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NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

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The Role of Health Departments in Administering Federal HIV/AIDS Programs

State public health agencies serve an essential and unique role in the delivery of HIV/AIDS prevention, care and treatment programs. The agencies are entrusted through U.S. law as the "central authorities of the nation's public health system" and as such, bear the primary public sector responsibility for health.[1] State public health responsibilities include: disease surveillance; epidemiology and prevention; provisions of primary health care services for the uninsured and indigent; and overall planning, coordination, administration, and fiscal management of public health services.

CORE FUNCTIONS OF STATE HEALTH DEPARTMENTS

Three core functions of public health according to the Institute of Medicine (IOM):
- Assessment
- Policy Development
- Assurance

State public health agencies provide leadership, resources and technical assistance to local and community-based agencies and work in partnership with the federal government, other state and local agencies and community-based entities to meet the needs of all citizens within their borders. State and local health departments have a primary responsibility to address the disproportionate impact of HIV/AIDS on communities of color, and to improve health outcomes for these populations.

State public health departments conduct each of these activities as part of their response to the HIV/AIDS epidemic:

- **Collecting and analyzing information**: State health departments have established systems to collect and analyze data on the number of individuals living with HIV/AIDS and detailed demographic data on individuals receiving services through federally funded HIV/AIDS prevention and care programs. This data is then reported to the federal government in the aggregate to inform its overall HIV prevention and care strategies.
- **Ensuring accountability**: State health department staff conduct site visits to ensure that the appropriate level and quality of HIV/AIDS prevention and care is delivered by providers in their jurisdictions.
- **Planning**: State health departments are responsible for coordinating planning for the delivery of both HIV prevention and care services. This coordination involves convening local health jurisdictions, scientists, providers, community members and consumers, as well as developing comprehensive statewide prevention and care plans.
- **Setting policies and standards**: State health departments set, monitor and enforce policies and standards that guide the provision of care and prevention services across providers in their jurisdictions.

State public health agencies have responsibility for administering the bulk of federal HIV/AIDS and state resources allocated for prevention, care, and treatment.

- **Carrying out national and state mandates**: State health departments are the lynchpin in ensuring that federal and state mandates are carried out. These mandates include things such as the federal requirements to implement partner notification programs and to protect the confidentiality of people with HIV/AIDS.
- **Managing and overseeing environmental, educational, and personal health services**: State health departments manage and oversee the comprehensive statewide delivery of HIV prevention education and care services. This ensures that a continuum of services is provided without duplication of effort.

- **Assuring access to health care for populations disproportionately affected by HIV/AIDS**: State health departments coordinate outreach to underserved populations, providing tailored HIV prevention interventions and increasing access to primary care.
- **Developing resources and capacity and providing technical assistance**: State health departments provide technical assistance and capacity building services to HIV prevention and care providers, assisting them with providing the highest quality of targeted HIV prevention education and care.
- **Responding to health hazards and crises**. Since the beginning of the HIV/AIDS epidemic, state health departments have been the primary entities responsible for monitoring the epidemic and identifying outbreaks or clusters of cases in neighborhoods or communities.

THE ROLE OF STATES IN HIV/AIDS PREVENTION

HIV prevention and surveillance programs are funded by the U. S. Centers for Disease Control and Prevention (CDC) under general authority provided by federal public health law. Although Congressional Appropriators frequently direct HIV prevention funds for specific activities, there is no legislation dictating how HIV prevention resources are allocated by CDC.

Since 1988, CDC has provided HIV prevention resources to 65 state, local, and territorial health departments to implement comprehensive HIV prevention programs in their jurisdictions. In FY2006, state, local, and territorial health departments received $293 million for these efforts. States conduct the following efforts as part of their comprehensive HIV prevention programs:

Counseling, Testing, Partner Counseling, and Referral Services: States provide and coordinate the delivery of counseling, testing, including rapid testing, referral (CTR) and partner counseling and referral services (PCRS) programs which are aimed at ensuring that individuals and their partners learn their HIV serostatus, receive counseling on behavior change to avoid infection or prevent transmission, and obtain referrals for prevention and care services.

Health Education/Risk Reduction: States provide support for and technical assistance on targeted education and outreach activities for individual, group, and community-level interventions and street and community outreach. These programs include peer education in correctional facilities, educational services to Spanish speaking populations, in-service trainings for social service/AIDS service agencies, services using indigenous community educators and peer opinion leaders, street outreach with homeless people and injection drug users (IDUs), education programs for African American religious leaders, and skills-building activities on risk reduction.

Community Planning: Since 1994, state and local health departments have implemented a community planning process to ensure the participation of infected and affected communities in the development of effective HIV education and prevention interventions. This process assists state and local health departments with the targeting of resources to populations at highest risk and encourages development of effective interventions.

Capacity Building: States provide financial and technical assistance to strengthen their own infrastructure and that of non-governmental organizations they fund to deliver effective prevention programs.

Public Information: State public health agencies are responsible for the collection, evaluation, and distribution of public information and materials.

Prevention Research and Program Evaluation: States conduct prevention research and program evaluation activities to monitor progress, outcome and impact of the programs they support, as well as to assess needs and develop culturally appropriate services.

THE ROLE OF STATES IN HIV/AIDS CARE & TREATMENT

Ryan White CARE Act – Part B

Part B of the CARE Act provides funds to all states, the District of Columbia, Puerto Rico, and U.S. territories to improve the quality, availability and organization of care services for people living with HIV. Part B is designed to assure that people living with HIV have access to quality medical care, regardless of whether they live in rural, suburban, or urban areas. States received over $1.06 billion in federal funds in FY2006, including $790 million in dedicated funds to support AIDS Drug Assistance Programs (ADAPs). This includes almost $9 million in federal ADAP funds awarded to states with demonstrated severe need for HIV-related medications. ADAPs are state-administered drug programs that provide access to HIV/AIDS medications for low income, uninsured and underinsured individuals. The vast majority of states (40) provide state general revenue funding to augment federal ADAP dollars.

> In FY2005, ADAPs provided medications to over 134,000 uninsured and underinsured people living with HIV/AIDS.

Part B base (non-ADAP) funds may be used to support a wide range of services including outpatient medical and dental care, supportive services (e.g., case management and client transportation services), rehabilitative services, home and community-based health care services, and continuation/purchase of health insurance coverage. States may also use Part B base funds to support HIV counseling, testing and referral services in care settings. Part B base funds allow states to provide a continuum of enabling services that are critical components of comprehensive HIV care, the hallmark of the Ryan White Program. Part B also provides supplemental grants to states to support HIV services in emerging communities—cities reporting between 500 and 999 reported AIDS cases in the most recent five years. States also receive almost $7 million for outreach to minority communities to bring individuals into care through the Minority AIDS Initiative.

THE ROLE OF STATES IN HIV/AIDS EPIDEMIOLOGY & SURVEILLANCE

> Of CDC's total HIV prevention budget of $629 million in FY2005, state and local health departments received approximately $68 million to conduct HIV/AIDS surveillance and seroepidemiologic activities.

HIV/AIDS epidemiology, surveillance and seroprevalence activities provide data that are critical to targeting the delivery of HIV prevention, care and treatment services. State health agencies are uniquely positioned to conduct these activities because of the expertise, statutory authority, and confidentiality protections of existing public health disease surveillance and reporting systems. States conduct a variety of surveillance activities to monitor the HIV/AIDS epidemic. The five main types of surveillance are discussed below:

Core Surveillance: Core surveillance is the primary source of population-based data on persons living with HIV and AIDS in the U.S. AIDS case surveillance is conducted in every state and territory, as well as six cities directly funded by the CDC.[2] Core surveillance programs include monitoring the number of yearly cases of newly diagnosed HIV infections and AIDS cases and identifying trends from surveillance data.

Incidence Surveillance: HIV incidence surveillance was developed to provide reliable and scientifically valid estimates of the number of newly-acquired HIV infections. Jurisdictions conducting incidence surveillance are also eligible to participate in Variant, Atypical, and Resistance HIV Surveillance, a project that collects samples of specific HIV specimens and tracks the different HIV strains seen in the jurisdiction. Jurisdictions funded to conduct incidence surveillance collect and test blood specimens from all newly reported HIV infections; calculate population-based estimates for HIV incidence; and monitor and track HIV strains for resistance to antiretroviral drugs.

Behavioral Surveillance: The National HIV Behavioral Surveillance project is a multi-year CDC sponsored surveillance effort whose goal is to measure an extensive set of HIV risk behaviors and related risk factors among

selected high-risk populations in 26 cities with the highest number of people living with HIV/AIDS at the end of 2000. The project attempts to identify the prevalence of and trends in Men who have Sex with Men (MSM), Intravenous Drug Users (IDU), and heterosexual HIV high-risk behaviors.

Morbidity Monitoring: The Morbidity Monitoring Project (MMP) is developing a surveillance system that is nationally representative of HIV-infected persons receiving medical care in the U.S. Twenty states and six cities have been selected for the project, which utilizes HIV care providers to collect the data. The three primary goals of MMP are: to supplement core HIV/AIDS surveillance data with linked medical record abstractions and patient interviews; to provide data to estimate quality of care, clinical outcomes, risk behaviors, health care utilization and unmet needs among HIV-infected persons receiving medical care; and to provide population-based data to aid in policy planning, resource allocation and evaluation of prevention and treatment initiatives in the U.S.

Enhanced Perinatal Surveillance: This program monitors progress made in reducing of perinatal HIV transmission. The near elimination of mother-to-child HIV transmission is the greatest success of HIV prevention in this country. Enhanced perinatal funds go to state and local health departments that are in high-morbidity areas (60 or more HIV-positive women giving birth) that have HIV surveillance.

THE ROLE OF STATES IN STD PREVENTION & TREATMENT

State and local public health agencies administer both HIV and STD prevention and care services and have worked to closely link these programs to strengthen efforts in addressing these co-morbidities.

Federal funding for STD prevention and treatment has been in existence since the early part of this century and is currently administered by CDC under general authority. CDC's total FY2005 STD prevention and treatment budget is approximately $160 million. Of this, approximately $121 million was provided directly to state and local health departments. State STD prevention programs also provide surveillance and data management, leadership and program management, outbreak response plans, and evaluation activities.

THE ROLE OF STATES IN HEPATITIS PREVENTION

CDC provides funding to 48 states, three cities, the District of Columbia, and the Indian Health Service to support a hepatitis C coordinator position. The role of the coordinator is to work with other public health programs to integrate viral hepatitis prevention services into existing settings (e.g., STD and HIV clinics). The average funding award of $80,000 in FY2006 supports little more than personnel costs, leaving no funds for service provision (e.g., hepatitis A and B vaccine, hepatitis B and C testing). CDC's budget for addressing chronic adult viral hepatitis was $18 million in FY2007.

THE ROLE OF STATES IN HIV-RELATED HOUSING

HOPWA funds are used to meet local community needs including short-term transitional supported housing and/or rental assistance for low income persons with HIV/AIDS, building community residences, and providing coordinated home care services.

The Housing Opportunities for People with AIDS (HOPWA) program is the centerpiece of the federal housing response for people living with HIV/AIDS. Created in 1990, HOPWA is a formula-funded, flexible program that gives states and localities hardest-hit by the AIDS epidemic desperately needed resources and local control over the use of these resources to meet the housing needs of people with HIV/AIDS. In FY2007, states and local jurisdictions received $286 million for HOPWA services. HOPWA will serve approximately 63,000 people with these funds.

[1] *"The Future of Public Health."* Institute of Medicine, January 1, 1988.
[2] The six cities directly funded by the CDC are: Chicago; Houston; Los Angeles; New York; Philadelphia and San Francisco.