

**Office of AIDS
Health Disparities Framework, June 2010**

I. Introduction and Background

This document describes a framework to support the coordinated, division-wide health disparities reduction approach at the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA). The Framework is currently conceived of as the first of three major steps to address health disparities:

- Step 1: Develop Health Disparities Framework
- Step 2: Develop Population Profiles and integrate into the Annual California HIV/AIDS Epidemiologic Profile¹
- Step 3: Develop Population Action Plans to inform program and policy decisions²

For the purposes of this Framework, OA defines populations of interest as “those uniquely impacted by HIV/AIDS.” OA’s health disparities approach will also be informed by additional definitions included in the Appendix.

OA’s health disparities approach impacts and is impacted by all areas of OA. OA’s strategic goals, consistent with the National HIV/AIDS Strategy, are to:

- Minimize the number of new HIV infections
- Maximize the number of people with HIV infection who access appropriate care, treatment, support, and prevention services
- Reduce HIV/AIDS-related health disparities

OA Goals and Strategies Framework is represented in the figure below. OA aims to utilize the broad expertise of OA staff to reduce health disparities in HIV **prevention, detection, and care/treatment** by initially focusing on the “**understand**” and “**leverage**” components. **Funding** decisions may be influenced in the context of Step 3, the Population Action Plans.



¹ Template and first four profiles currently under development. We plan to seek input on these before finalizing the approach.

² To be developed after Population Profiles are complete. Will be utilized by OA and the California Planning Group (CPG) in the development of OA’s integrated Surveillance, Prevention and Care Plan.

II. What We Need to Know - Step 1: Ongoing Analysis of Impact and Needs

The three primary sources of information described below will be used to **understand** the magnitude of the epidemic, the current reach of OA programming and stakeholder priorities. At a minimum, analyses will include race/ethnicity, gender (including transgender), age, geography, and behavioral/risk categories (such as men who have sex with men, injection drug users, and “no identified risk” women). The following data will be presented in the Population Profiles³.

A. Ongoing Assessment of OA Epidemiological Data

At a minimum, the following epidemiologic variables will be evaluated for each population of interest in order to **understand** the relative magnitude of HIV/AIDS:

1. Cumulative HIV and AIDS cases ever reported
2. Current HIV/AIDS disease burden measured by:
 - Number of persons living with HIV and AIDS
 - Rate of persons per 100,000 population living with HIV and AIDS
 - Estimated rate of new infections
 - Mortality rate per 100,000 population due to HIV disease
3. Annual HIV diagnoses since names-based HIV reporting (2006) measured by:
 - Number of persons diagnosed with HIV annually
 - Annual rate of HIV diagnoses per 100,000 population
4. Annual AIDS diagnoses measured by:
 - Number of persons diagnosed with AIDS annually
 - Annual rate of AIDS diagnoses per 100,000 population
5. Pertinent data provided by supplemental surveillance sources, e.g.
 - National HIV Behavioral Surveillance
 - Medical Monitoring Project

B. Ongoing Assessment of Program Evaluation Data

At a minimum, the following program evaluation variables will be evaluated for each population of interest in order to **understand** the relative reach of OA funded programs:

1. Utilization of HIV **prevention** interventions from LEO database and supplemental data: Outreach Services, Individual-level Interventions, Group-level Interventions; CDC’s effective behavioral interventions; Prevention with Positives; and Partner Services.
2. Utilization of HIV **detection** interventions from the LEO database and supplemental data: For rapid and conventional HIV testing, the number of tests, the number who report previous testing, number of positive tests, number who receive results, and the number of those with positive tests referred for medical services and for Partner Services.

³ Comparisons will be made between the population of interest and the most relevant comparator population(s). The denominators will vary depending on the specific question and may include general population prevalence, HIV/AIDS prevalence, etc. These will be specified in the Population Profiles.

3. Utilization of HIV **care/treatment** interventions from ARIES database and supplemental data: Each Ryan White/OA HIV Care Program Service category; ADAP; HOPWA; Medi-Cal Waiver and CARE-HIPP⁴.

C. Stakeholder perspectives

OA will solicit ongoing input from stakeholders to critically analyze epidemiology and program data and provide input regarding OA's responsiveness to the needs of targeted populations. Stakeholders include: California Planning Group (CPG); Local Health Jurisdictions (LHJs); Community-based Organizations (CBOs)/Clinics; Consumers; Advocates and other interested parties.

III. What We Need to Know - Step 2: Ongoing Evaluation of External Resources

A. Literature and guidelines

OA will routinely conduct literature reviews to ensure that OA programs and policies are informed by the best science and guidance regarding health disparities. OA will integrate this information into our programming and policy approach as is feasible and appropriate.

B. External funding, technical assistance, capacity building resources; potential internal and external collaborators

OA will perform ongoing assessment of potential resources including, but not limited to, those resources targeting specific populations. OA will leverage these resources or provide information to support providers' efforts to leverage resources to respond to unmet needs.

IV. What We Need to Do - Strategic Goals and Objectives

The Framework is designed to benefit:

- Office of AIDS Staff and CPG
- Service Providers: LHJ staff, CBOs and Clinics⁵
- Community Stakeholders and Consumers

A. Office of AIDS Staff and CPG

Goal: All OA programs and policies reflect a commitment to reduce health disparities in HIV/AIDS **prevention**, **detection** and **care/treatment** and are informed by OA staff with relevant knowledge and skills.

Objective 1: Provide staff with training to increase capacity to reduce health disparities.

Objective 2: Modify OA programs and policies to support reduction in health disparities.

B. Service Providers: LHJs, CBOs and Clinics

Goal: OA supports OA-funded LHJs, CBOs and clinics to provide HIV/AIDS **prevention**, **detection** and **care/treatment** services aimed at reducing health disparities.

Objective 1: Use data to drive programs and target services⁶.

Objective 2: Identify and disseminate information about fiscal/grant resources⁷.

⁴ ADAP = AIDS Drug Assistance Program; HOPWA = Housing opportunities for Persons with AIDS; Medi-Cal Waiver is a medical case management program; CARE-HIPP is an insurance continuation program.

⁵ Includes both those funded and not funded by OA

⁶ Provided in Population Profiles and other data as needed

Objective 3: Identify and disseminate information about direct services resources.

Objective 4: Identify and disseminate information about training, technical assistance (TA) and capacity building resources.

Objective 5: Identify and disseminate information about community education resources.

Objective 6: Assist providers in implementing best practices at reducing health disparities⁸.

Objective 7: Assist providers to implement policy change to reduce health disparities.

C. Community Stakeholders and Consumers

Goal: Community perspectives will regularly inform OA's work.

Objective 1: Ensure that community stakeholders are educated about and have access to OA's health disparities work and related projects.

Objective 2: Solicit and incorporate input from community stakeholders on a routine and ongoing basis to ensure that OA programs and policy reflect an understanding of a wide range of perspectives.

⁷ Objective 2 – 5: Provided through [OA's RIDL \(Resource Identification, Dissemination and Linkage\) Task Force](#)

⁸ Provided by OA expert staff

Appendix: Additional Definitions of Health Disparities

1. Centers for Disease Control and Prevention (CDC):

<http://www.cdc.gov/nchhstp/healthdisparities/>

Despite prevention efforts some groups of people are affected by HIV/AIDS...more than other groups of people. The occurrence of (HIV/AIDS) at greater levels among certain population groups more than among others is often referred to as a health disparity. Difference may occur by gender, race or ethnicity, education, income, disability, geographical location and sexual orientation among others. Social determinants of health like poverty, unequal access to health care, lack of education, stigma and racism are linked to health disparities.

2. United State Department of Health and Human Services (HHS):

http://www.healthypeople.gov/document/html/uih/uih_2.htm

(See Goal 2: Elimination of health disparities)

Health disparities includes differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.

Factors contributing to health disparities include poverty, unequal access to health care, and lower educational attainment. Intertwined with these factors are dynamics such as racism and homophobia. People's physical location—e.g., urban vs. rural and living situation—in addition to social networks and social stigma, also contribute.

3. Minority Health and Health Disparities Research and Education Act of 2000:

106th Congress of the United States. Minority Health and Health Disparities Research and Education Act of 2000. 114 STAT.2495-5111. Public Law 106-525:2000.

Health disparity in a population is defined as a significant disparity in the overall rate of disease incidence, prevalence, morbidity, or survival rates in the population as compared to the health status of the general population.

4. National Institutes of Health:

106th Congress of the United States. Minority Health and Health Disparities Research and Education Act of 2000. 114 STAT.2495-5111. Public Law 10

Health disparities are differences in the incidence, prevalence, mortality and burden of disease and other adverse health condition that exist among specific population groups in the United States

5. National Association of Chronic Disease Directors

<http://www.chronicdisease.org/i4a/pages/index.cfm?pageid=3447>

Health disparities are differences in the incidence, prevalence, mortality, burden of diseases and other adverse health conditions or outcomes that exist among specific population groups in the United States. Health disparities can affect populations groups based on gender, age, ethnicity, socioeconomic status, geography, sexual orientation, disability or special health care needs and occur among groups who have persistently experienced historical trauma, social disadvantage or discrimination, and systematically experience worse health or greater health risks than more advantaged social groups.

6. Institute of Medicine

Institute of Medicine's Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (pages 3-4; © 2003)

Health disparities refer to racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention

7. Health Resources and Services Administration (HRSA)

Goldberg, J., Hayes, W., and Huntley, J. "Understanding Health Disparities." Health Policy Institute of Ohio (November 2004), page 3.

Health disparities are "population-specific differences in the presence of disease, health outcomes, or access to health care.