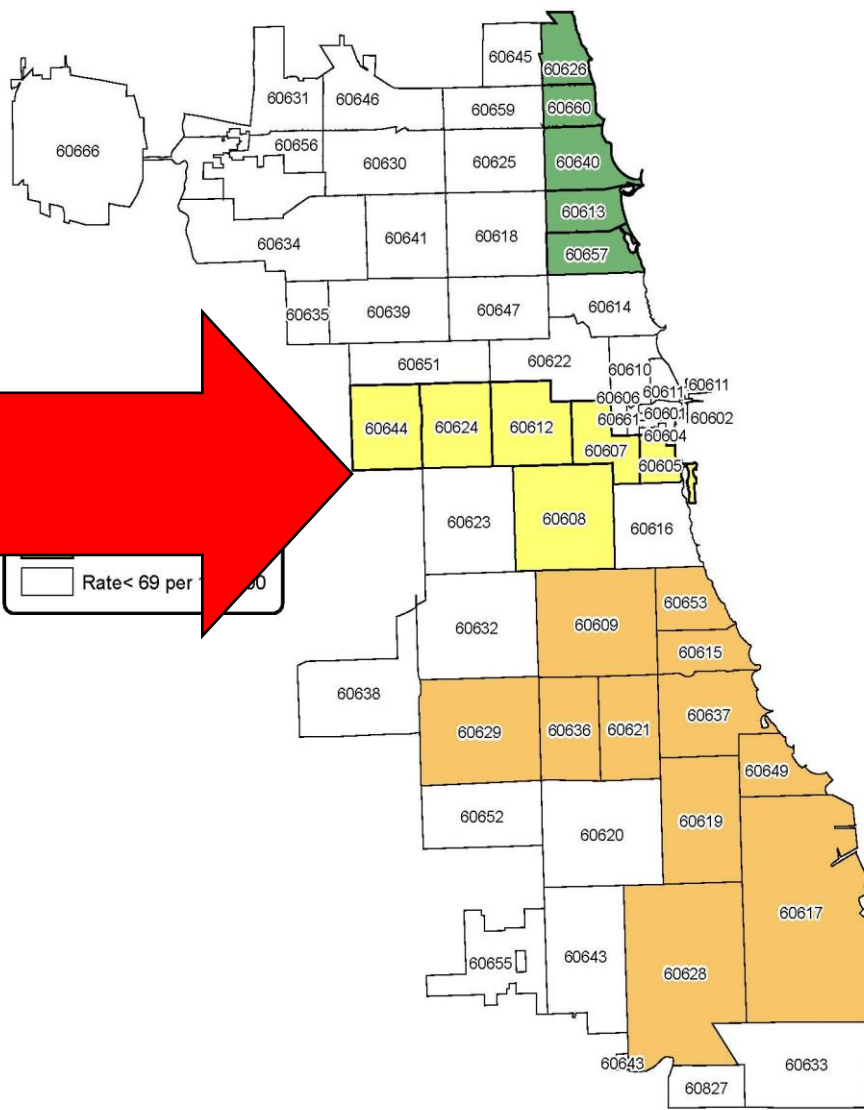
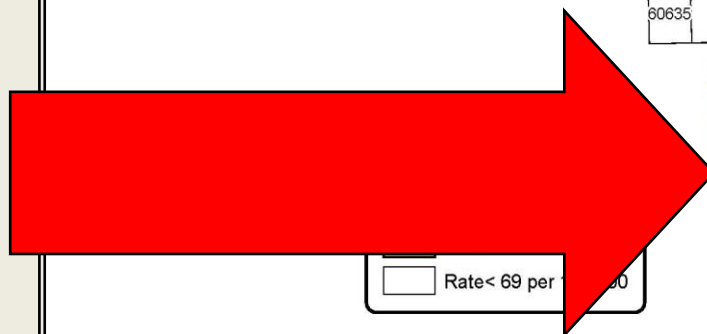


# CLUSTER B

Average Annual HIV(not AIDS) Rate >69.1 per 100,000\*  
by Zipcode, Chicago 2006-2007, as of 6/08

## Zip Codes

- 60601
- 60607
- 60610
- 60612
- 60622
- 60624
- 60644
- 60651
- 60661



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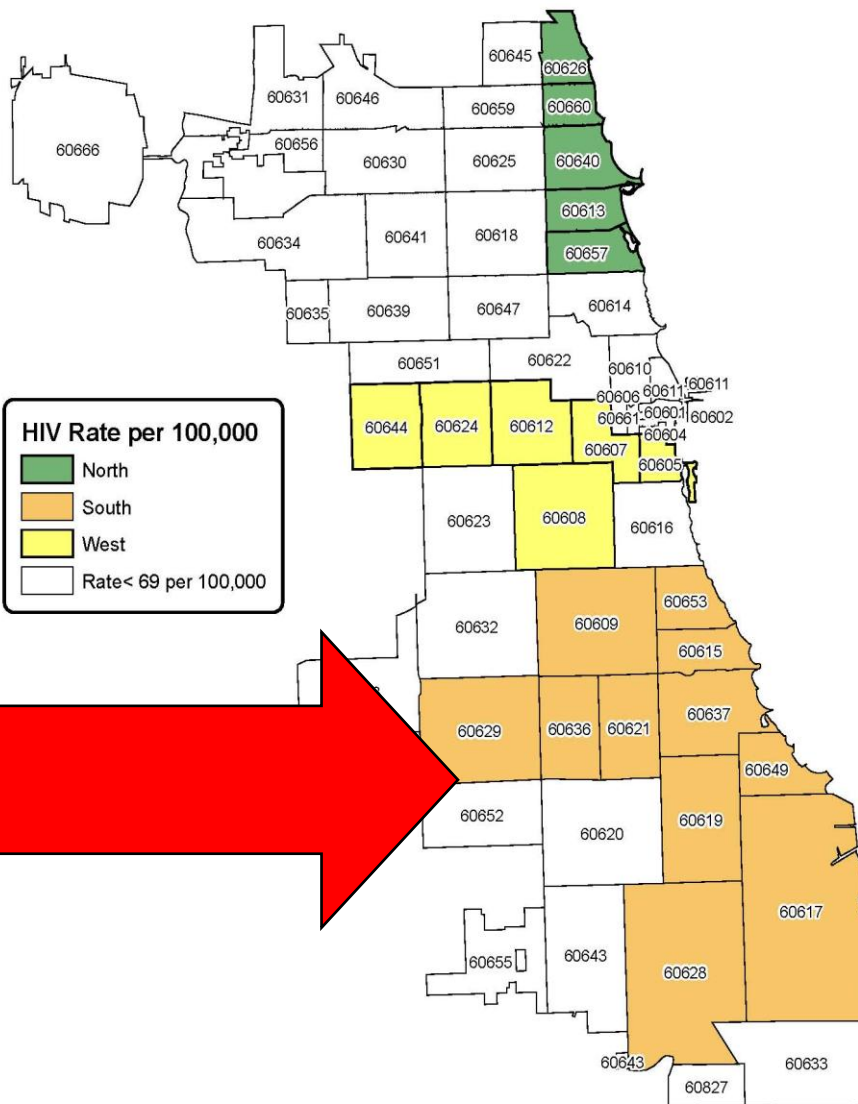
\*Includes 3 zipcodes with rate <69.1 that had a significant rate increase from 2002-2003  
Chicago Department of Public Health  
Office of HIV/AIDS Surveillance, September 2008

# CLUSTER C

## Zip Codes

- 60609
- 60615
- 60619
- 60620
- 60621
- 60628
- 60629
- 60636
- 60637
- 60643
- 60649
- 60653

Average Annual HIV(not AIDS) Rate > 69.1 per 100,000\*  
by Zipcode, Chicago 2006-2007, as of 6/08



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\*Includes 3 zipcodes with rate < 69.1 that had a significant rate increase from 2002-2003  
Chicago Department of Public Health  
Office of HIV/AIDS Surveillance, September 2008

# 2008 Rec. # 1 Cont.

- **Rationale –**
  - Cluster model was established in the 2005 priority setting process as a way to group zip code areas with high HIV incidence.
  - Upon analysis of recent HIV incidence data, the Populations Committee voted to retain these clusters as a framework for prevention services and funding.



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# 2008 Recommendation # 2

- Implement projects for both youth and adults  
(Adults ages 25+ and Youth ages 13-24)



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# 2008 Populations—High-Risk Populations

- HIV incidence data were considered across several levels
  - Zip Code
  - Gender
  - Race / Ethnicity
  - Age
  - Mode of Transmission
- Together, these variables illuminate the highest-risk HIV-negative populations in the City (highest-risk means HIV incidence rate > 50 per 100,000)



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# 2008 Cluster A Target Populations

- Non-Hispanic White MSM age 25+
- Non-Hispanic Black MSM age 25+
- Hispanic MSM age 25+
- MSM all races age <25



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# 2008 Cluster B Target Populations

- Non-Hispanic Black MSM, ages 25+
- Non-Hispanic Black MSM, ages <25
- Non-Hispanic Black High Risk Heterosexual Females, ages 25+
- Non-Hispanic White MSM, ages 25+



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## 2008 Cluster C Target Populations

- Non-Hispanic Black MSM, ages 25+
- Non-Hispanic Black High Risk Heterosexual Females, ages 25+
- Non-Hispanic Black MSM, ages <25
- Non-Hispanic Black High Risk Heterosexual Females, ages <25



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# 2008 Populations

## Decision-Making Method

- The Committee used the data to create a model that identifies:
  - Areas (zip codes) with highest HIV incidence
  - Populations at high-risk for acquiring / transmitting HIV within these areas
- The model redistributes unidentified risk cases to known high risk populations and collapses MSM/IDU to IDU.



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# 2008 Recommendation # 3

## Recommendation # 3 – Populations

- Implement Citywide projects for IDU and Special Concerns populations.
- *Note:* Other target populations will be served within designated clusters A, B and C.

Rationale: based on community presentations and current gaps in services, HPPG recommends a more focused approach for target populations within the clusters.



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# 2008 Rec. # 3 cont.

Special Concerns Populations were identified based on the following criteria:

- is not / may not be adequately covered in other priority recommendations.
  - is marginalized.
  - is known to engage in high-risk behavior(s).
  - is known to be disproportionately represented in other health categories.
  - has known HIV risk co-factors.
  - is in need of specialized services.
- There exists no other system to handle the HIV prevention needs of the SCP.



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# 2008 Recommendation # 4

Fund the following Special Concerns Populations:

1. Transgender Individuals
2. Individuals involved in the Sex Trade
3. Individuals with Physical and Developmental Disabilities
4. Non-English / Non-Spanish Speaking Individuals
5. Homeless Individuals
6. Post Incarcerated Individuals



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# 2008 Rec. # 4 cont.

*Note: Transgender prevention services should also include syringe access education and/or linkage services for trans clients*



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# 2011 Recommendation #2

- Funding for city wide and cluster programs must include prevention programs for PLWHA.
  - Rationale: Specifically target individuals who are HIV positive and face other challenges such as substance use and homelessness.
  - CDPH to include funding for prevention for positives (PLWHA) in the next RFP.
  - Integration of ECHPP into prevention services in next funding cycle for PLWHA.



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# 2011 Recommendation #3

## 2011 Amendment to 2008 Cluster B Target Population

- Non-Hispanic Black MSM, ages 25+
- Non-Hispanic Black MSM, ages <25
- Non-Hispanic Black High Risk Heterosexual Females, ages 25+
- Non-Hispanic White MSM, ages 25+
- Hispanic MSM age 25+



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# 2011 Recommendation #4

- EQM committee to determine:
  - Focus on home-grown interventions suitable and culturally sensitive to high-risk populations and linkage to care for PLWHIV
    - High-Risk HIV-Positives:
      - Specifically target individuals who are HIV positive and face other challenges such as substance use and homeless (Linkage to Care, CDBG)



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# Questions



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# 2011 Evaluation/Quality Management



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# E/QM Committee

- Members
  - Reginald Jackson
  - Meme Wang
  - Thomas Lyons
  - Eunice Smith
  - Beth Sullivan
  - Estella Goolsby
  - Evelyn Bell-Bey
  - Craig Johnson
- Co-Chairs
  - Leveon Perkins
  - Chevy Williams
- CDPH Liaisons
  - Rick Ortiz
  - Victoria Romero
- Acknowledgements:
  - David Amarathithada,  
and Mark Younkings,  
CDPH



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# Role of E/QM committee

- Evaluation and quality management are functions of the community planning process that ensure that HIV prevention programs meet the needs of clients and provide the best services available.
- Role of EQM committee:
  - Identify intervention best practices
  - Evaluate community planning process



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# 2011 E/QM Recommendations



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# Recommendation #5

- Retain recommendations as put forth in 2008 Priority Setting year
  - Recruitment Interventions
  - Focused Interventions
  - Culturally Relevant DEBI and Homegrown Interventions
  - Prevention Services for HRH, MSM, IDU, Youth, Special Populations (SP)
  - Minimum Standards for Interventions



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# 2008 Interventions



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# 2008 Recommendation #5

## Recommendation #5 - Interventions

- At least one focused intervention must be coupled with at least one recruitment intervention

### Focused Interventions:

- Individual Level Intervention (ILI)
- Group Level Intervention (GLI) and
- Comprehensive Risk Counseling and Services (CRCS)
- Comprehensive Syringe Access and Exchange Programs



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# 2008 Rec. #5 cont.

## Recruitment Interventions:

- Outreach
- Health Communication/Public Information(HC/PI)
- Community Level Intervention (CLI)
- Social Marketing
- Internet Based Intervention



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# 2008 Rec. #5 cont.

- Supplement: DEBIs (Diffused Effective Behavioral Interventions) and “homegrown” interventions are equally acceptable frameworks for implementing the above interventions.

Rationale: Finishing Committee determined that organizations should demonstrate capability to plan and implement DEBI and “homegrown” interventions in the RFP process.



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## 2008 Rec. #5. cont.

- Delegate Agencies that choose to implement a DEBI are strongly encouraged to select one that is culturally relevant (such as *Many Men Many Voices*, *D-Up* and *Vibe* as a best practice for African American MSM) and coupled with an appropriate recruitment intervention.



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# 2008 Recommendation #6

## Recommendation #6 – Interventions

- Interventions proposed by organizations must address specific recommendations for the target populations they will be serving (HRH, IDU, MSM, Youth, etc.).



# 2008 Rec. #6 cont.

## Recommendations for High Risk Heterosexual (HRH) Interventions should:

- focus on increasing HIV and STI testing among at-risk HRH.
- increase Health Communication/Public information targeting at-risk HRH.
- expand access to free condoms for at-risk HRH.
- focus on HIV prevention skill building for at-risk HRH women (e.g. negotiation skills, discussion of serostatus) .



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## 2008 Rec. #6 cont.

### **Recommendations for Men who have sex with men (MSM) interventions should:**

- focus on maintaining high rates of HIV testing among MSM.
- focus on increasing STI testing among MSM.
- maintain access to free condoms for MSM.
- target the issue of “condom fatigue” among MSM
- target the relationship among drug use and casual sex among MSM.



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# 2008 Rec. #6 cont.

## Recommendations for Injection Drug User (IDU) Interventions should:

- focus on maintaining high rates of HIV testing among IDU.
- focus on increasing STI testing among IDU.
- focus on maintaining and expanding access to condom use for IDU.
- maintain and expand access to Needle Exchange Programs
- focus risk reduction on sharing injection equipment.  
(cookers, cotton, rinse water)



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# 2008 Rec. #6 cont.

## Recommendations for Youth Interventions should:

- focus on maintaining HIV testing among MSM under 25.
- focus on increasing the number of NHB women under 25 who know the serostatus of their casual sex partner.
- focus on decreasing the number of NHB women under 25 who have unprotected sex with their casual sex partner.



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# 2008 Recommendation # 7

## Recommendation #7 - Interventions

- All interventions must address HIV Counseling & Testing, STI & Hepatitis Integration (which may include basic education & referral, screening & counseling, vaccination for Hepatitis A/B and/or treatment).
- Supplement: Finishing committee determined that allowable costs may include Hepatitis vaccines, STD medications and related medical supplies.



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# 2011 Recommendation #6

- Incorporate Internet Based Interventions into HIV prevention programming
  - Conduct recruitment and outreach via internet
  - Develop innovative ways to provide prevention services through the internet
    - Health education
    - Linkage to care/services



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# 2011 Recommendation #7

Incorporate STI integration into minimum standards for all interventions

- includes basic education, referral, screening, counseling, and treatment and /or vaccination for Hepatitis A/B and bacterial STIs



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# 2011 Recommendation #8

Prioritize interventions that target those who are unaware of their HIV status

- The CDC estimates that 1 in 5 persons are unaware of their HIV status, and estimates within specific risk groups are higher. Interventions that reach those who are unaware of their status is key to preventing HIV transmission.



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# 2011 Recommendation #9

Prioritize interventions that conduct repeat testing of high-risk groups

- MSM
- Drug Users
- Seronegative partners of HIV+, ex-offenders



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# 2011 Recommendation #10

## Prioritize interventions that align with National HIV/AIDS Strategy

- Interventions that seek to reduce new infections
- Interventions that identify new infections, link HIV+ to care, and retain them in care
  - Including outreach to networks of identified positives
- Interventions that reduce disparities



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# 2011 Recommendation #11

Require programs to include an evaluation component as part of their activities

-- Having evaluative measures is key to measuring the impact of our programs.

Requiring some degree of evaluation within programs will help us measure quality and effectiveness of HIV prevention services.



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# Questions



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# 2011 Joint Committee



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# Gap Analysis

- In the 2011 PS process HPPG Populations and Evaluation Quality Management committee(s) unanimously agreed to continue the 2008 gap analysis recommendations.



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# 2008 Recommendation #8

## Recommendation #8 – Needs Assessment/Gap Analysis

- Revise methodology of Resource Inventory (RI): Coordinate annual Resource Inventory at the local, county and state level to ensure agencies only fill out 1 RI per year.
- If coordination is not possible, wait on the RI until methodology can produce useable data as not to burden agencies.
- *Note: RI will be addressed within the NA/GA committee*



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# 2008 Recommendation #9

## Recommendation #9 – Needs Assessment/Gap Analysis

- Maintain current levels of IDU prevention in order to maintain decreases in HIV prevention rate in this population.



# 2008 Recommendation #10

## Recommendation #10 – Needs Assessment/Gap Analysis

- ▣ Continue post-incarceration HIV prevention work, include prevention with currently incarcerated populations.

### Supplement

- Establish communication and collaborations with the county system.
- ▣ Ensure access to HIV testing/counseling.
- ▣ Ensure access to condoms
- ▣ Incorporate HIV Prevention work with the juvenile detention center.



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# 2008 Recommendation #11

## Recommendation #11 – Needs Assessment/Gap Analysis

- Fund HIV prevention services in non-traditional settings:
  - Party Line
  - Sex Parties
  - Internet
    - In the same way we have brought HIV prevention services to bathhouses, bars, clubs and public parks, we need to add these settings to our current non-traditional settings.



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# 2008 Recommendation #12

## Recommendation #12 - Needs Assessment/Gap Analysis

### Data and Research:

- A.) All surveillance/research conducted by CDPH (such as Project CHAT) should include all youth (13-24 years of ages).
- B.) Include and standardize transgender information (MTF & FTM) in surveillance data, surveys and reports.
- C.) Include & standardize all data, surveys, and reports with a race/ethnicity component to include Asian Pacific Islanders, American Indian and Alaskan Natives.



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## 2008 Rec. #12 cont.

- **Note:** CDC does not currently allow for behavioral research for youth under the age of 18. Additionally, IDPH is responsible for development and maintenance of HIV surveillance forms.
- As such, CDPH is currently working with various workgroups, CDC and IDPH to address barriers in data collection. The Exec and NA/GA committees will continue to prioritize data collection issues.



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# Joint Committee Summary

## New Interventions:

- offer the potential to effectively prevent and/or identify new HIV infections
- provide services that are not currently or are only limitedly provided by other systems
- conducted in non-traditional settings
- target high-risk populations/situations
- have a history of proven effectiveness in promoting positive change
- initiate/enhance collaboration
- to reduce barriers to accessing HIV prevention services



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# Questions



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# Counseling & Testing Partner Services Success

- In 2007, 33,515 HIV tests were performed through CDPH-supported testing programs, while in 2010 77,251 tests were performed.
- In 2007, CDPH offered partner services to 105 individuals with new HIV infections, while in 2010 248 individuals were offered partner services.
- In 2007, 118 contacts were notified of a possible exposure to HIV, while in 2010 236 individuals were notified.
- In 2007, 57 contacts to HIV received an HIV test as a result of partner services, while in 2010 133 received a test.
- In 2007, 10 new HIV infections were identified through partner services, while in 2010, 19 new infections were identified.



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# Project CHAT Successes

- In 2008, 60% of Chicago MSM met CDC's HIV testing recommendation of at least 1 test a year
- In 2008, 98% of HIV positive Chicago MSM who were aware of their status had seen a doctor for their infection
- In 2008, 75% of Chicago MSM received free condoms in the past 12 months
- In 2009, most IDUs in Chicago used a needle exchange to get clean needles



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# MOTION

To accept the final recommendations presented by HPPG priority setting committees for the 2011 City of Chicago HIV prevention priorities; and to forward these recommendations, as stated, to CDPH for implementation in 2012.



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# FULL BODY VOTE



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