



State of California—Health and Human Services Agency
California Department of Public Health



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Governor

SEP 11 2008

TO: PREVENTION THINK TANK PARTICIPANTS
AND OTHER INTERESTED PARTIES

SUBJECT: PREVENTION THINK TANK FINAL REPORT

On May 13 and 14, 2008, the California Department of Public Health, Office of AIDS (CDPH/OA) held a "HIV Prevention Think Tank" meeting in Emeryville, California. The primary purpose of the "HIV Prevention Think Tank" meeting was to review guidelines and evidence related to selected HIV prevention strategies, learn more about implementation challenges and successes at the local level, and discuss the interest in and potential for possible state-wide scale up. This meeting was intended to start a process of thinking about what the HIV prevention future may look like in California with respect to funding and guidance from CDPH/OA.

The topics addressed at the meeting included: post-exposure prophylaxis, prevention with positives, acute HIV screening/testing, behavioral interventions, HIV screening/testing in sexually transmitted disease programs, HIV screening in emergency departments and other health care settings, and Partner Counseling and Referral Services.

The enclosed report is a review of the meeting. For those of you who participated, we want to express our gratitude for your time and effort. For those of you receiving this report who did not participate, this meeting (and document) represents the beginning of a rigorous and inclusive process that will ultimately result in a thorough evaluation of CDPH/OA's HIV education and prevention programs. CDPH/OA, in consultation with numerous stakeholders, is considering HIV prevention priority program areas. This evaluation and planning process will help guide decisions regarding CDPH/OA policies, staffing, local funding, training opportunities, technical assistance, and other aspects of our HIV prevention work.

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As we move forward, this process will include:

- Active discussion among all CDPH/OA staff attendees and other staff within CDPH/OA branches (HIV Care, HIV Education and Prevention Services, and HIV/AIDS Epidemiology);
- Focus groups and/or key informant interviews with representatives of local health departments, community-based organizations, clients, advocates, and academics, which we intend to have completed by the end of 2008; and
- Presentations to and discussions with various stakeholder groups, including the California HIV Planning Group, Latino Advisory Board, Center of Excellence for Transgender HIV Prevention, the California African American HIV/AIDS Coalition, local prevention and care and treatment planning councils. We anticipate this process will be on-going into 2009.

As we move forward in this evaluative process of HIV education and prevention activities, we welcome input from all parts the community. Please feel free to distribute this information to people who you think may find it of interest.



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Enclosure

**Office of AIDS
PREVENTION THINK TANK
Meeting Report
May 13 and 14, 2008**

The California Department of Public Health, Office of AIDS (CDPH/OA) hosted the Prevention Think Tank Meeting in Emeryville, California, on May 13 and 14, 2008. Forty-five external participants attended. Michelle Roland, Chief, CDPH/OA, and Kevin Farrell, Chief, HIV Education and Prevention Services Branch, CDPH/OA, were the meeting facilitators. Also in attendance were 28 other CDPH/OA staff and two additional guests, bringing the total of attendees to 77. The 45 participants represented the Centers for Disease Control and Prevention; University of California, Office of the President, California HIV Research Program (CHRP); San Francisco AIDS Foundation; Sonoma County Center of HIV Prevention and Care; CDPH/Sexually Transmitted Disease (STD) Control Branch; San Francisco Department of Public Health; Los Angeles Department of Public Health; San Diego County Health and Human Services Agency; University of California, Los Angeles (UCLA) Program in Global Health David Geffen School of Medicine; Center for Mental Health Research on AIDS, National Institutes of Mental Health (NIMH); University of California, San Francisco, Clinical Laboratory; San Francisco General Hospital; Neuropsychiatric Institute (NPI)-Center for Community Health, Semel Institute for Neuroscience, UCLA; CDPH/OA's HIV Prevention Research and Evaluation Section; University of California, San Diego, Antiviral Research Center; University of California, Center for AIDS Prevention Studies; East Bay AIDS Center; San Francisco City Clinic; Los Angeles Gay and Lesbian Center; and the Alameda County Medical Center.

The topics discussed were Post-exposure Prophylaxis, Prevention with Positives, Acute HIV: Technology and Outreach, Behavioral Interventions, HIV Testing: Emergency Departments and Hospitals, HIV Testing: STD and other Clinics, Partner Counseling and Referral Services (PCRS), and Priorities, Evaluation, and Capacity Building Needs, and Next Steps. Each topic was briefly introduced by one or two presenters, followed by discussions from three to four "implementers" (people from public health or service agencies who had, or have wanted to, implement the intervention). After each presentation, an open discussion forum was facilitated by Kevin Farrell with Michelle Roland charting the discussion. At the end of each discussion, Michelle Roland provided a synopsis of the topic.

The Prevention Think Tank was conceived and conducted by CDPH/OA because the "State of HIV Prevention" is in flux. With up to 250,000 Americans unaware of their HIV status (25,000 – 40,000 in California alone) and up to 60,000 new infections annually (6,000 to 9,000 in California), HIV prevention strategies are ripe for review. CDPH/OA decided to look into eight strategies that currently have federal or state recommendations in place and review the current "state of the art" in each and then

hear comments from participants about current use as well as the future potential for each. A very rich discussion followed.

This single meeting was not intended to produce quick results or provide simple answers. Instead, this is the beginning of a long and involved process to facilitate a review of CDPH/OA HIV prevention activities and help us chart a course for the future.

The following is a topic-by-topic review of the presentations and the discussions that followed each.

Post-exposure Prophylaxis (PEP)

Highlights of the PEP Presentation - Michelle Roland, MD, Chief, CDPH/OA:

- It is not known if non-occupational PEP is effective as there are no efficacy data and probably never will be due to ethical and feasibility concerns regarding control groups.
- PEP is not 100 percent effective in any setting.
- Primary prevention is critical.
- Cost-effectiveness depends on appropriate targeting of services, e.g.,
 - San Francisco program cost effective.
 - French program – low risk exposures, not cost-effective.
- Critical to develop effective follow-up system – must be proactive with follow up.
 - Retention during PEP dispensing stages.
 - Retention during PEP adherence stage.
 - Retention for follow-up HIV testing.
- Medication alone will not prevent HIV infection.

Discussant No. 1 on PEP – Andrew Reynolds, San Francisco City Clinic

- Believer in PEP.
- Brings in high-risk people, chance to test for all STDs.
- Performs 200-250 PEPs per year, provides extensive follow up.
- Main barrier is cost.
- Rarely leads to repeat use of PEP and increased risk behavior.

Discussants No. 2 and No. 3 on PEP – Anna Baylor, M.D., and Sheri Brenner, M.P.H., County of Sonoma

- No funding available in Sonoma County.
- PEP is a prevention opportunity; going to try to use PEP as a prevention "carrot," and that despite the fact that the meds are not funded, we hope to roll out the program and document the inability to provide meds when that is the case. We will add PEP services to our resource guide for our county's HIV clients.
- Good partner with PCRS.
- PEP does not fit with Sonoma's clinical or prevention paradigms.
- Since it is not a mandate or categorically funded, not the highest priority.

Open Discussion Highlights:

- Need to determine criteria by which things are evaluated as effective.
- Awareness of PEP needs to be increased.
- Is there enough data for this to be a teachable moment for high-risk clients; is there enough data to support resource allocation and demand?
- If prevention counseling works at all, why would it not work with PEP?
- Need more data on med adherence outside of clinical trial setting.
- No equivocal data that PEP is cost effective?
- Need to be clear about infrastructure availability; is the high-risk community interested in PEP?
- Do not build a stand alone system for PEP.
- Need statewide standardized guidelines.
- Highly targeted PEP is the way to go.
- Can PEP be used to get high-risk people into other effective interventions?
- Very few people have only one opportunity for exposure.
- How do we marry the clinic and behavioral systems?
- If no infections averted, what criteria do we use to prioritize?
- What should the strategy for PEP be?
- What criteria can be used to decide on effectiveness?
- How to target outreach, social marketing campaign, telephone hotlines?
- Majority of people at risk are comfortable with their level of risk.
- World Health Organization guidelines say integrates PEP with other services.
- Highly targeted PEP works (i.e., meth users).
- Limited data in research settings and none in community settings.
- Is PEP most “bang for the buck?”
- Does PEP offer an expansion of access for clients?

Prevention with Positives (PwP)

Highlights of the PwP Presentation - Cynthia Grossman, Ph.D.

- Secondary HIV Prevention, Treatment Adherence, and Translational Research (these are the research priority areas for this branch at the NIMH).
 - Interventions that delay or prevent negative health outcomes.
 - Interventions that improve adherence to medications regimens.
 - Methods to improve coping and psychological consequences of living with HIV.
 - Improve access to care for underserved populations.
- Behavioral prevention works (and we have some tailored interventions for certain subgroups).
 - Options Project – brief intervention provided at every clinical visit; showed decline in unprotected sex over 18 months.
 - WILLOW – for African American HIV-positive women; showed decrease in incidents of STDs over 12 months.
 - Healthy Relationships – group level intervention – disclosure key component; showed decline in unprotected sex over 12 months.

- Healthy Living Project – 15 sessions on meds adherence; showed 36 percent reduction in unprotected sex at 20 months.
- Living in the Face of Trauma (LIFT) – survivors of childhood and sexual abuse; showed decline in unprotected sex at 12 months.
- How does it work (we know some about the components of interventions that work, primarily through published meta-analyses and reviews).
 - Theory-based interventions.
 - Behavioral skills.
 - Delivered by skilled interventionists.
 - Co-location of care or other services.
 - Repeat behavioral assessment.
- Where do we go from here:
 - Significant effects, but could do better especially with certain sub-groups (we need a greater range of efficacious interventions and interventions that track the changing demographic of the epidemic).
 - Limited attention to cultural, contextual factors (though the research does not limit these factors, except for mental disorders and substance abuse, our current interventions do not address them directly).
 - Include an emphasis on quality of life beyond sexual risk reduction.
 - Integrate approaches to address multi-levels and multiple factors (stigma, disclosure).
 - Dissemination and Implementation (high need and directly related to a recent NIMH program announcement---see link this link for the announcement).
 - Dissemination, Implementation, and Operational Research for HIV Prevention Interventions.
 - www.grants.nih.gov/grants/guide/pa-files/PA-08-166.html.

Discussant No. 1 – Alice Gandelman, M.P.H., California STD/HIV Prevention Training Center

- PwP is perfect intersection between prevention and care.
- Different funding sources dictate how funding can be spent and this creates a barrier to integration.
- Recruitment and retention of clients are issues in non-clinical community-based settings.
- Clinical care centers may be ideal settings for PwP interventions, yet currently most PwP interventions funded and implemented in education and prevention non-clinical settings.
- Some PwP challenges exist in clinical settings, including time needed to conduct, development of skills to effectively conduct, and reimbursement issues.
- Next steps: move from acquisition risk continuum to a transmission risk continuum (with emphasis on prevention of transmission rather than prevention of acquisition).
- Address stigma/other issues experienced by persons living with HIV (e.g., racism, homophobia, disclosure issues, etc.).
- Develop Provider Standards of Practice, provide training/technical assistance as appropriate (training may not address program/infrastructure barriers).

- Encourage/require integration of prevention and care services via current funding mechanisms (e.g., via education and prevention, CTR, early intervention program, care and treatment, etc.).

Discussant No. 2 – Lee Klosinski, Ph.D., Center for Community Health NPI, Semel Institute for Neuroscience, UCLA

- Evidence-based interventions were developed during the late 1980s and 1990s and reflect the epidemic and perceptions of risk and risk behaviors of that pre-highly active antiretroviral therapy (HAART) era.
- Behaviors lead to HIV transmission and interventions change behaviors. Evidence-based behavioral interventions targeting people living with HIV are similar to the HIV monotherapy available in the late 1980s and early 1990s: they are expensive, not available to most people living with HIV, and when used alone, only efficacious for a short period of time.
- This suggests the need for combination prevention therapy for people living with HIV: behavioral plus biomedical interventions, including HIV testing, treatment, PEP, PrEP, male circumcision, and microbicides.
- This combination prevention therapy operates at three levels:
 - Integration with medical care: there are challenges getting service providers to understand that prevention services are a constitutive part of routine HIV care; patient adherence; both areas have a long way to go.
 - Personal: the risk calculus for HIV-infected individuals is different than for HIV-uninfected for acquiring HIV and is often overlooked in prevention planning.
 - Parts of the community do not buy the idea of re-infection and therefore dismiss the importance of protected sex between infected individuals.
 - Having an undetectable viral load is equated with not having a risk of HIV transmission and is license for unprotected sex.
 - Cultural shifts are limiting prevention messages: the popularity and growth of gay “barebacking” pornography signifies how former limits are being redefined.
 - Community: all evidence-based interventions share common factors including trying to persuade individual to limit personal freedom for altruistic reasons.
 - At this stage of the epidemic, it is not clear how to make persuasive appeals for HIV-infected individuals to limit their personal freedom for the sake of slowing or stopping the epidemic.

Discussant No. 3 - Mark Cloutier, M.P.P., M.P.H., San Francisco AIDS Foundation

- In large urban areas of California, HIV has become endemic among gay men of all colors.
- Following the pattern of sexually transmitted infectious diseases without a cure, HIV transmission has (temporarily) stabilized at high rates adding to the reservoir of HIV infection.
- This growing reservoir, given patterns of unprotected anal intercourse, hint at a coming increase in new incidence setting off another epidemic transmission rate.

- In absence of the visible disease process and the presence of effective treatment that makes HIV a disease which may not lessen life expectancy has led to an equivocal beliefs about acquisition of HIV.
- Given the evidence about reducing community level viral load to levels that reduce transmission, we should reinvigorate strategies to get everyone who is clinically appropriate on HIV treatments.
- Public health strategies of partner notification need to be strengthened.
- Behavioral prevention should be nested in strategies from developmental psychology that understand what sex accomplishes for gay men in terms of developmental epochs.
- Current behavioral interventions create time limited changes in behavior and wash out over time.

Open Discussion Highlights:

- Every intervention tried has worked, 25 percent self-disclosure indicates reduction in unprotected sex or increase in condom use.
- An ideal timeframe is three-month booster of interventions, seen at routine checks.
- There are proven interventions that work in clinic settings.
- What is overall goal? Reduce or eliminate? Behavior or infections?
- Reducing dollars means do more with less. In time of reduction in resources, PwP is high priority.
- Staff retention is an issue.
- PCRS can create the ongoing relationship and long term integration, but full integration is needed.
- In the men who have sex with men (MSM) community, what are reasonable expectations for positives and negatives?
- There must be a “system solution” rather than rely on individuals.
- Risk assessment itself is a good intervention.
- How PwP is implemented is crucial.
- PwP interventions need to be set up to meet the needs of the targeted population.
- Consider structural interventions (i.e., housing, food, as part of PwP interventions).
- Doctor’s priority is not prevention.
- Silo funding is problematic.
- Need to combine care with prevention.
- Integrate clinical training with prevention to get PwP part of provider world.
- Need to consider population and environment.
- Language to use with positives needs to be non-blaming, non-stigma, etc.
- American Medical Association support needed.
- Primary care provider has the most impact, opportunity to integrate prevention.
- Interventions work for a while, long term is needed for risk behavior change.
- Research is needed to identify strategies that work.
- Re-look at best practices.
- Opportunity to think about synergy.

Acute HIV: Technology and Outreach

Highlights of Acute HIV: Technology and Outreach presentation No. 1 – Bernie Branson, M.D., Centers for Disease Control and Prevention (CDC)

- Although high viral loads are observed during the period between detecting RNA and anti-bodies, the period between infection and the first detection of RNA is the period when most damage to the immune system occurs.
- Clinical Syndrome of Acute HIV.
 - Forty to 90 percent develop symptoms of Acute HIV, similar to symptoms of a viral illness: fatigue, fever, pharyngitis, lymphadenopathy, and rash.
 - Fifty to 90 percent with symptoms seek medical care
 - Providers considered acute HIV for 16 percent of patients who sought care.
 - Of those diagnosed with Acute HIV, 50 percent were seen at least three times before diagnosis.
 - U.S. Public Health Service guidelines recommend an HIV RNA test in conjunction with an HIV antibody test for patients with a clinical syndrome compatible with acute HIV infection who report recent high-risk behavior.
- Current assays detect antibodies at different times after infection, depending on test being used.
- There is no perfect test, and no test completely eliminates the window period.
- High viral loads within three weeks of becoming infected increase transmitting the HIV infection.
- Viral loads in genital secretions increase with STD infections and may not correlate with plasma viral loads.

Presenter No. 2 – Chris Pilcher, M.D., San Francisco General Hospital

- Acute HIV Infection (AHI) detection programs appear highly cost effective, due to both increased case identification and averting transmission to sex partners and infants.
- Important to understand context of HIV testing - using a different tests not finding others to test. Expense of adding RNA is more cost effective than adding new tests.
- Testing 9-17 percent appears to be by people of acute infections in only 1 percent of the population.
- Community perspective:
 - AHI contributes 9-17 percent of all HIV transmissions in the United States.
 - AHI transmission may truly dominate in high-risk (MSM) communities where regular HIV antibody testing has become an acceptable harm reduction strategy.
- Patient (individual) perspective:
 - Many partners exposed and at risk for each case of AHI.
 - Average ten partnerships per three months during AHI.
 - Forty-one percent meth use, 91 percent RAI, 61 percent unprotected RAI.
 - Expect two to five secondary cases per AHI case without urgent intervention
- Targeting Strategies:
 - Increase diagnostic testing.
 - Routine HIV screening with AHI testing in select clinics.
 - Targeted AHI testing to individuals within clinics.

- Key Operational Challenges:
 - Develop and validate criteria for targeted AHI screening.
 - Revise public health marketing strategies.
 - Develop and pilot standardized counseling messages and scripts.
 - Develop and pilot systems coordinating.
 - Pilot systems for centralized NAAT.
 - Urgently evaluate new diagnostic algorithms amenable to decentralized AHI testing.

Discussant No. 1 – Precious Stallworth, Los Angeles Gay and Lesbian Center

- In Los Angeles metro, high positivity rate, creates larger pool of possible exposures. Targeted testing in areas that are highly impacted with HIV will provide a higher yield of acutely infected people.
- Having STD screening with HIV screening makes a difference. STDs and HIV have the same risk. When you provide one service without offering the other, you may miss an opportunity to treat and inform a client of an infection. This is counterproductive to public health.
- Telling a client their rapid test is negative provides a base line for the client. If the test rapid test is negative, you can then process the NAAT test to see if the client is acutely infected. Counselors must tailor their message so that clients know that the rapid HIV test can provide information about a client's status as it relates to where they are in their window period; the NAAT test has a much shorter window and will provide greater certainty for the client.
- Acute testing can be valuable for those who may go out and have unprotected sex upon hearing a negative rapid test. The client is informed that though their rapid test is negative they will need to return for their NAAT test result.
- NAAT testing gives greater opportunity to not infect someone else. Clients who are acutely infected are most infectious in this stage and do not test positive on a standard antibody test.
- Denial of risks on part of patients is a factor. Clients who test positive may disclose low to no risk factors. Upon learning they are positive, they begin to recall encounters that may have put them at risk. Acutely infected clients have a better opportunity of remembering risky encounters as the occurrence is recent.

Discussant No. 2 – Susan Little, M.D., UCSD Antiviral Research Center

- Identifying which AHI screening method to use and when:
 - Varies by AHI prevalence, risk group.
 - Challenges – no direct evidence that preventive counseling during HIV screening changes risks, although several behavioral interventions have been shown to reduce self-reported high-risk behaviors.
 - NAAT has shown to be cost-effective but not inexpensive, strains system financially.
 - Which screening algorithm would best identify highest risk populations.
- Crazy idea – universal screening for AHI, scale up rapid testing, limit pre- and post-test counseling to opt-out requirements stated in Assembly Bill 682.
- Develop strategies to allow all public health sites to participate in AHI screening.

Discussant No. 3 – Terry Cunningham, M.A.O.M., San Diego County Health and Human Services Agency

- San Diego is a conservative area where some innovative programs have run into resistance.
- Cross training of CDI HIV Counselors and Testers with CDI Field Investigation has had limited success.
- Need to engage in NAAT testing, has been working when precipitated by rapid testing
- Concerns: Extensive consent form; reimbursements; cross-training of CDI staff, some can and some cannot.

Open Discussion Highlights:

- Just bringing up AHI is important, but will not work everywhere.
- NAAT may need to be implemented selectively.
- If you do not have capacity, need to look at establishing the capacity, like blood banks.
- People not disclosing risks or not recognizing risks?
- Getting people to test center is biggest barrier.
- RNA not sensitive enough to eliminate Ab testing to find acute HIV.
- What would we do different with someone who is AHI versus just HIV positive, anything?
- Given limited resources, where does AHI fit?
- Uncomfortable offering a less sensitive test in a public venue than a private venue.
- Combine RNA plus oral test equals the best public health outcome.
- Targeting the highest risk populations is essential.
- Work to develop testing algorithm.
- San Diego posts negative results on Internet, law limits alerting positives online.
- Goal? Biggest impact on epidemic.
- Should goal be to increase overall screening and target NAAT?
- Must be responsible for where we spend our testing dollars.
- Routine testing is best.
- African American heterosexual women present for care late.
- Can not ignore cost, cost versus diagnosis not cost versus test.
- Critical to consider phlebotomy laws.
- NAAT is the way of the future.
- Counseling messages must be different.
- Missed opportunities have occurred, people must understand when they are informed they have AHI.
- When people are told of AHI status, they have a different attitude towards sero-sorting.
- Bottom line - people who do not know they are positive are infecting others, not just AHI individuals.
- Lots of undiagnosed HIV infected, lots of late presenters.
- Work with the Food and Drug Administration to increase new tests for AHI.
- Limited resources for phlebotomists an issue.

Behavioral Interventions

Highlights of Behavioral Interventions Presentation - Charles Collins, Ph.D., CDC

- Why the emphasis on evidence-based prevention practices?
 - In 1984-2000, focused on CTR, but encouraged home-grown, locally developed risk-reduction interventions.
 - In 2000, Institute of Medicine criticized CDC for failure to disseminate evidence-based interventions.
 - A way to ensure accountability to U.S. tax payers.
- How were Diffusion of Evidenced-Based Interventions (DEBIs) selected:
 - Interventions had rigorous evaluations that demonstrated reduction in HIV transmission risk behaviors.
 - Some DEBIs did not meet all the criteria but were selected due to the at-risk population they reached and the evidence of efficacy.
 - Behavior change had to occur, not just intention to change or attitude change.
 - Behavior change had to be sustained a minimum of 90 days.
 - Minimum of 70 percent client follow up.
- Eight new DEBIs for 2008-09.

Presentation No. 2 - Chris Krawczyk, Ph.D., CDPH/OA, HIV Prevention Research and Evaluation Section

- CHOICEHIV Web site – tool for helping local health jurisdictions (LHJs) and community-based organizations (CBOs) select interventions.
 - Shows degree of scientific evidence.
 - Provides a list interventions, can sort by target population, behaviors, demographics, etc.
- Consider efficacy versus effectiveness.
- New interventions versus new understanding. (Do we need to focus our energy on developing and implementing new interventions, or do we need to focus our energy on better understanding factors that influence the success of existing interventions?)
- What approaches and methods are needed for establishing effectiveness?
- What outcomes and factors need to be measured in order to establish intervention effectiveness?
- Apply theory to need/community or vice versa. (In developing interventions or better understanding factors of successfully implementing interventions, should we start with a behavioral theory or start with the community perspective and apply theory accordingly?)

Discussant No. 1 – Alice Gandelman, M.P.H., California STD/HIV Prevention Training Center

- Best-practice (a.k.a., locally developed) interventions should be further evaluated to determine outcomes.
- Efficacious, or evidence-based interventions (e.g., EBIs, DEBIs) should be promoted.
- Need to further study the implementation of efficacious interventions in practice or “real-world” settings.

- Because EBIs are not currently required in California, cannot yet understand implementation issues.
- CBOs in California have not been very receptive to D/EBIs, perhaps because they do not see the relevance for their communities.
- More efforts should be made to describe the relevance of EBIs, and resulting risk reduction/behavioral outcomes, while supporting the evaluation of locally developed interventions.

Discussant No. 2 – Grant Colfax, M.D., M.P.H., San Francisco Department of Public Health

What are we talking about when we talk about efficacy? Well designed randomized interventions that show behavioral change.

- Define efficacy of behavioral interventions. Many best-designed randomized interventions that show behavioral change do not have a biologic endpoint. RESPECT had an STD endpoint, not specific to HIV.
- Effectiveness – are we hitting the populations we need to hit, are participation rates acceptable?
- Efficacy questionable, effectiveness unknown. How much behavior change is necessary for reduction in HIV incidence?
- A 3.25 year study – 11-23 percent self-report reduction in risk behavior, no change in HIV status EXPLORE – 11-23 percent self-report reduction in risk behavior, no statistically significant reduction in HIV infection rates.
- How do you measure outcomes?
- Struggle to adapt interventions. To what extent are these interventions feasible, manageable, sustainable, and to what extent can they include large numbers of persons at risk for HIV?

Discussant No. 3 - Judy Auerbach, Ph.D., San Francisco AIDS Foundation Behavioral Interventions

- Sociological perspective points to some limitations in reliance on behavioral interventions
 - Put discussion of behavioral interventions in the context of the question, “What is meant by ‘evidence’ in evidenced-based interventions?”
 - Assumption that only data from randomized controlled trials constitutes evidence has meant that the method has driven the question rather than the other way around
 - Behavioral interventions are based on limited theoretical models, chiefly from health psychology, that have limited the set of questions and the methodologies employed.
 - Behavioral interventions have been designed around a single or a couple of characteristics of individuals that somehow have been deemed to be most relevant in HIV transmission (e.g., race/ethnicity, sex/gender, age, etc.) when we are dealing with whole people with multiple characteristics operating in whole environments that influence their identities and behaviors.
 - While behavioral interventions have produced **efficacy** data, the question is what happens at a population level, where we are interested in **effectiveness**?

- Published interventions show on the average anywhere from 0-30 percent risk reduction. Most data are self-reported, and the question remains, how valid are these data?
- Just as is true in biomedical science, behavioral and social science needs to go back to fundamental questions about what contributes to risk and protection for individuals and groups that can be modified through interventions of multiple sorts and at multiple levels.

Discussant No. 4 – Tom Coates, Ph.D., UCLA Program in Global Health David Geffen School of Medicine

- Recognize that prevention is hard.
- Some EBIs are no more effective than placebo.
- Motivation – what major motivators do we have to convince people to change their behavior, forego something for the better good, forego their rights?
- Incentives – need a strong, theoretical model, cash looks promising.
- Substances – Meth – 25 percent of men equal 43 percent of infection, alcohol needs more attention.
- How do we engage community leaders?
- Need to be creative.
- In the world where HIV decreased dramatically and you will find political support.
- New academic, medical, behavioral data needs to be gathered.
- Maybe simplicity is the way to go

Open Discussion Highlights:

- Stop using acronyms in interventions.
- Support gay marriage.
- Affect the tide of the way things are happening in the community as a whole.
- Most EBIs need to be based on social behavioral theory.
- CDC would like to look at more interventions, not sure if answer is “home grown,” however.
- DEBIs get lots of criticism.
- Need rich display of options.
- Difference in targeting interventions and marketing interventions.
- Change behavior versus change disease incidence, would be good to have both but CDC has to choose behavior first.
- Epidemic is 26 years old; community with HIV is very different now.
- Spending most money on least effective progress, irresponsible to fund behavioral interventions that are not getting results.
- Biomedical measures are very narrow, behavioral interventions are broad.
- Need to address underlining issues: homelessness, drug use, homophobia, etc.
- HIV tests do not prevent infections, it is the test result. Look at in relationship to consequences/contacts as prevention tool.
- CDC made a rational decision based on science, what makes California unique?
- Community planning process – let it continue or make change?
- Workforce we need is probably not workforce we have.

- Issues around efficacy and evidence we use in this political climate makes it very difficult.
- Irresponsible not to address racism, homophobia, substance use, access to care, sexism, etc.
- Using same framework will have same outcome.
- Struggle with seeing research data vs. the real world.
- How many times does an intervention take to make a difference.
- Social and structural issues are too complicated to deal with is our usual speech, let's not give up so easily.
- Needle exchange may not address drug use, but it does address HIV transmission.
- Deal with epidemic now while working with where the science is now.
- Behavioral interventions/approaches has a role to play over all topics.
- Behavioral interventions are complex; it is their nature to be.
- Develop strategies to address the broader issues not just what the individual may do.
- Need to work within the community to find interventions that work.
- Implementation is the problem not the science.

HIV Testing: Emergency Departments (ED) and Hospitals

Highlights HIV Testing; ED and Hospitals presentation - Doug White, M.D., Alameda County Medical Center

- HIV screening in ED.
 - Ideal venue, high-risk clients, uninsured and underinsured.
 - Rapid test – high yield, feasible, replicable.
 - Challenges – cost, sustainability, buy-in, and dissemination.
- Revise CDC recommendations.
 - Prevention counseling is not required.
 - Communicate test results – same as other diagnostic/screening tests.
 - Provide follow-up care.
- American College of Emergency Physicians.
 - HIV testing in the evaluation of acute care conditions should be available in an expeditious and efficient fashion similar to testing and results for other conditions.
 - HIV screening, when deemed appropriate, must meet the following conditions.
 - Practical and feasible.
 - Can not interfere with the primary acute care mission.
 - Offered based on prevalence and needs of community.
 - Must adequately address patient confidentiality, informed consent, provider training, need for counseling, linkage to care.
 - Must meet local and state requirements.
 - Contingent upon adequate funding.
- Critical ongoing research.
 - Opt-out screening studies.
 - Evaluation of clinical programs.
 - Retrospective analysis of testing databases.

- Unanswered questions.
 - Best practice models.
 - Point of care versus laboratory.
 - Existing staff versus supplemental staff.
 - Opt-out versus opt-in.
 - Screening versus targeted versus diagnostic testing.
 - Reimbursement.
 - Next steps for California.
- Barriers to implementation.
 - Cost.
 - Buy-in.
 - Sustainability.
 - Integration models.

Discussant No. 1 and No. 2 – Brad Hare, M.D., San Francisco General Hospital and Barbara Haller, M.D., Ph.D., San Francisco Clinical Laboratory

- Testing: Lab-based testing utilized over POCT due to regulatory and personnel issues
- Disclosure: Primarily responsibility of ordering clinician (results entered into hospital electronic record immediately by lab personnel). Back ups for preliminary positive disclosures: 1) all preliminary positives phoned to PHAST outreach team based in the HIV clinic on daily basis; 2) all preliminary positives faxed to CDPH outreach team on weekly basis.
- February through December 2007: 65 percent of new HIV diagnoses made in ED or urgent care, compared to primary care or inpatient units.
- Prevalence study in ED (March 2007): 1,820 patients tested: 146 (8 percent) previously known to be positive, 14 (0.8 percent) were positive with no record of prior positivity, 1 case of acute HIV.
- Areas for expansion: broader opt-out testing in ED; expanding testing in urgent care; enhancing linkage capacity; defining metrics for adequate linkage; linking to community clinics when appropriate, rather than exclusively hospital-based HIV clinic; sustainability of funding.

Discussant No. 3 – Beth Kaplan, M.D., San Francisco General Hospital Emergency Room

- Goal to treat and send out.
- Collaborative effort – buy-in from administrations and support from community.
- Training – doctors and social workers to be integrated.
- Make it simple.
- Explain relevance – feedback is important to ED doctors, but they do not want to do continuation care.
- Get social work service to back up doctors when giving positive results.
- Work on referrals.
- Change culture with resources you have, do not want to set up system that would fall if funding ceased.

Discussant No. 4 – Steve O’Brien, M.D., Alta Bates Summit Hospital

- Surveyed 154 ED providers, worried about follow up, did not feel trained to give results.
- ED not advertised as a place to get HIV test, everyone seen in ED is offered test, triage registered nurse (R.N.) will provide list of community HIV test sites for those who only want an HIV test.
- Of 3,500 unique patients tested, 17 new positives and 29 false positives.

Open Discussion Highlights:

- High false positive results rate being addressed with manufacturer of test.
- Start thinking about the next generation of tests.
- Key to prevention – choice of partner is No. 1 most important factor, known status.
- Centralized lab reporting.
- Issues surrounding names based reporting.
- Money and resources, increase money for testing, OA historically funded community-based testing.
- Proportion of test done to those that already know status.
- Each test is appropriate if engages person into care.
- Targeting decisions made based on risk which includes locale.
- Makes sense to offer testing in ED/clinic/in-patient settings, primary care clinics offers continuity of care.
- Going to the community there is the opportunity to address the community, psycho-social issues that exist.
- Priority setting needs to include labor and delivery setting.
- Look at NAAT in future to affect accuracy.
- Preliminary false positives is an issue not only for clients but also the providers, undermines morale.
- Have learned control groups on behavioral studies getting six to nine months C&T do have changes in behavior.
- Must figure out ways to get more high-risk people to get tested for knowing their status does change their behaviors for a while.
- Black community is very reluctant to receive services.
- When people test positive, risk behavior declines; what is the effect of a negative result?
- How do we get routine linkage?
- More linkage into care.
- Can not put money where there is low prevalence settings.
- California needs more simple responses to C&T.

HIV Testing: STD and Other Clinics

Highlights on HIV Testing: STD and other clinics presentation - Gail Bolan, M.D., CDPH/STD Control Branch

- Challenges of integrating HIV testing in STD clinic.
 - Resources.

- Staffing.
- Patient flow.
- Data requirements.
- Unanswered Questions.
 - Should routine HIV testing be standard of care in STD clinics?
 - What HIV testing technologies are most appropriate at STD clinics?
 - How many acute infections are we missing in treating STDs without coupling of new HIV test technologies?
 - How can we harmonize/streamline risk factor data collection?
 - How are we going to pay for this?
- False positives in syphilis also happens.
- Screening tests still good even if it comes back false positive.
- Harm can be done when screening test yields false positive, need a protocol.
- Best predictor in women, asking if there is any possibility their sexual partner may have had another sexual partner, if yes, then test.
- In terms of HIPPA: lots of misunderstanding, public health needs to be exempt, public health can do more and needs to.

Discussant – Chris Hall, M.D., M.S., California STD/HIV Prevention Training Center

- HIV is an STD.
- More funding needed in STD clinics since most staff and resources are stretched already.
- Makes sense to test in STD clinics since a patient testing positive for an STD is at higher risk of HIV as well.

Open Discussion Highlights:

- Mobile vans are the best way to reach high-risk, hard-to-reach populations.
- Reaches people who are not sick and have no symptoms.
- Some populations are wary of the medical establishment.
- Issues with getting laboratory results to clinics and State.
- A significant percent who test already know they are HIV positive.
- Need to increase opportunities for testing in African American communities.
- Community clinics that treat and care for HIV positives are good setting for HIV testing; their existence alone states there is HIV.

Partner Counseling Referral Services (PCRS)

Highlights on PCRS – Sam Dooley, M.D., CDC

- Need to reach:
 - infected persons not aware of their status.
 - HIV positives aware of their status but not in care.
 - Non-infected persons at very high risk.
 - Not aware of risk; engaging in high-risk behaviors.
 - Aware of risk, continuing high-risk behaviors.
 - PCRS can be used to reach all three categories.

- All persons with newly-diagnosed or reported HIV infection should be offered PCRS at least once. At the time of diagnosis or as soon afterwards as possible.
- Programs should:
 - Use surveillance and disease reporting systems to help identify persons with HIV.
 - Strongly consider using individual-level data if appropriate security and confidentiality procedures are in place.
 - Work with providers of HIV screening, testing, and care to ensure that clients are offered PCRS as soon as possible after diagnosis.
- Referral/notification methods:
 - Accommodate a mix of notification strategies.
 - Strongly encourage provider referral.
 - For self-referral, provide coaching and monitor success.
- Cost-effectiveness.
 - Small number of analyses suggest that cost-effectiveness of PCRS is similar to that for CTR.
- Efficiencies of PCRS.
 - Need to identify methods for maximizing the efficiency of partner elicitation and partner notification to make best use of limited resources.
 - Supplemental methods – social network strategy for recruiting high-risk persons for C&T may be beneficial and probably easy to build into PCRS.

Discussant No. 1 - Peter Kerndt, M.D., M.P.H., STD Programs, Los Angeles County Department of Public Health

- Traditional partner notification approaches - provider disclosure by LHJ DIS/PHI, clinician or case manager; patient self disclosure; provider assisted shown to be most successful.
- Consistent benefit to individual and community from PCRS/Partner Services; nearly all partners accept counseling and most testing when contacted; on average one in five are new HIV; one in five known HIV; three in five test negative. Benefit to all from counseling or referral for medical evaluation or other prevention services.
- No one strategy, PCRS, Behavior Interventions, emergency room testing, mobile vans, is going to work for every individual in every setting.
- Multiple approaches are needed; (e.g., Internet notifications, CBO-based and employed disease infection specialist trained to same standard as Public Health (PH), working as co-equal partners with PH.
- Consider what works best with least amount of resources; evaluate and target activities based on best evidence.
- Priority for PCRS - AHI, new HIV infection, old HIV with new STD, women, especially any pregnant women with HIV (or any STD).
- Barriers - different CDC guidelines for HIV and STD; different data systems to measure outcomes; insufficiently trained personnel and staff turnover, community leadership support for and community perception of Partner Services. Prior stigmatization of PN/PCRS by PH linked to opposition to HIV reporting by name.

Discussant No. 2 – Sophia Rumanes, M.P.H., Los Angeles County Office of AIDS Programs and Policy

- Newly diagnosed patients more receptive to notifying their partners.
- PCRS is a great way to get both HIV-positive and HIV-negative clients into appropriate prevention programs.
- Need for community engagement and buy-in regarding PCRS given historic issues and misperceptions.
- Newly diagnosed more receptive.
- Complement to PHI/DIS approach.
- Immediate linkage important.
- CBO resistance.
 - Partner Services intrusive.
 - Not a critical prevention intervention.
 - Health department mistrust.
- Significant training needs.
 - Counselors.
 - Coordinators.
 - CBO leadership.
 - Departmental.
- Limited community planning group buy in equals limited investment.
- Consistent PCRS data sharing can influence perception.

Discussant No. 3 - Gail Bolan, M.D., CDPH/STD Control Branch

- PCRS has been a challenge in California.
- Number of provider barriers; doctors will say, no I will not offer PCRS to my clients.
- At a crossroads of looking at PCRS.
- Bringing up PCRS at the same session as patient receives HIV-positive diagnosis may not work or be appropriate.

Open Discussion Highlights:

- PCRS works across the board for all behavior risk groups.
- PCRS needs to be within care settings.
- DIS persons learn on the job, skills are tough to learn in training.
- Look at clusters of infections.
- Syphilis disclosure is different than HIV disclosure.
- Should everyone providing testing be trained in PCRS, hard to train and expensive.
- In California, self-disclosure is preferred, is there data to show it is effective?
- Part of problem is integration, if integrated into other services, it works.
- Identify providers with high volume and provide resources to do service.
- Need high yield year in and out to be cost effective.
- Outside of cost, moral obligation.
- Ideal model is to repeat offering.
- If person doing PCRS is imbedded in CBO, they become recognizable to clients.
- Public health needs to market PCRS to general medical providers.
- Focus on certain areas.

- Training needs to be done well.
- Need new approaches to notification, some newly positive people only give e-mail addresses.
- Must have right people to do PCRS.
- Need new interventions for new diagnoses.
- In California, third-party notification is rare.
- While having provider do the disclosure, this does little to encourage the client to disclose to future sex partners.
- California is diverse, one size does not fit all.
- Acceptance of surveillance data could facilitate PCRS.
- Encouraging CBOs to take this on would be more successful.
- Medical providers know little about PCRS.

Priorities, Evaluation and Capacity Building Needs, and Next Steps

Prioritizing the Interventions Discussion – Susan Buchbinder, M.D., HIV Research Section, San Francisco Department of Public Health

- Need to make decisions that drive down the numbers.
- Can not separate prevention and care, rather add care component to prevention.
- Look at what drives resources.
- What strategy will get the largest number to know their status, and get positives into care.
- Bring up testing levels in high-risk populations, make testing routine for MSMs.
- All biomedical interventions need a behavioral component.
- PEP – nice service but not making the most impact.
- NAAT – not really necessary.
- Biggest impact is in diagnosing unidentified. Sero-sorting.

Open Discussion Highlights

- What about structural interventions?
- Flexibility key.
- Substance use is a big issue.
- Meth.
- Mental health.
- What is our goal? Reduce infections by 25 percent, 50 percent affects priorities.
- Prioritize high impact geographic areas.
- Current national plan in development, not a plan for everyone.
- Look at prevalent pool, rate of partner change, probability of transmission per event, duration of infections – find HIV positives plus track.
- We collect numbers but not why numbers exist.
- Cut back on data to that which is critical.
- Need to get more understanding of effectiveness.
- Look at interventions from an individual, societal, and community level. Gay marriage is an example of societal level, substance use of individual level.
- More money and better tests.

- Need to leverage low cost opportunities.
- Need capacity building for CBOs.
- There is a role for CBOs, can not have interventions just at medical settings.
- Need for operational research.
- Isolate substance use intervention apart from meth intervention.
- Need for other substance abuse interventions.
- In MSM community there exists a 20-40 percent higher use of Meth.
- Internal evaluation is not working, need paradigm shift, shift to public health approach.

Highlights from Evaluation Needs presentation – Bart Aoki, Ph.D., CHRP

- Need to look at what evaluation needs remain.
- Methods must be multi-disciplinary.

Open Discussion Highlights on Evaluation:

- CDPH/OA needs to review interventions to see what works.
- Interventions must be targeted, need to modify programs.
- CDPH/OA needs to entertain other world cases if California is going to embark on new direction.
- National Institute of Health research may not be as relevant as it needs to be.
- Accountability versus evaluation.
- Give same message, reduce partners, and use a condom, regardless of HIV status.
- Marketing and dissemination approach missing.
- What kinds of data will it take to make a change: observational, program evaluation, modeling?
- We can not expect CBOs to be evaluators.
- Ninety percent of prevention interventions are done by community providers and we can only expect limited information from them.
- Need to make data collection easy.
- Not only what type of data to collect, but also for how long.
- Change models for evaluation, change structure, process/outcome evaluation.
- Can small changes have a big impact?
- Are decisions being based on assumptions, need to check our assumptions.
- Evaluation equals capacity building.
- Participants of this Prevention Think Tank are only a subset of the people who need to be around this table.
- Need methodologists in the discussion; evaluation scientists.
- Evaluation is capacity building.
- There is good evidence for why we should do most of these interventions.

Highlights of Capacity Building Presentation – Rashad Burgess, M.A., CDC

- CDC is taking a critical look at capacity building.
- Need right staff, adequate training, evidence-based interventions, high skills, cultural competency.
- Need to intensify capacity building in high incidence areas.

- CDPH/OA should think about: are CBOs funded adequately, funding training and technical assistance adequately, what are the approaches to disease prevalence?

Highlights of Open Discussion:

- Money an issue, need to hire quality staff that can reduce turnover.
- Resources are becoming very difficult.
- Small CBO model is dangerous, need to fund organizations that are long standing and not dependent on one grant.
- In terms of PwP, there needs to be social alternatives, create social circumstances.
- CBOs are first responders, challenge to hold them accountable.
- Need common set of metrics for HE/RR, standards to apply.
- Geo-mapping in Los Angeles shows prevention providers not where HIV concentrated.
- Funders need to see that funded agencies have what they need to succeed.
- Behavioral interventions are a key part of everything we do in both clinical and non-clinical settings.
- Need more novel interventions for positives.
- If PEP works, will need capacity building in community settings.
- Goal is not how to do more but to get people to think about things differently.
- Can not increase productivity without giving up something.
- What are we doing that is effective and how do we know it is effective?

Next Steps Discussion by Michelle Roland, MD, Chief, CDPH/OA (very abbreviated notes)

- Consensus in this group to not expend resources to develop PEP. Although it has individual value, the public health value is uncertain and it does not appear to be a high priority at this time.
- Acute HIV – the technology is evolving (e.g., with fourth generation antibody assays), all tests narrow the window but do not eliminate it. State to consider support of integrating into appropriate venues with high incidence.
- If we focus our resources on increasing non-acute testing in medical and correctional settings, what is the impact of moving money away from other areas?
- PwP – Need more information about what is being done and effective interventions. Support in this meeting to scale up.
- PCRS – Need to do more here; scale up strategy is going to take some time.
- Behavioral interventions – State to continue to explore current and future investments here.
- One possible vision – in terms of how money is allocated to LHJs in the future.
 - A defined percentage must go to areas of priority for prevention interventions.
 - Proportionate to amount and intensity of choices from this menu of items, will get capacity building as needed.
 - A defined percentage of funding used for other things.
 - Identify resources to do meaningful evaluation.
 - Leverage new sources of funding for evaluation.
 - Importance of flexibility, all LHJs are different, need different models.

Final Highlights from Participants:

- Two to three bad financial years to come, consider taking bold action.
- Look at jails, Title IV.
- Look at other sources of money, SAMSA increase HIV funding.
- Share with us CDPH/OA's short-term goals.
- National discussion about youth volunteers, what would it look like if California tried to attract young people to the HIV table.
- Testing in ED and STD clinics would be a good thing.