RECOMMENDATIONS FOR STATE ACTION ON HIV AND AIDS PREVENTION

by participants of

The State Leaders Roundtable on HIV and AIDS Prevention
A Meeting of Central State Legislators and State Health Officials
St. Louis, Missouri
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Edited by

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"One thing is for sure in politics - there will always be pressure. The role for state leaders in HIV prevention is to stand up to the pressures on the basis of the firm ground of knowledge and what works."
Robert Wentz, State Health Officer
North Dakota Department of Health

"It's not going to be the case anymore, if it ever truly was, that the solution [for HIV prevention] will be developed in the petri dish behind a closed door. The solution comes on the telephone, in the collaborative meetings, it comes from identifying everyone's piece of the puzzle."
Peggy Stokes Nielson, Communications Consultant

INTRODUCTION

Legislators and state health officials, U.S. Centers for Disease Control and Prevention (CDC) officials, national HIV experts and people living with HIV disease convened at the "State Leaders Roundtable on HIV and AIDS Prevention: A Meeting of Central State Legislators and State Health Officials," in St. Louis, Mo., on November 19 -- 21, 1992, to formulate recommendations for state action in the fight against HIV. The two-day invitation-only meeting was sponsored by the National Conference of State Legislatures (NCSL) through financial support from the CDC and Burroughs Wellcome Company.

This document presents the state leaders' recommendations for action on six priority HIV and AIDS prevention issues. The opinions of the individuals attending the meeting do not necessarily reflect their states' official policy or NCSL's official policy on HIV and AIDS. This report also contains the leaders' perceptions of their states' successes and challenges in HIV prevention and includes questions health officials and legislators should consider as they develop HIV prevention policies and programs.

The state participants attending the meeting included key legislators and top state health officials from **Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota** and **Wisconsin**. Peggy Stokes Nielson, communications consultant of Nielson and Associates in Albany, Ga., facilitated the meeting. The meeting participants are listed at the end of this report.

STATE SUCCESSES AND CHALLENGES IN HIV PREVENTION

The following identifies the state successes and challenges in HIV prevention specified by the state legislators and health directors during the roundtable. While the leaders were proud of their states' victories in combatting HIV, they were humbled by the many and somewhat unpredictable challenges of the fight against HIV in its second decade.

SUCCESSES

Many of the state leaders conveyed that much of their HIV prevention accomplishments are a result of basing HIV policy and program responses on science rather than emotion. For instance, **Michigan** leaders were pleased that HIV issues addressed in their state have been defined by the scientific experts rather than the political process.

A number of state participants, including those from **Illinois, Indiana, Michigan, Minnesota** and **North Dakota,** stated that the enactment of confidentiality laws has been one of their more important accomplishments to prevent HIV. Protecting confidentiality is a critical element in removing barriers to HIV prevention, said the leaders.

Many states also listed public-private sector and intergovernmental collaborative efforts for HIV prevention as meaningful achievements. **Michigan, North Dakota** and **Oklahoma** participants said

that close coordination between public health and legislative leaders has enabled their prevention work. According to the **Kansas** contingency, out of the adversity of fiscal limitations, the state has developed successful collaborative efforts to leverage funds.

Creation of strong community-based systems for prevention and care were listed among the main successes of the states of **Indiana, Iowa** and **Wisconsin**. Likewise, **Missouri's** officials were proud of their nationally recognized program, in which the state works in partnership with communities to provide a comprehensive delivery system for HIV and AIDS prevention services.

Ohio has carefully monitored information about the number of AIDS cases among high-risk groups and responded to the changing trends by expanding counseling and testing availability and targeting prevention services to high-risk people.

CHALLENGES

There is still much more work to do in HIV prevention, according to both legislators and agency officials. For many states, the list of challenges in HIV prevention efforts was longer than the list of successes.

Participants from **Kansas, Nebraska, Minnesota** and **South Dakota** concurred that greater efforts must be made to seek out and educate those who are hard to reach. And, they said, their states need to improve upon their efforts to target HIV education and prevention services to people at high risk. Prevention efforts within the state correctional system in both **Indiana** and **Wisconsin** need improvement, according to representatives of those states.

Providing effective HIV education to young people was listed by a number of state leaders as a major challenge. Participants from **Nebraska, North Dakota, Oklahoma, South Dakota** and **Wisconsin** said they continually meet resistance or opposition in their efforts to ensure the provision of adequate HIV education in the schools. Leaders from **Indiana** and **Oklahoma** expressed frustration over the barriers that local community control creates to further HIV prevention activities, particularly in the schools. **Minnesota** participants were concerned about the media's use of sexual messages in advertising and would like to see better media coverage of HIV/AIDS issues.

State participants from **Kansas, North Dakota, Ohio, Oklahoma** and **South Dakota** expressed concern about how public denial about risk, misinformation, fear and apathy among both the public and policymakers impede HIV prevention efforts and fuel the spread of HIV. Leaders felt this is a particularly chronic problem in states with low numbers of AIDS cases.

Participants from **Minnesota** and **Michigan** struggle with the appropriate way to address the public concerns about HIV-infected health workers and universal hospital testing of patients. **Michigan** leaders were concerned about the erosion of confidentiality protections.

Missouri state health officials are challenged with meeting the increasing demand for care and services as more HIV-infected people choose to be tested. As a result, they would like to improve collaborations with neighboring states that share HIV clients.

According to **Nebraska** participants, there is a great need to strengthen the working relationships between the public health and the legislature on HIV prevention.

There was a general belief among the group that prevention efforts should still be the number one response to the epidemic. **Illinois, Iowa** and **Kansas** state officials contended that more political attention and resources should be directed at HIV prevention over AIDS care.

Illinois leaders were frustrated with the inability to secure funding for prevention efforts because of difficulties in proving effectiveness and showing tangible outcomes of interventions. Likewise, **Minnesota** officials are exploring better ways to document the effectiveness of funding for HIV prevention. Providing adequate funding and personnel to carry out HIV interventions is a challenge facing **North Dakota** and **Ohio.**

Overall, participants believe that state funding is balanced between prevention and care, yet the state leaders were concerned that federal money appears to tip more toward treatment with a marked decline in funding for HIV prevention.

HIV PREVENTION PRIORITY ISSUES AND KEY POINTS IN THE RECOMMENDATIONS FOR STATE ACTION

Controlling the spread of HIV among high-risk women, adolescents, and injection drug users topped the list of priorities requiring state action, according to the state legislators and health officials attending the roundtable. The participants also concurred that states must provide effective HIV education in public schools; prevent the spread of HIV in rural communities; address public concerns about exposure to HIV from infected health workers; and provide access to a continuum of services for people with HIV infection.

The following are the salient points of the recommendations by the state leaders:

- Access to drug treatment and a broad spectrum of support services for women of child-bearing age is crucial to control the spread of HIV to chemically dependent women and their children.
- Access to timely information about the characteristics of people that engage in high-risk behaviors is essential to effectively target populations at particular risk.
- Comprehensive and skill-based HIV education programs in the schools is key to changing risk-taking behaviors of youth. Moral and religious concerns and local control must be addressed when developing programs.
- Scientific and medical evidence instead of public fears should continue to drive policy debates on the HIV-infected health worker issue. Public concerns must be addressed. Limitations in a health worker's practice must be considered on a case-by-case basis.
- Interventions that focus on the health problems of greater concern to rural residents will simultaneously be effective at controlling the spread of HIV.
- Thorough cost-benefit analysis and community involvement in program design and implementation greatly improve the chances for acceptance and funding of HIV/AIDS continuums of care.
- Allowing for program flexibility of categorical funding will decrease the need for new money and new programs.
- A broad spectrum of collaboration must occur among government, communities and the private sector to ensure acceptance, effectiveness and adequate funding of HIV prevention activities.

- Providing for ongoing evaluation efforts is the key to program success and continued support.

RECOMMENDATIONS FOR STATE ACTION

The six priority HIV prevention issues and recommendations for state action developed by the state leader participants are outlined below. In formulating their recommendations, many of the groups addressed: policy and program requirements, funding issues, collaborations needed, and the roles of the legislature and the state public health department. Comments from meeting participants follow many of the recommendations.

PRIORITY I

Targeting prevention efforts to high-risk women and youth.

The group that addressed this issue focused their recommendations on targeting interventions to women and youth they considered most at risk, including: chemically dependent women of child bearing age and out-of-school youth. Emphasis was placed on the need for collaboration among a variety of state agencies and community organizations and the importance of community involvement and commitment in prevention efforts. In addition, the group members stressed the importance of defining, identifying and locating out-of-school youth to successfully target prevention efforts to those young people.

A. Targeting HIV prevention efforts to chemically dependent women of child bearing age.

Program/Policy Requirements. Provide community-driven outreach and referral to treatment programs with no waiting time. Provide a broad spectrum of services to support chemically dependent women to prevent a relapse into their drug habit, including: medical care, child care, housing, mental health and legal services. Ensure that drug rehabilitation services monitor and follow-up clients to prevent relapse. Provide for evaluation of programs to determine the effectiveness in preventing drug use and HIV transmission and to ensure that the services are responsive to community needs.

Funding. Adequate financial support is key to the success of the program. States must strive to unify and combine funding from federal, state and local resources. Solicit and integrate private sector funds.

Collaborations. Collaboration must occur among federal, state and local government. Social, health and corrections agencies must work together. Involve the religious and education communities, HIV/AIDS service organizations and community-based organizations.

Identify the roles of the various organizations and develop partnerships to avoid duplication of services and determine ways organizations can support each other.

Role of the Legislature. Legislators must become informed on the relationship of chemically dependent women and HIV prevention. Clarify the mission of a policy to address the issues.

Make sure that the programs are meeting the needs of the communities represented by legislators. Provide oversight of the intervention programs and assess the program effectiveness in responding to community needs. Ensure that there is community input about program effectiveness and convey the community's response to the health department and those who implement programs.

Help "sell" the interventions to the community and support the health department in program implementation.

Role of the Health Department. Develop the plans, implement the programs, manage the resources, and evaluate community response. Seek alternative resources. Promulgate rules and regulations. Ensure that the community embraces the programs.

B. Targeting prevention efforts to out-of-school youth.

Program/Policy Requirements. Provide outreach to young people wherever they may access services or recreation such as homeless shelters, corrections facilities, on the street, block and neighborhood groups, recreation centers, youth treatment centers, Job Corps, community health centers, sexually transmitted disease (STD) clinics, and teen clinics. Community outreach is vital to reduce the HIV risk for out-of-school youth.

Provide at-risk youth with a spectrum of services, including health, social and educational services. Train outreach workers to resolve conflicts and help teens manage their anger.

Funding. Access funding from a combination of federal, state and local resources, including the private sector.

Collaborations. The health department, law enforcement, criminal justice system, mental health agencies, community based organizations, schools, social services, and churches must work together to reach at-risk youth. Involve communities, as they know the needs of their youth and can determine where the outreach will be most effective. Utilize media to target HIV prevention messages to youth and work with the media to help broadcast positive role models.

Role of the Legislature. Evaluate proposed and enacted legislation to remove barriers to HIV education for youth. Monitor media messages.

Role of the Health Department. Plan, implement, develop and evaluate programs. Manage resources and seek out new funding.

Group members: Senator Margaret Smith, Illinois
Representative Ed Crocker, Oklahoma
Dennis Stover, Director, Division of AIDS, Indiana
Ted Northup, Chief, Bureau of AIDS Prevention, Missouri
Ken Baldwin, Director, Bureau of Public Health, Wisconsin
Clara Maddox, Rodgers Health Center, Missouri
Gianis LalSandhu, Department of Health, Missouri

PRIORITY II

Targeting prevention efforts to injecting drug users (IDUs).

Drafting policy, developing HIV prevention programs and collaborating in order to change the HIV risk behaviors of substance abusers is hinged on knowing the characteristics of drug-using populations. Yet, information on substance abusers is difficult to access, according to the state policymakers who addressed this issue. Consequently, inaccurate assumptions may be made about the appropriate people to target, and programs may not be effective at reaching people engaging in high-risk activities.

Because the demographics of drug users and types of illicit drugs being used is continually changing, there must be ongoing efforts to gather data, and program development must be based on the most recent information available, advised group members. The state leaders acknowledged that vast amounts of information exist from federal organizations, such as the National Institute on Drug Abuse (NIDA), mental health and public health departments, sexually transmitted disease clinics, drug

treatment centers and research centers. But lack of data dissemination or a central data resource appears to create a weak link in development of effective policies. A central resource would facilitate better use of the available information and help drive policy and programs, suggested the participants.

Program/Policy Requirements. Compile and use existing information and gather new data as needed on drug users.

Implement a multi-faceted initiative to control spread of HIV to drug abusers, including:

1. Provide for drug abuse treatment on demand by increasing treatment slots.

2. Implement needle exchange programs to reduce transmission of HIV and encourage referral to drug treatment.

3. Decriminalize possession of injection equipment for adults.

4. Provide outreach, education materials and prevention services to injecting drug users to help reduce risk-taking behaviors. Utilize all forms of outreach, including street outreach of users, prison outreach, and outreach to sexual partners of intravenous drug users.

5. Provide for ongoing evaluation of programs and the ability to refine the programs.

Funding. Access state and federal funding sources. Develop alternative funding, such as utilizing a percentage of traffic fines or the proceeds from sale of confiscated property during drug seizures to help fund drug treatment.

Collaboration. Drug treatment programs, health departments, community-based organizations and law enforcement must collaborate to acquire data. Attain information from federal agencies and community-based organizations.

In targeting prevention efforts to drug abusers, collaborate with a wide spectrum of groups, including: drug treatment programs, program evaluators, people at-risk and their needle and sexual partners, community-based organizations, churches and religious groups, and community leaders.

Role of the Legislature. Demand timely and appropriate data to give better direction and make better policy. Identify those state agencies to be responsible for data collection. Appropriate funds to increase availability of drug abuse treatment. Revise statutes to decriminalize needle possession (which may promote needle sharing). Disallow use of incriminating evidence in drug busts that may help to prevent HIV transmission, such as bleach bottles or condoms.

Role of the Health Department. Ensure development and implementation of research-based programs. Provide for ongoing research and evaluation of program effectiveness in changing high-risk behaviors. Refine programs as indicated. Collaborate with research groups and universities to develop and evaluate behavior changing programs for intravenous drug-using populations.

Participant Comments. Sally Finney, director of the AIDS program at the **Kansas** Bureau of Disease Control, described her state's "inreach" efforts to help identify and assist substance abusers with drug treatment placement. The Topeka health department employs an onsite substance abuse counselor in the sexually transmitted disease (STD) clinic who counsels patients who have mentioned alcohol or other drug abuse incidents during their visits for STD treatment. The state finds that bringing the counselor to the client is a far more effective way to provide for drug treatment placement rather than referring an individual for counseling at another site.

In Kansas City, a health department counselor regularly visits private drug abuse treatment facilities to persuade them to provide access for indigent clients. According to Finney, this effort has been effective in getting treatment for people who lack health care coverage.

Representative Michael Bennane of **Michigan** contended that state laws that make possession of drug paraphernalia illegal are ineffective at changing the behavior of IV drug users and actually promote the spread of HIV. "We are forcing people to reuse needles," commented Representative Bennane. He criticized legislators who promote such legislation at the expense of furthering the rampant spread of HIV through injection drug use. The Michigan policymaker advocated re-evaluation of laws that ban the use or possession of drug paraphernalia and to "seriously consider loosening that up to allow the IV drug use community access to clean needles."

Group Members: Senator Patricia Miller, Indiana
Representative Michael Bennane, Michigan
Representative Thomas Springer, Wisconsin
Sally Finney, Director, AIDS Program, Kansas
Willie Bettelyoun, AIDS Resource Team, South Dakota
William Dotson, Director, Community Outreach for Risk Reduction Program, Missouri

PRIORITY III

Providing HIV education in public schools.

The group that addressed HIV education in the schools noted that this issue is a political hot potato. Some of the areas that generated controversies, according to the state policymakers were: the appropriateness of sex education in the schools, the definition of "comprehensive" education, and the provision of "skill-based" information.

Further, participants expressed discomfort over the fact that much is still unknown about the effectiveness of school education in changing high-risk behaviors. They suggested that HIV curricula be modified as more is learned about what works. Still, the group dismissed "scare tactics" as an effective education approach.

The public health officials argued that HIV education must go beyond teaching facts about HIV exposure. Rather, the focus should be on discussing behavior modification. Young people must understand that much of their health status is determined by personal behaviors, said the agency officials.

Policy/Program Requirements. Provide for comprehensive school education addressing a wide range of health topics in grades kindergarten through 12. Structure programs that are acceptable to the majority of the parents. Allow, parents who object to HIV education for their children the option to keep their children out of the program. "Opt out" addresses the moral or religious concerns some parents have about HIV education in the schools. Incorporate health education in various parts of the student's curriculum, not just as a separate class.

Provide HIV and health education curricula in higher education for students studying to be teachers.

Funding. Integrate funding streams, particularly federal and state funds. Seek out opportunities for private sector and foundation funding.

Collaborations. Form a "blue ribbon" task force that represents a variety of interests, including individual citizens, to design model curriculum.

Role of the Legislature. Encourage the collaboration and interactions among the public health department and education agency so "all the players are at the table."

Role of the Health Department. Ensure that the HIV curriculum is science-based. Help establish links with the department of public instruction and other key groups.

Participant Comments. **Minnesota** Representative Dave Bishop expressed concern about the lack of health education components in public universities for science teachers. He said academicians do not like to have legislatures make policy about curriculum. **Kansas** Senator Sandy Praeger added that it is important that education budgets include health education training for teachers in schools of higher education. Both new and existing teachers need this kind of support, she said.

Oklahoma Representative Ed Crocker expressed frustrations about resistance from his constituents who are opposed to certain HIV curricula or adolescent prevention efforts based on religious or moral reasons. He referred to a November 1992 *Washington Post Weekly* article, "Religious Right Finding Victory in Defeat." Representative Crocker said campaigns have been waged against many Oklahoma legislative members and himself, based upon allegations of spreading pornography. Representative Crocker said, "We are getting accused of being in favor of pornography because we want to inform people at high risk how to go about reducing their risk."

Representative Crocker appealed to legislators to be willing to take the "political heat" for "the good people in the agencies who are in the trenches, doing the work day by day." Legislators must articulate and sell the HIV prevention programs to their constituents, asserted Crocker.

Senator Praeger agreed with Representative Crocker that there is considerable pressure exerted by the "religious right" on legislators who support comprehensive school education. "We have that pressure in **Kansas** to not do these things in schools because 'schools are for educating'--that's the message they will try to convey. If we don't do this in schools, we miss our main opportunity to reach young people," warned Senator Praeger.

Group Members: Representative C.J. Prentiss, Ohio
John Lumpkin, Director, Department of Public Health, Illinois
Arturo Coto, Deputy Director, Department of Health, Nebraska
Robert Wentz, State Health Officer, Department of Health, North Dakota
Martha Roper, Parkway School District, Missouri
Mike Lauber, Tusco Display, Ohio

PRIORITY IV

Making AIDS "real" in rural and low HIV incidence areas.

Increasing awareness about the spread of HIV is a major challenge in parts of the country with a low-incidence of HIV. It requires a less disease-specific intervention strategy, according to the group members that addressed this issue. Although AIDS is not the number one health issue, many of the major public health problems in rural areas occur from behaviors that also put people at risk for HIV. Participants advised that increasing awareness in rural America is a nationwide challenge because there are rural portions of every state.

Program/Policy Requirements. Identify and address the health and social problems of main concern to rural communities that indicate risk factors for HIV infection. These include alcohol abuse, sexually transmitted diseases and teen pregnancy.

Convene a planning or coordinating body which consists of local health departments, local hospitals and community action agencies. Community health centers or Red Crosses could be the catalysts to convene the appropriate individuals to develop strategies focusing on rural health problems.

Funding. Make existing funding streams more flexible to allow for collaboration, particularly between categorical funding programs.

Collaborations. Develop collaborations among local health departments, family planning clinics, sexually transmitted disease clinics, alcohol abuse treatment agencies, schools, businesses, banks and farm bureaus.

Role of the Legislature. Create incentives to facilitate the logical integration of services among categorical funding programs.

Role of the Health Department. Carry out four primary functions:

1. Data Collection and Needs Assessment--Assess the needs of the community by collecting information on rural health problems that put people at particular risk for HIV such as: sexually transmitted diseases (STDs), teen pregnancy and alcohol abuse.

2. Policy and Program Planning--Convene the key individuals in the community to formulate aggressive strategies to attack rural health problems that put people at risk for HIV.

3. Assurance--Assure that services are provided. The local health department should not have to provide all the services itself but rather coordinate efforts and make sure that somebody in the community is providing the needed health services.

4. Evaluation--Make sure that the health needs of the community are being met. This can be assessed by analyzing the changes in data collected by health departments on the occurrence of these problems.

Participant Comments. Michael Moen of the **Minnesota** Division of Disease Prevention commented, "To tell rural citizens that AIDS is their number one health problem is a great disservice to them, because it's not." He contends that although there will continue to be some cases of HIV infection and AIDS in rural areas, there probably never will be large number of AIDS cases. "The challenge becomes how to get AIDS on the agenda, get some action, and get past the apathy that naturally occurs," said Moen.

Participants concurred that funding is not always necessary for a community to address rural public health issues. Much of it already exists, such as family planning funding. Because many political reasons exist for the popularity of categorical funding programs, states should try to find ways to develop the ability and flexibility to link with new or other programs, advised group members.

Group Members: Representative Edwin Olson, South Dakota
Senator Judy DeMers, North Dakota
Christopher Atchison, Director, Department of Public Health, Iowa
Michael Moen, Director, Division of Disease Prevention, Minnesota
Rosalind Brannigan, National Leadership Coalition on AIDS, Washington, D.C.
Lillian Schaefer, Red Cross, Missouri

PRIORITY V

Protecting patients and health care workers from exposure to HIV.

Science and public fears clash when state policymakers address the issue of HIV-infected health workers, concurred many group members. Medicine and science have proved that the risk of HIV transmission from an infected health worker to patient is remote (and preventable). Yet the public's perception is that the potential risk for transmission of HIV from health care workers to patients is much greater. Nine out of 10 Americans want to know the HIV status of their health care provider, according to a 1992 article in the Journal of the American Medical Association. This poses a dilemma for state policymakers who attempt to base policy on the best information available while trying to allay public anxieties.

Much of the group's recommendations were based on the 1991 Treasury/Postal Appropriations Act that requires state health departments to adopt Centers for Disease Control and Prevention guidelines or their equivalent to prevent the transmission of HIV and other blood-borne diseases in health care settings. Also, the group recommended that states develop policies that address public concern about patient exposure to HIV from HIV-infected health workers. (The group suggested that elements of state health worker policies should include information from the National Conference of State Legislatures' *State Legislative Report* "HIV-Infected Health Workers: Debating the Issues," August 1992.)

Policy/Program Requirements.

1. Adopt the Centers for Disease Control and Prevention (CDC) guidelines for universal infection control procedures for all health care workers, as well as all appropriate health care facilities. Consider the potential functional impairments of infection control procedures that could interfere with job performance. Adopt safer needle devices, such as needleless or needle recessed intravenous systems, as a way to minimize the potential transmission of the virus.

2. Require training of all health care workers in infection control practices and universal precautions, including the appropriate use of handwashing, protective barriers, and the use and disposal of needles and sharp instruments. Provide an annual update for all health care workers to review new developments in infection control procedures.

3. Adopt the CDC guidelines for the immunization procedures against hepatitis B infection. Consider vaccinating health workers against HIV when such a vaccine becomes available.

4. Strongly encourage those health workers who perform exposure-prone procedures to know their HIV status. Make voluntary testing the standard.

5. Report positive HIV antibody test results of health care workers to the state department of health.

6. Monitor the HIV-infected health workers status through the department of health. Consider any limitations in practice of an individual health care worker on a case-by-case basis through a review panel. The panel should consider the risk prone behaviors and procedures of the health worker's practice.

7. Define "exposure-prone procedures," taking into account the specific procedure and the skill and technique of the infected health care worker.

Participant Comments. There was considerable debate over mandatory versus voluntary testing of health workers. Group members advised against mandatory testing. Also, there was concern that mandatory reporting of HIV might be a disincentive for health care workers to seek voluntary testing.

There was also much discussion about the appropriate agency to receive test results of the infected health worker. Some participants advised against licensing boards getting that information because they doubted the ability of licensing boards to maintain confidentiality. Licensing boards may have public members who lean toward adopting punitive measures, rather than dealing with the problems in a scientific manner, contended a few group members.

The group briefly touched on the issues surrounding universal testing of patients as a way to protect health workers from potential exposure to HIV. It was felt it would be impractical, costly and unnecessary as all health care workers are required to follow universal precautions when caring for all patients. Members were leery of the implementation of mandatory testing of patients because of concerns about the ability to maintain patient confidentiality and the potential for discrimination and loss of medical insurance coverage. Participants felt it was important to maintain the health insurance rights of those who may be HIV positive.

Group Members: Senator Sandy Praeger, Kansas
Representative Dave Bishop, Minnesota
Senator Cap Dierks, Nebraska
Catherine Lessard-Virskus, Office of Legislative Policy,
Department of Public Health, Michigan
Peter Somani, Director, Department of Health, Ohio
Eddie Hedrick, University of Missouri Hospitals and Clinic, Missouri

PRIORITY VI

Providing for a coordinated continuum of HIV services from prevention to care.

Providing continuums of care from HIV testing to AIDS care are important for two reasons, said the group members. First, states can maximize opportunities to stress HIV and AIDS prevention messages because often the site for educating people at particular risk for HIV infection is the same as the intake point for care of those who are HIV infected. Two, comprehensive continuums of care for those with HIV infection can be cost-effective ways to deliver care and prevent progression to AIDS. This, in turn, helps enhance and prolong productive lives for those living with HIV.

Policy/Program Requirements. Engage in the following activities to develop a continuum of care:

1. Assess the needs of the community for prevention, care and support.
2. Determine the financial and personnel resources needed, including the need for volunteers.
3. Conduct a cost/benefit analysis of the proposed program.
4. Assess the resources that are required to implement and conduct the continuum of care.
5. Develop a coordinated plan that addresses all possible issues, and mobilize the necessary support (from the public and private sector) for full implementation of the plan.
6. Develop a comprehensive continuum of care program that integrates the full needs of the client and the community.

Funding. Determine funding necessary to implement the plan. Assess the resources available and the potential resources from the public and private sector. Implement aggressive marketing campaigns to access potential private sector resources.

Collaborations. Involve a wide spectrum of public and private agencies, organizations and leadership. Engage public health, public and private education, the social welfare system (public and private), and business and labor communities in the effort. Also, cultivate participation from foundations, community organizations, the religious communities and the voluntary sector, such as Rotary clubs, Kiwanas, Red Cross, and the United Way.

Involve the media to help get the attention and support of the legislature in states where the public health agency is forbidden to lobby the legislature. Media is also important in selling the program to the community.

Role of the Legislature. Invest in HIV/AIDS prevention as a long-term savings. Provide leadership in selling the program to the public. Leverage public sector investment to recruit and attract private sector resources to help support the continuum of care.

Role of the Health Department. Provide leadership. Plan, manage and coordinate programs. Provide technical assistance to the involved organizations and individuals. Market the program to the community. Recruit new participants from the community into the program. Establish a development office to attract and secure private sector resources. Develop committed efforts to identify people who are at risk and who are HIV infected.

Participant Comments. The participants acknowledged that because of prevailing budget crises in many states, legislatures are reluctant to fund HIV programs and more likely to cut services. Information on cost-benefit analysis of a potential program is key in getting legislative support, the group members emphasized. Legislators must be sold that an investment in a continuum of care will lead to future reduced costs and effective use of resources.

Group members held **Missouri's** HIV Care Coordination program, implemented in 1989, as a model of a continuum of care that was well supported by the legislature. Missouri's program provides ongoing one-on-one client interaction and statewide networks to assist people living with HIV. Care coordinators locate and expedite services, coordinate services, and monitor and ensure quality of care. The program encompasses partnerships among the public and private sector with input from state, local and private agencies. The goal is to help people with HIV have access to effective and efficient services they need to help them maintain the highest possible quality of life.

An adjunct benefit of the Missouri program is that it creates incentives for people to get tested knowing there are services and support available to them.

Group Members: Representative Pat Harper, Iowa
John Bagby, Director, Department of Health, Missouri
Joan Leavitt, Commissioner, Department of Health, Oklahoma
Ken Williams, Centers for Disease Control and Prevention, Georgia
John McCleary, South Dakota
Margaret Skelley, Association of State and Territorial Health Officials

QUESTIONS FOR CONSIDERATION

At the conclusion of the roundtable meeting the facilitator Peggy Stokes Nielson posed the following questions for legislators and health officials to consider as they develop and refine HIV prevention programs and policies.

PUBLIC HEALTH

Is public health consulting with the community to design and implement programs?

Is public health utilizing all of the resources available and considering nontraditional means to fund programs?

Are the appropriate audiences being targeted?

Are cultural diversities considered when developing HIV prevention efforts? Are the messages and messengers appropriate?

Have infrastructures been created to support outreach and intervention programs and those personnel providing the services?

LEGISLATURES

Are legislators clear on the appropriate and effective HIV interventions for targeted populations?

In developing HIV policy, such as HIV testing, are lawmakers clear on the goals of the policy?

Has there been careful consideration and critical analysis of whether a proposed policy or program will actually accomplish the intended goals?

Are all the possible outcomes of a policy considered before the proposal is put to a vote?

Has integrating existing efforts and funding streams been considered rather than creating new programs? Is public money being leveraged "so that one plus one makes 10?"

STATE LEADERS ROUNDTABLE ON HIV AND AIDS PREVENTION
A MEETING OF CENTRAL STATE LEGISLATORS AND STATE HEALTH OFFICIALS

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