City of Philadelphia
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Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS

ECHPP Workbook #1

Situational Analysis and Goal Setting

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Division of HIV/AIDS Prevention

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Introduction

The City of Philadelphia is committed to improving lives of people in Philadelphia: people who live, work, learn, invent, and play here. Led by Mayor Michael A. Nutter and Deputy Mayor for Health and Opportunity and Commissioner of Health Donald F. Schwarz MD MPH, the City government is guided by values of respect, service, and integrity. It aims to produce a government that works smarter, faster, and better. Four core areas are emphasized to produce specific results in economic development and jobs, enhancing public safety, investing in youth and protecting the most vulnerable, and reforming government.

National AIDS Strategy Vision

The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstances, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

In October 2010, the City's Department of Public Health (PDPH) received a one-year cooperative agreement to participate in Phase I of the Centers for Disease Control and Prevention (CDC) initiative *Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS* (ECHPP – pronounced "***E'****-chip*"). This document, *ECHPP Workbook #1*, documents Step 1 "Situational Analysis" and Step 2 "Goal Setting" based on CDC guidance, use of the best available evidence, and analysis. The companion volume, *ECHPP Workbook #2*, documents goals, strategies, and objectives. A third document, *ECHPP At-A-Glance*, is a summary of both *Workbooks*.

The Enhanced Plan identifies the optimal combination of coordinated HIV prevention, care, and treatment services that can maximize the impact of these services on reducing new HIV infections in the City. It is designed to contribute directly to achieving the vision of the National HIV/AIDS Strategy (NHAS) and its three broad goals:

1. Reducing new HIV infections.
2. Increasing access to care and improving health outcomes for people living with HIV.
3. Reducing HIV-related disparities.

Philadelphia's Enhanced Plan consists of:

- 22 interventions
- 27 unique goals
- 50 individual strategies
- 74 specific, measureable, achievable, realistic, and time-based objectives, which together maximize impact on reducing new HIV infections, and
- 5 data sources for monitoring ECHPP activities.

In general, the plan:

- Reaches at-risk youth in new ways;
- Emphasizes availability of services in geographic locations and venues that reach men who have sex with men (MSM), Blacks, Latinos, and injection drug users (IDU)s; and
- Leverages, and where feasible, coordinates numerous resources, particularly Ryan White Program's (RWP) early intervention resources including Minority AIDS Initiative (MAI) funding through the Federal Health Resources and Services Administration (HRSA), as well as other Federal funding including CDC, HRSA resources other than RWP, Substance Abuse and Mental Health Services Administration (SAMHSA), Housing Opportunities for People with AIDS (HOPWA) and other Housing and Urban Development (HUD) resources, along with State and City funds.

In combination, the ECHPP plan:

- Directs greater resources to testing in clinical and non-clinical settings.
- Addresses real and perceived barriers to routine testing that have existed in State law since 1990.
- Increases the emphasis on interventions and public health strategies involving people with HIV/AIDS and high-risk HIV-negative persons.
- Decreases over time the number, type, and level of funding for evidence-based interventions targeting only HIV-negative persons with a concurrent increase in interventions targeting people living with HIV.
- Significantly expands the City's existing condom distribution program.
- Introduces free condom distribution dispensers to a large number of at-risk youth ages 13-19 in location accessible to this age group.
- Addresses missed opportunities for prevention of new perinatal transmissions of HIV.
- Broadens the number of internal and external partners such as PDPH's Division of STD Control, the City's Office of Addiction Services (OAS), the HIV Prevention Section of the State Department of Health's Bureau of Communicable Disease, and the Special Pharmaceuticals Benefits Program (SPBP), which is Pennsylvania's AIDS Drug Assistance Program (ADAP) administered by the State's Department of Public Welfare (DPW).
- Initiates development of policies, procedures, and financing for non-occupational post-exposure prophylaxis (nPEP).

Development of the Enhanced Plan was informed by and enhances the City's Comprehensive Prevention Plan (August 2009) and Comprehensive Prevention Plan Update (August 2010), Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning for the Philadelphia Eligible Metropolitan Area (2009), Integrated Resource Inventory for HIV Care and Prevention (December 2008), Philadelphia Eligible Metropolitan Area Ryan White Part A Comprehensive Plan, all of which were developed by the City's Office of HIV Planning (OHP) according to

Federal grant requirements.[1] In addition, two recent special studies further informed the ECHPP planning process: Improving HIV Prevention Services for Gay, Bisexual, and Other Sexual Minority Men in Philadelphia (March 2010), and Technical Report: Association between HIV/AIDS Rates and Geographic Areas of Severe Need in Philadelphia (January 2011) .

Further, the Enhanced Plan takes into account relevant findings in the recent peer-reviewed literature. In addition, PDPH used local data to conduct modeling on nPEP; patterns of HIV screening in clinical settings and linkage to care and services by gender, age, race/ethnicity, and risk; disparities in access to and retention in care; and geomapping.

HIV/AIDS in Philadelphia

In 2009, the City and County of Philadelphia's total population was 1.5 million persons, of whom 44% are Black, 40% are non-Hispanic White, and 12% Hispanic/Latino. More than one-quarter (27.2%) are under the age of 20. More than 350,000 residents, representing nearly one-quarter of the population are people with disabilities.[2] The City covers 135 square miles in southeastern Pennsylvania, and is the core of the Philadelphia-Camden-Wilmington, PA-NJ-DE-MD Metropolitan Statistical Area (MSA), the population of which is 5.8 million.

Like other areas in the northeastern U.S., Philadelphia is experiencing both opportunities and threats in health and well-being. The 2009 Gallup-Healthways Well-Being Index, based on interviews with more than 353,000 Americans asked individuals to assess their jobs, finances, physical health, emotional state of mind, and communities. Of the 162 cities in the survey, the Philadelphia MSA ranked 84th, just below the midpoint.[3] Local data further illustrate the severity of need here. As recently as 2009, the rates of sexually transmitted diseases (STDs) (excluding HIV) in Philadelphia were among the top 10 highest in the nation: #10 for syphilis, #5 for gonorrhea, and #5 for chlamydia. Interim data for 2010 suggest equally high rates. Meanwhile, the 2009 Youth Risk Behavioral Survey indicates that 15% of youth in Philadelphia report having had a sexual encounter for the first time before 13 years of age and 63% of youth ever had sexual intercourse. Philadelphia youth also report sexual intercourse with four or more persons during their life 1.8 times more frequently than the national average.

AIDS came to Philadelphia early. As of December 31, 2009, a total of 19,237 persons were living with HIV/AIDS (PLWHA) in Philadelphia. This translates to about 1.3% of the total population. Of these, 11,362 are living with AIDS and 7,875 are living with HIV. HIV Incidence Surveillance (HIS) was implemented in Philadelphia in July 2005 as part of a 34-site nationwide effort to improve HIV incidence estimates. Based on HIV cases reported to PDPH through June

[1] OHP administers and coordinates the activities of the HIV Prevention Community Planning Group (for the City of Philadelphia) and the Ryan White Health and Human Services Planning Council (for the 9-county EMA comprised of Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties in Pennsylvania and Burlington, Camden, Cumberland, and Gloucester Counties in New Jersey).
[2] US Census Bureau, accessed on December 30, 2010 at http://quickfacts.census.gov/qfd/states/42/42101.html
[3] Gallup-Healthways Well-Being Index accessed on December 30, 2010 at http://www.well-beingindex.com/

2009, it is estimated that 110 people per 100,000 population ages 13 years and older are infected with HIV. This rate is 5 times the national average for 2007.

Since the beginning of the epidemic in Philadelphia, HIV/AIDS has disproportionally affected minority populations. African Americans represent the majority of all cases of HIV/AIDS regardless of the mode of transmission (men who have sex with men, heterosexual sex, and injection drug use). HIV/AIDS rates are greatest among African American men, followed by Latino/Hispanic men, African American women, Hispanic women, white men, and white women. Racial and ethnic minorities face a number of challenges that contribute to the higher rates of HIV infection. The socioeconomic issues associated with poverty, including limited access to health care, housing and HIV prevention education, directly and indirectly increase the risk for HIV infection for African Americans and Latinos/Hispanics and their sexual networks and affect the health of people living with HIV.

Of all new HIV infections, African Americans account for two-thirds of cases, with an estimated rate of 176 infections for every 100,000 adult population (13 years and older) (see Figure 1, below). Seventy-two percent of new infections were among males and 28 percent in females with rates of 173 and 57 new infections for every 100,000 population, respectively. MSM are acquiring HIV at an alarming rate in Philadelphia; an estimated 2.5% of all MSM in Philadelphia became infected with HIV in 2007. Currently, 2.0% of African Americans, 1.8% of Latinos, and 0.6% of whites are living with HIV/AIDS in Philadelphia.

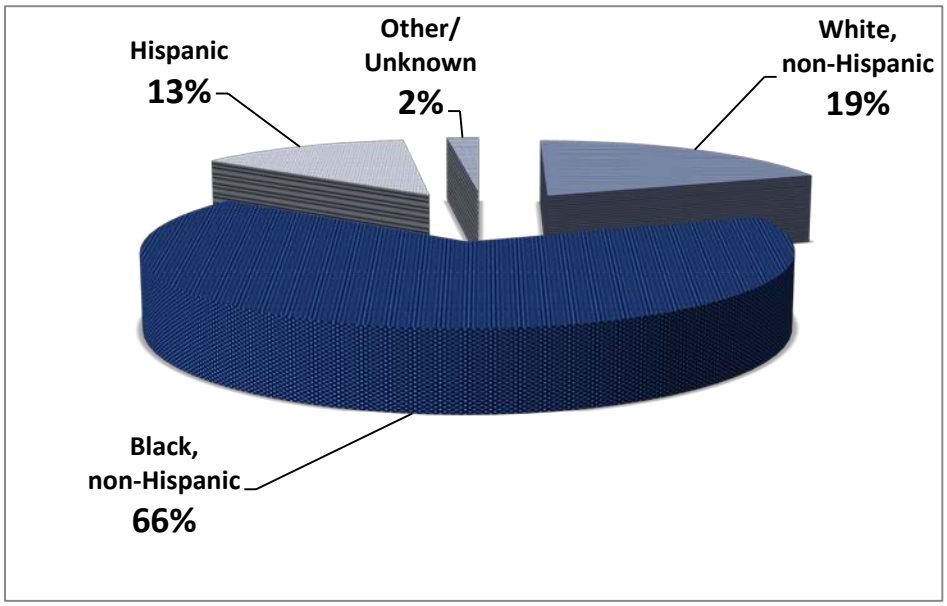

Figure 1: Newly Diagnosed HIV Infections in 2008 by Race

People who are unaware of their HIV status drive the epidemic. At the national level, up to 70% of new sexual transmissions of HIV are by the 25% of people who are unaware of their status (Marks, Crepaz and Janssen, 2006). In Philadelphia, about 5,000 individuals – roughly 21% of all

people with HIV/AIDS in the City – are HIV-infected but unaware of it. People who are unaware of their status are by definition not in HIV care and may transmit HIV to their sex or needle sharing partners. These at-risk individuals must be reached, encouraged to be tested for HIV, and then immediately linked to ongoing medical care and prevention.

Philadelphia's Public Health Response to HIV/AIDS

PDPH, through the AIDS Activities Coordinating Office (AACO) and the HIV Prevention Community Planning Group (CPG), has directed multiple efforts to address the challenges that HIV/AIDS transmission poses to public health efforts and to meet the changing care and prevention needs of people living with HIV/AIDS and the general public. AACO develops, monitors, and evaluates the large majority of all HIV/AIDS-related prevention and care services in Philadelphia. AACO is the Ryan White Part A grantee for the nine-county area in and around the City, including Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties in Pennsylvania and Burlington, Camden, Gloucester, and Salem Counties in New Jersey. AACO also administers Ryan White Part B funds in the five southeastern counties of Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties). AACO administers all state and local HIV prevention funds in the City of Philadelphia and is directly funded by the CDC under several cooperative agreements for HIV prevention services in the City.

Currently, AACO provides $13.3 million to 31 agencies to implement 68 prevention programs (including HIV testing and counseling) of which 27 are evidence-based prevention interventions. Of those 31 agencies, 20 (or 64%) are racial/ethnic minority-run agencies. A priority is to dramatically increase HIV testing in high incidence, geographically targeted areas in order to increase the number of people who know their HIV status. New HIV testing efforts target populations at high risk for HIV infection: incarcerated individuals, youth with many sexual partners, adult MSM, heterosexuals with many sexual partners, and IDU. Undiagnosed individuals are reached through strategies incorporating social networks testing targeting HIV-positive and at-risk persons. Through coordination of AACO prevention and care resources, people who test positive for HIV are linked to high quality medical care and have the support services that they need to stay in care. Other recent efforts include:

- Expanded testing at intake in Philadelphia jails;
- Expanded testing in neighborhoods, community centers, parks, homeless shelters, and out-side school environments;
- Expanded testing in emergency rooms and other primary care settings;
- Launched a media campaign using strategically placed billboards to publicize HIV testing; and
- Organized a collaborative testing event with African American churches to help reduce the stigma of HIV.

AACO has also implemented a social networks project to reach African American MSM through web-based strategies; integrated HIV, sexually transmitted infections, Hepatitis C, and tuberculosis diagnosis and treatment through our CDC-funded Program Collaboration and

Services Integration (PCSI) project; collaborated with the CDC's "9 1/2 minutes…" campaign; and supported community forums, events, and conferences focused on HIV/AIDS prevention.

Taken together, these efforts represent a comprehensive strategy for preventing the transmission of HIV in Philadelphia. Early testing and diagnosis of HIV provides the most treatment options and the highest probability that a person can take advantage of the many life-saving treatments now available. Initiatives that are in place to identify new positives and link them to medical care are showing effect. For example, new AIDS cases for all racial and ethnic groups and for all transmission modes *declined* 65% between 2005 and 2009. Trend data on concurrent HIV/AIDS data (persons diagnosed with AIDS within 12 months of their HIV diagnosis) indicate *fewer* persons are being diagnosed late in the course of disease. For example, in 2006, 36% of persons diagnosed with HIV had an AIDS diagnosis within 12 months compared to 27% in 2008, a *decline* of 11%. Further evidence that persons with HIV are being diagnosed earlier comes from CD4 data. The average (median) CD4 count at the time of HIV diagnosis has *increased* from 257 cells/µL in 2006 to 356 cells/µL in 2008, an improvement of nearly 40%. Persons over age 40, heterosexuals and those with no identified risk are more likely to present late in the course of HIV infection compared to other groups.

For people with confirmed HIV infection, a range of primary medical, diagnostic and necessary supportive services are funded by AACO to meet the needs of uninsured people living with HIV/AIDS. With about $30 million a year in Federal, State, and City funds, AACO annually provide HIV/AIDS care services in the region through an extensive, diverse, and geographically accessible network of medical and related service providers. To address disparities in health-related outcomes, AACO develops and integrates effective and culturally competent services into the network of care to reduce barriers to care among historically disenfranchised and under-served populations.

AACO also funds and coordinates an extensive system of medical case management (MCM) services that facilitate access to and retention in primary medical care and to address unmeet basic human needs, particularly housing. MCM services are available at 73 sites throughout the City, although access to the system is centralized and operated by AACO. People diagnosed with HIV are linked through the centralized intake process to case managers who are culturally competent and located throughout the City. This results in better coordination, access, and timely response to urgent client needs. Specialized case management services also are available to meet the special needs of populations such as persons recently released from jail or prison.

AACO also engages in client-level outcomes monitoring and evaluation to track performance and outcomes. This ensures that people living with HIV disease who are in care receive the highest quality services that meet or exceed public health service guide-lines for HIV medical care.

Guide to Readers

This *Workbook* contains a situational analysis and goals for the Enhanced Plan distributed among 22 interventions and public health strategies. Philadelphia's ECHPP interventions are:

Required Interventions

1. Implement routine, opt-out screening for HIV in clinical settings.
2. Implement HIV testing in non-clinical settings to identify undiagnosed HIV infection.
3. Target condom distribution to HIV-positive persons and persons at highest risk of acquiring HIV infection.
4. Provide post-exposure prophylaxis to populations at greatest risk.
5. Implement efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment.
6. Implement linkage to HIV care, treatment, and prevention service for those testing HIV positive and not currently in care.
7. Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons.
8. Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons.
9. Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive person.
10. Implement STD screening according to current guidelines for HIV-positive persons.
11. Implement prevention of perinatal transmission for HIV-positive persons.
12. Implement ongoing partner services for HIV-positive persons.
13. Implement behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV.
14. Implement linkage to other medical and social services for HIV-positive persons.

Recommended and Local Interventions

15. Target condom distribution to HIV-negative persons in the general population who are at risk of HIV infection.

16. Conduct HIV and sexual health communications or social marketing campaigns targeted to relevant audiences.

17. Support clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive persons and patients at highest risk of acquiring HIV

18. Conduct community interventions that reduce HIV risk.

19. Support behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship.

20. Integrate hepatitis, tuberculosis, and STD testing, partner services, vaccination, and treatment for HIV-infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines.

21. Target use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis.

25. Support syringe access services.

Interventions Not Included
Intervention 22: For HIV-negative Persons at Highest Risk of Acquiring HIV, Broadened Linkages to and Provision of Services for Social Factors Impacting HIV Incidence such as Mental Health, Substance Abuse, Housing, Safety/Domestic Violence, Corrections, Legal Protections, Income Generation, and Others. **Intervention 23: Brief Alcohol Screening and Interventions for HIV-Positive Persons and HIV-Negative Persons at Highest Risk of Acquiring HIV.** **Intervention 24: Community Mobilization that Create Environments that Support HIV Prevention by Actively Involving Community Members in Efforts to Raise HIV Awareness, Building Support for and Involvement in HIV Prevention Efforts, Motivating Individuals to Work to End HIV Stigma, and Encouraging HIV Risk Reduction Among Their Family, Friends, and Neighbors.**

Workbook #1 consists of several sections. The **situational analysis** section describes key features on how each intervention or public health strategy is currently being used or delivered. All of the considerations required by CDC are addressed. Additional items, where necessary, are included. Prior to consideration of goals, and upon completing the situational analysis, potential opportunities for maximizing the impact on reducing HIV infections were identified. Whenever possible, sources are cited.

The **goal setting** section delineates how to optimize the provision of HIV prevention, care and treatment in Philadelphia. Goals are defined as broad aims that define the intended results of each intervention or public health strategy included in the Enhanced Plan. A description, rationale, and role are provided for each intervention goal, as follows:

- *Description*: Clear and detailed statement of the intervention goal.
- *Rationale*: Description of how the intervention goal will maximize the plan's impact on reducing new HIV infections and HIV-related health disparities.
- *Role:* Description of the extent to which the goals of the intervention or public health strategy is part of an optimal combination of efforts described in the plan.

When developing goals based on the situational analysis, numerous sources of information were considered, including:

- Local epidemiologic data
- Current available resources
- Opportunities for leveraging resources across partners and funding streams
- The results of a gap analysis
- Priority areas from existing HIV/AIDS comprehensive plans
- Efficacy and best practice data
- Cost information
- Cost-effectiveness data
- Special local needs assessment studies

PDPH developed and applied nine principles to guide goal-setting.

1. ECHPP goals should be evidence-based.
2. Are few in number.
3. Are stated broadly.
4. Can be achieved by as few SMART objectives as possible that may include specific locations where interventions or public health strategies should occur.
5. Link to *National AIDS Strategy* objectives and associated goals.
6. Strategically enhance other ECHPP goals (where appropriate).
7. Strategically enhance the Philadelphia portion of the Ryan White Program system (Part A, Part B, Part C, Part D, Part F, and Minority AIDS Initiative funds) (where appropriate).
8. Strategically enhance other publicly funded goals including but not limited to other Federal (e.g. SAMHSA), State, and other City programs (where appropriate).

9. Where necessary, include structural objectives that can be addressed by new or revised policies, procedures, or other official actions.

Together, the goals of the Philadelphia Enhanced Plan:

- Modernizes policies and practices to increase HIV testing in clinical settings.
- Expands social network testing.
- Shifts spending priorities to geographic locations that will better yield identification of new positives.
- Greatly expands the City's existing condom distribution program, including a new effort to make free condoms much more widely available to at-risk youth.
- Strongly emphasizes early identification of individuals with HIV/AIDS and linkage to and maintenance in the City's robust system of quality HIV medical care and medical case management.
- Shifts the target population of most evidence based behavioral interventions to people living with HIV/AIDS.
- Expands use of new and traditional media.
- Leverages existing efforts to link to African American HIV-positive heterosexuals, and other populations who lack access to ongoing health care and are disproportionally affected by HIV in Philadelphia, to HIV care persons incarcerated in the City jail system.
- Expands availability of syringe services and linkage to harm reduction and medical care and other services for IDUs.
- Provides new opportunities for partner services to be delivered.
- Initiates ongoing use of HIV and STD data sets to identify co-infected persons and link them to appropriate care and treatment.
- Facilitates an already planned initiative to eliminate perinatal transmissions.
- Enhances existing efforts to improve program collaboration and services integration among disease control programs for hepatitis, tuberculosis, partner services, vaccination, and other health services.
- Provides an opportunity to complete formative research leading to a comprehensive evidence-based community level intervention targeting a single high-risk population to be determined through community-based planning.
- Enables initiation of a formal approach to the appropriate use of nPEP as a tool for HIV prevention.
- Provides additional data on process and outcomes to measure performance and to better inform future planning, priority setting, and resource allocation decisions.

The final section of the *Workbook* provides information on who participated in developing this plan, the data that were used, and the decision-making process that was followed.

Several appendices are included.

- Appendix 1 describes the primary data sets available for development of and future measurement of the Enhanced Plan.

- Appendix 2 lists secondary sources from the literature that informed the development of goals. This list also includes relevant CDC recommendations and guidelines.

- Appendix 3 includes additional data that further inform Workbook #1.

- Appendix 4 provides maps of Philadelphia with testing and clinical care sites indicated.

- Appendix 5 is a glossary of terms and acronyms.

In conclusion, local evidence demonstrates that more Philadelphians know their HIV status and more people with HIV are entering HIV care earlier in the disease course. These trends are hopeful signs because through proper medical care, people who know their HIV status can slow or even prevent progression of HIV disease to AIDS. Further, people who know their status can take steps to prevent transmission of HIV. Enhanced comprehensive HIV prevention planning and implementation builds on these trends and the City's substantial response to HIV/AIDS. It is possible to imagine a day when in the City of Philadelphia no new AIDS cases will be diagnosed and new transmissions of HIV will be rare.

Intervention 1: Implement Routine, Opt-out Screening for HIV in Clinical Settings

Routine, opt-out screening for HIV in clinical settings in Philadelphia is impeded by State law, the Confidentiality of HIV-Related Information Act (P.L. 585, No. 148) known as Act 148. At the time of enactment in November 1990, HIV testing was primarily targeted at individuals from high risk populations and blood donors. Act 148 was designed to guarantee privacy, confidentiality, and education for those tested. The goals were ensured by the requirement for pre-test counseling which included education about HIV prevention, and for signed informed consent. In an attempt to minimize possible testing barriers resulting from State Act 148, PDPH and providers have successfully navigated implementation of routine screening in clinical settings. This ensures that all testing protocols fully comply with Act 148 in Philadelphia, while standardizing and streamlining the consent process in a way that fits appropriately into individual clinical settings and CDC recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings (CDC, 2006). PDPH also participates in the state-wide Act 148 Advisory Work Group. Recently, State Senator Edwin B. Erickson and 8 co-sponsors introduced Senate Bill 290 which amends Act 148 to remove barriers to routine testing in clinical settings. The legislation, which is endorsed by the American Academy of HIV Medicine, was referred to the State Senate's Public Health and Welfare Committee for consideration on January 26, 2011.

Other barriers to routine testing are:

- Lack of awareness on the part of the public as well as providers regarding the need for all persons aged 13-64 to know their HIV status and for persons with risk factors to get tested annually.
- Lack of uptake of CDC's recommendations for routine testing in clinical settings.
- Lack of integration of routine HIV testing into clinic flow operations.
- Misunderstanding on the part of providers of procedural options that are available to fully implement routine screening within the requirements of State Act 148.
- Lack of reimbursement for HIV testing from public and private third-party payers.
- Entrenched misconceptions and stigma regarding HIV/AIDS.

A. Situational Analysis

All providers in public and private clinical settings play an important role in routine screening, including – but not limited to – those working in hospital emergency departments (EDs), urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health care facilities, clinics serving the homeless, and primary care clinics.

Since 2006, PDPH has funded routine screening in a variety of clinical settings serving high-risk populations, including African Americans, MSM, individuals with a history of substance abuse, individuals presenting for services at STD clinics, and jail inmates. Approximately 86% of all HIV tests administered in 2009 were rapid HIV tests.

HIV surveillance trend data suggest that when availability of HIV testing increases, fewer persons are being diagnosed late in the course of disease. This is likely because individuals are getting tested earlier in the course of their infection. For example, in 2006, 36% of persons diagnosed with HIV had an AIDS diagnosis within 12 months compared to 27% in 2008. Further evidence that persons with HIV are being diagnosed earlier comes from CD4 data. The median CD4 count at the time of HIV diagnosis has increased by nearly 40% from a median of 257 cells/µL in 2006 to 356 cells/µL in 2008.

HIV screening in clinical settings occurs throughout Philadelphia. PDPH funds clinical testing sites in geographically-defined areas with the highest rates per 100,000 population of new diagnosed HIV, as shown by the map in Appendix 4.

PDPH provides training and information about how to comply with State Act 148 of 1990 to its funded screening programs. See Intervention 5, below, for more information about plans to update State Act 148.

1. What was the PDPH's 2009 budget for testing in clinical settings?

The PDPH budget for HIV screening in 2009 in clinical settings was $3,244,150. This funding is a combination of CDC Cooperative Agreement, CDC PS07-768/PS10-10138 funds, State, Ryan White, and City General Revenue funds.

2. How many facilities were funded or supported in 2009?

In 2009, PDPH-funded or supported 191 clinical facilities to conduct HIV screening.

3. What types of clinical facilities did PDPH support?

PDPH supported 16 types of clinical facilities.

Clinical Site Types	Number
Correctional Facility	9
Emergency Room	8
Inpatient Facility	1
Inpatient-Drug/Alcohol Treatment	1
Inpatient-Hospital	5
Other	2
Other Outpatient Facility	64
Community Health Center	27
Drug/Alcohol Treatment Clinic	25
Family Planning Site	29
PDPH District Health Center	10
HIV Specialty Clinic	4

Clinical Site Types	Number
Prenatal/OBGYN Clinic	1
Private Medical Practice	3
School/University Clinic	1
TB Clinic	1
Total number of sites	**191**

Figure 2. HIV Screening in Clinical Settings Supported by PDPH in 2009, by Type

Intake testing at the Philadelphia Prison Health System is also an essential component of early identification of high-risk populations. Routine HIV screening in the City jail system at medical intake has been implemented in Philadelphia. This screening is especially important for testing a population of high risk heterosexual African American men who do not seek regular medical care and who may never have been offered the HIV test or learned of a prior positive test result. Over 10,000 tests per year are provided in the jail system.

Community health centers (CHCs) are important testing sites (Institute of Medicine, 2011). In 2008, CHCs nationally administered 753,801 HIV tests (Health Resources and Services Administration, 2009). In Philadelphia, PDPH supports 27 CHCs with laboratory services and rapid test kits through cooperative agreements. CHCs report testing data to PDPH, and are included in the figure above.

4. What was the seroprevalence for HIV tests conducted in clinical settings supported by PDPH?

In 2009, 53,166 HIV tests were conducted in clinical settings with PDPH funding. Of that total, 326 newly identified positives were found, producing an average seropositivity rate of 0.61%. More details about HIV screening in clinical settings, such as linkage to care and services, are found in Appendix 3. In 2009, African Americans accounted for the largest share of individuals who are screened in clinical settings (72%), followed by Whites (12%), Hispanics (5.7%), and Asians (2.3%). Heterosexuals of all races accounted for the most HIV screening in clinical settings (60%), but had the lowest seropositivity rate of all risk groups (0.28%). Risk groups with higher than average seropositivity rates (2.0%) occurred among men who have sex with men (MSM), injection drug users (1.24%), African Americans (0.70%), males (0.88%), persons over the age of 44 (0.87%), and persons 25-44 years of age (0.76%). Additionally, among the 28 male-to-female transgender persons tested in clinical settings in 2009, 3 were HIV-positive, for a rate of 10.71%.

5. What PDPH funding outside of the CDC is used to support this activity?

The total funding outside of CDC funding to PDPH to support HIV screening in clinical settings is RWP: $602,463; State through the SAMHSA Community Block Grant award to the City's Office of Addiction Services: $481,162; City: $63,570; and State Health Department: $30,000. (This funding is included in the $3.2 million amount mentioned in Question 1, above.) Details about

funding outside of PDPH for routine screening in clinical settings are not known at this time. For example, information about HIV screening funded by health insurers (including Medicare) is unavailable.

B. Goal Setting

Expanding routine HIV screening and immediate linkage to HIV treatment offers the greatest health benefit and is cost-effective. However, even substantial expansions of screening and treatment programs are insufficient to by themselves markedly reduce the number of new infections without a concurrent and substantial reduction in population-wide risk behaviors. (Long, Brandeau and Owens, 2010). Hence, ECHPP provides both "test and treat" interventions in combination with other strategies such as expanded condom distribution and syringe access programs to at-risk populations.

Goal 1.1: Routine HIV screening is provided in clinical settings located in Philadelphia.

HIV screening programs in health care settings helps to minimize the complexity and stigma of such programs, and they take advantage of the fact that 81% of adults in the U.S. – and an estimated 903,000 adults over the age of 20 in Philadelphia – see a health care provider at least once a year.

Goal 1.2: Medical providers in Philadelphia gain awareness of the need to offer routine HIV screening to patients ages 13-64.

As mentioned above, clinical providers and their patients need the information and tools necessary to fully implement routine screening. Raising awareness among all types of providers on the need to offer routine HIV screening to patients ages 13-64 and annual screening to high-risk individuals, and information on the technologies that are available will maximize the plan's impact on reducing new HIV infections and HIV-related health disparities.

To address this knowledge gap, existing resources for providers and patients are already available. For example, CDC's ***HIV Screening Standard Care*** resource kit, which provides tools for implementing HIV screening (illustrated below), can be promoted by PDPH and distributed to clinical providers throughout the City. The kit contains provider materials, including an annotated guide to CDC recommendations and rationale for screening; patient education materials in easy-to-read English and Spanish brochures and posters to inform patients about HIV and the importance of HIV screening, and links to key organizations and information sources for HIV screening.

Patient Brochure *Resources Fact Sheet* *Poster* *Annotated Guide to CDC Recommendations*

Other tools will also be distributed, such as model consent forms consistent with State Act 148, materials on perinatal screening, and materials with information linking newly diagnosed individuals to local high quality HIV care and other services.

Should State Act 148 be amended, a new cycle of information dissemination and training on the new law will occur. The focus will be all internal medicine, family practice, pediatric, and obstetrician/gynecology physicians in Philadelphia.

The goals of this intervention serve a high-priority, fundamental role in the plan. Hundreds of new cases of HIV infection will be identified each year and linked to ongoing HIV care. Further, other intervention goals, described below, require the availability of routine testing in clinical settings.

Intervention 2: Implement HIV Testing in Non-Clinical Settings to Identify Undiagnosed HIV Infection

A. Situational Analysis

Most of the HIV testing provided through PDPH in non-clinical settings (in 2009, 86%) uses rapid test technology. This ensures that HIV-negative people are informed of results immediately. Additional specimens can be collected to confirm the results of preliminary positive clients and extra efforts can be taken to ensure accurate contact information is obtained for intensive follow-up to ensure they return for confirmatory results, and are quickly referred and linked to medical care. Anonymous testing sites work with clients who receive a preliminary positive result to conduct the confirmatory test confidentially.

1. <u>What was the PDPH's 2009 budget for testing in non-clinical settings</u>?

PDPH provided $4.24 million to support HIV testing in non-clinical settings in 2009 through a combination of Federal, State and local sources.

2. How many agencies were funded in 2009?

PDPH provided funding to 21 agencies to provide HIV testing in non-clinical settings. About 21,000 (28%) of all HIV tests provided with PDPH funding in 2009 occurred in non-clinical settings.

3. What was the seroprevalence for HIV tests conducted by agencies supported by PDPH?

The seropositivity rate among individuals undergoing HIV testing in non-clinical settings was approximately 1.19%, double the rate among individuals undergoing testing in clinical settings (0.61%). Of the individuals testing preliminary positive, 68% returned for their confirmatory test, and 37% of those returning were successfully linked to care services. Of all individuals undergoing HIV testing in non-clinical settings, more than half were African American and 5% were Hispanic, with 1.22% and 1.37% seroprevalence, respectively. Seropositivity data by gender, age, race/ethnicity, and transmission category are shown below.

Gender	Number tested	Number of new positives	Seropositivity rate
Female	7,635	34	0.45%
Male	13,090	212	1.62%
Trans-F2M	56	0	0.00%
Trans-M2F	136	5	3.68%
Total	**20,917**	**251**	**1.20%**

Age	Number tested	Number of new positives	Seropositivity rate
>12	276	7	2.54%
13-24	6,415	61	0.95%
25-44	9,372	126	1.34%
44+	4,692	54	1.15%
Total	**20,755**	**248**	**1.19%**

Race/Ethnicity	Number tested	Number of new positives	Seropositivity rate
Asian	498	5	1.00%
Black/AA	11,094	135	1.22%
DK/Declined	1,834	32	1.74%
Hispanic	1,313	18	1.37%
Other	387	9	2.33%
White	5,507	49	0.89%
Total	**20,633**	**248**	**1.20%**

Transmission category	Number tested	Number of new positives	Seropositivity rate
Heterosexual	12,261	54	0.44%
IDU	1,888	34	1.80%
MSM	4,247	148	3.48%
No Risk	833	2	0.24%
Not Asked/ Declined	130	1	0.77%
Other	1,489	11	0.74%
Total	**20,848**	**250**	**1.20%**

Figure 3. Seroprevalence for HIV Tests Conducted by Non-Clinical Agencies, 2009[4]

4. What funding outside of the CDC is used to support this activity?

Funding outside of CDC administered by PDPH to support HIV testing in non-clinical settings is City: $710,673, RW: $522,191, and State: $1,061,656. In addition, Ryan White Part C grantees are required to provide HIV testing, and Part D funds may be used to support these services. A high level of coordination and administrative efficiency has been achieved because the Ryan White Part A grantee is also the Ryan White regional Part B grantee and the grantee for CDC funds and for state and local funds. For the four community based agencies funded directly by CDC for HIV prevention (Family Planning Council, Mazzoni Center, Public Health Management Corporation, and The Philadelphia AIDS Consortium), PDPH collects all HIV testing data, processes and cleans it, and submits it to CDC.

5. How many HIV testing sites were there in 2009?

More than 450 HIV testing sites were available in Philadelphia in 2009.

B. Goal Setting

Goal 2.1: Increase the number of people in high risk communities who know their HIV status.

PDPH currently operates and maintains a large and diverse early intervention system that is the product of a multi-year, multi-faceted strategy to implement routine HIV screening in clinical settings (as described above) and to reach high risk populations through targeted programming in clinical and nonclinical settings. PDPH works closely with community planning bodies and has put considerable emphasis on coordinating and integrating services across service systems. As mentioned above, PDPH and the four directly funded CBOs coordinate testing data.

Beginning in 2011, PDPH will implement a new requirement of all Ryan White Part A areas to enhance early identification of individuals with HIV/AIDS and link them to care. A logic model for the strategy appears below.

[4] Totals differ due to invalid/missing data elements for some variables.

Figure 4: Logic Model for PDPH Strategy of Early Identification of Individuals with HIV/AIDS

Inputs	Activities	Participants	Impact	Outcome Goals
▪ Ryan White Parts: A, B, C, D, F, MAI ▪ Direct CDC cooperative agreement funds for HIV prevention ▪ CDC expanded testing initiative ▪ CDC enhanced HIV prevention planning initiative ▪ CDC test and treat Initiative. ▪ CDC SMILE initiative ▪ Pennsylvania counseling and testing funds ▪ City counseling and testing funds ▪ Established network of 450 testing sites. ▪ 1,400 trained and certified HIV counselors ▪ Support for infrastructure development to integrate routine HIV screening in clinical sites and targeted HIV screening in non-clinical settings ▪ CBOs with direct cooperative agreements with the CDC ▪ Rapid and conventional HIV testing technology	▪ HIV screening in clinical settings ▪ HIV screening in non-clinical settings ▪ HIV screening at intake in Philadelphia jails ▪ Social networking programs targeting youth, MSM, IDU ▪ Social marketing and media campaigns ▪ Outreach for targeted testing ▪ Referral to preventive services ▪ Partner services ▪ Linkage to care ▪ Training and technical assistance for provider agencies ▪ Data collection ▪ Monitoring and evaluation	▪ PDPH District Health Centers ▪ City jails ▪ STD Clinic ▪ Emergency Departments ▪ CHCs ▪ Family planning clinics ▪ Labor and delivery rooms ▪ Private physicians ▪ In-patient settings ▪ CBO clinics (fixed and mobile) ▪ Community-based providers ▪ Parole offices ▪ Syringe exchange sites ▪ Anonymous testing sites	▪ HIV screening is routinely available in clinical settings. ▪ PDPH supports a diverse range of community-based HIV screening for targeted high risk populations (risk-based and geographically-based). ▪ HIV screening routinely available at intake in Philadelphia Jails. ▪ All individuals receive their test results. ▪ All individuals will receive confidential confirmatory tests even though initial test was anonymous. ▪ All high risk individuals and individuals who test positive are referred for prevention services and/or care. ▪ All individuals who test positive are linked to care.	▪ Increase in the number of individuals who are aware of their status. ▪ Increase the number of HIV-positive individuals who are in care.

In addition to routine screening, the effort includes:

- HIV screening in community-based settings targeting both risk-based and geographically based populations who may not regularly access health care;
- Social networks testing; and
- Shifting of Ryan White resources to high-yield sites.

See Intervention #6 for information on how persons newly identified with HIV are linked to care.

Intervention 3: Target Condom Distribution to HIV-Positive Persons and Persons at Highest Risk of Acquiring HIV Infection

A. Situational Analysis

PDPH's Condom Distribution Program (CDP), managed by the PDPH STD Control Program, increases easy and immediate access to free condoms for HIV-positive persons and persons at highest risk of acquiring HIV infection. CDP manages a comprehensive network of condom distribution sites in Philadelphia. These sites are selected to ensure accessibility for MSM, Black, Latino, and IDU populations. Cooperative Sites include community health centers, community based organizations, churches, corner stores, beauty salons, club and party promoters, house/ball mothers and fathers, adult clubs and bookstores, bathhouses, and college health centers. Adopt-a-Sites are typically non-traditional venues identified by our field staff as high-traffic locations where our target populations may congregate or visit, such as corner stores, adult bookstores, bathhouses, and beauty salons. Once identified, PDPH staff recruits and instructs the venue staff to distribute free condoms to their patrons, then "adopt" the venue and commit to delivering a monthly supply of condoms directly to the location during their field work. Cooperative Sites include a combination of non-traditional venues, school based programs, medical provider sites, club promoters, and community based organizations that agree to send a representative directly to CDPs pick-up location for a monthly supply of condoms. Cooperative Sites also include hosts of parties where high-risk activities may take place but which may not require a monthly supply of condoms.

1. <u>What was the PDPH's 2009 budget for condom distribution for HIV-positive persons?</u>

The budget for the cost of supplies for condom distribution is $76,000 (2010 amount). Funding is from the CDC Comprehensive STD Prevention Systems grant (47%) and the CDC Syphilis Elimination grant (41%), with the remaining 12% of supply costs from other sources. In addition, $40,000 is budgeted to provide condoms at all PDPH-funded HIV medical care and medical case management programs.

2. How many agencies were funded in 2009?

PHPD, through its CDC-funded STD Control Program, distributes condoms at 116 unique sites. In addition, condoms are distributed through 31 PDPH-funded HIV medical care and 21 medical case management sites.

3. What locations did agencies use for condom distribution?

About 120 locations are distribution sites:

- 16 AIDS service organizations
- 31 health centers
- 72 community sites including barbershops, bars, faith-based locations, mental health and substance abuse treatment centers, bookstores/sex-shops, shelters and student centers.

The current sites are listed below:

13th Street Pizza
56th and Richardson
5th Element Hair Studio
ActionAIDS
Addiction Medicine and Health Advocates
Adonis Cinema
Albert Einstein Medical Center Teen Health Center
Africom
Art Institute of Philadelphia
ASIAC (formerly AIDS Services in Asian Communities)
Attic Youth Center
BEBASHI
Blue Moon Hotel and Swim Club
Bottoms Up
Boys Latin
Brotherly Love Barbershop
By The Way
Carroll Park
Civic House
Coalition of African Communities Philadelphia (AFRICOM)
Community Council for Mental Health and Mental Retardation
Council of Spanish Speaking Organizations (Concilio)
Congreso de Latinos Unidos
Connect Kids to Health
Consortium Community Mental Health Center
Covenant House
District Council 33
Dirty Franks
Drexel Medicine Center for Women's Health
Drexel School of Nursing
Drexel Student Health Center
Early Head Start
First Corinthian Baptist Church
Freire Charter School
Gay and Lesbian Latino AIDS Initiative (GALAEI)
Gaudenzia Washington House
Germantown Settlement
Giovanni's Room Bookstore
Grays Ferry Medical Center
Greater Bibleway Temple
Hannah House Inc.
Haven Youth Center
Health Annex Family Practice and Counseling Network
Health, Hope, and Healing
Healthy Start
Hope Haven II (Part of Project H.O.M.E.)
Horizon House
How Ya Wannit Hair Salon and Barber Shop
Hunting Park Medical Center
InStyle Barber and Beauty Shop
Jonathan Lax Center
Jonathan Lax Treatment Center at Philadelphia FIGHT
Kenny Girl
Kenny's Saloon
Kensington Hospital
Key West Club
Kintock Group
Liberty Lutheran Services
Maternity Care Coalition
Mazzoni Center
Midnight Cowboy Project
Moore College of Art and Design
NE MOMOBILE
NET

North Philadelphia Health System
One Day At A Time
One Day at a Time-Treatment and Recovery Program
Pennsylvania Faith Based Education Resource Center
Painted Bride Arts Center
Papp's Pizza
Parkside Recovery Rehab Treatment Center
PDPH Strawberry Mansion Health Center
PDPH Health Care Center 1/STD Clinic
PDPH Health Care Center 2
PDPH Health Care Center 3
PDPH Health Care Center 4
PDPH Health Care Center 5
PDPH Health Care Center 6
PDPH Health Care Center 9
PDPH Health Care Center 10
PDPH TB Control Mobile Unit
People Helping People
Philadelphia College of Osteopathic Medicine
Philadelphia FIGHT
Philadelphia Women's Center
Philly Finesse
Public Health Management Corporation
PP FNE
Prevention Point Philadelphia
Princess House
Pro-Act
Project Safe
Ridge Avenue Homeless Shelter
SafeGuards Project, Family Planning Council
Sansom Street Cinema
Sharp Skill Barber Shop
Shot Glasses Café
South Philly MOMOBILE
St. Christopher's Hospital for Children
St. John's Community Service
Susquehanna Park Residential Treatment
Temple University Student Health Service
Thomas Jefferson University Hospital Family Medicine Department
Thomas Jefferson University Hospital Immunology Program
Top Hat Dance Studio
The Philadelphia AIDS Consortium
Travelers Motorcycle Club
Tribe of Fools
University of the Arts Student Health Services
University of the Sciences in Philadelphia
Valley Youth
Venture Inn
Verizon House
Women in Transition
Woody's Bar
Youth Outreach Adolescent Community Program (YOACAP)

The map in Appendix 4 shows how the sites are located in the areas associated with high prevalence of HIV.

4. Approximately how many condoms were distributed?

In 2009, 1.2 million condoms were distributed. In 2010, 1.7 million condoms were distributed.

5. Approximately how many HIV-positive persons were reached?

Data on condom users are not routinely collected. A PDPH survey in 2010, however, indicated that at least 52,000 condoms were distributed by PDPH-funded HIV medical care and medical case management sites; however, many sites distribute condoms but do not report the number distributed. Local data from the MMP project indicate that 48% of HIV-positive persons in care in Philadelphia had received free condoms in the past 12 months. In 2011, PDPH will require funded HIV medical care and medical case management sites to track the number of condoms distributed in places accessible to HIV-positive persons.

6. What funding outside of the CDC is used to support this activity?

An additional $84,000 in one-time-only funds was provided to this program in late 2010 by PDPH for expansion of the program including purchasing of a wider selection of brands of condoms. In addition, PDPH distributes 500,000 male condoms a year at a cost of $20,000 and 40,000 female condoms per year at a cost of $41,000 through the City jail system (by social workers, at educational sessions, and nurses stations) and through 31 HIV medical care and 21 medical case management PDPH-funded providers.

B. Goal Setting

Goal 3.1: Condoms are available to all HIV-positive persons and persons at highest risk of acquiring HIV infection accessing services at all City-funded sites and high risk community venues.

This goal continues and enhances PDPH's current condom distribution program described above. The rationale is that by expanding condom distribution, HIV transmission among individuals who know they are HIV positive and among high risk HIV-negative individuals will be reduced by encouraging higher rates of condom use. As demonstrated by a recent meta-analysis of structural-level condom distribution interventions, condom distribution programs are effective at increasing condom acquisition and use, including condom use among a wide range of populations, including youth, commercial sex workers, adult males, and populations in high-risk areas. Furthermore, condom distribution programs reduce incident STDs, and are shown to be cost effective and cost saving (Charania and Lyles, October 2010). Consequently, this goal will contribute significantly to an optimal combination of efforts described in this plan. PDPH will develop and implement new mechanisms to enhance data associated with condom distribution.

Intervention 4: Provide Post-Exposure Prophylaxis to Populations at Greatest Risk

A. Situational Analysis

Shortly after the CDC released its guidelines for non-occupational post-exposure prophylaxis (nPEP), PDPH tasked the Philadelphia local performance site of the AIDS Education and Training Center (AETC) to facilitate a work group of stakeholders to review the guidelines and consider possible policy and program recommendations. The group consists of PDPH staff, HIV clinical providers, and staff from family planning clinics and emergency departments. In 2009, the group was reconvened, partly in response to alarming reports of some women in Philadelphia not being offered nPEP following sexual assault. The work group developed guidelines that include clinical and risk assessments for patients who may have been exposed to HIV, rapid HIV testing guidelines, and appropriate antiretroviral regimens for individuals for whom nPEP is clinically indicated. As of early 2011, these guidelines are being finalized and will soon be submitted to Philadelphia's Health Commissioner for approval and implementation.

1. **Did the PDPH fund facilities to provide nPEP in 2009?** No.

2. **What was the PDPH's 2009 budget for this activity?** Zero.

3. **How many persons received nPEP at PDPH supported facilities in 2009?**

Data not collected.

4. **What funding outside of the CDC is used to support this activity?**

Non-occupational post-exposure prophylaxis medications are costly and may or may not be funded by insurers or by self-pay. To date, nPEP has been found to be cost effective only for men and women who reported receptive anal intercourse. PDPH has provides access to nPEP for some clients. PDPH does not currently have a formalized nPEP program, although (as mentioned above) draft guidelines are under PDPH review. The nPEP work group recently conducted a baseline survey to assess nPEP provision among HIV clinical providers in Philadelphia. The findings highlight generally low take-up of PEP in Philadelphia; only 7 of 17 sites surveyed had any patients request nPEP. When asked to quantify the number of patients requesting nPEP, 4 hospitals reported having fewer than 10 individuals request nPEP. One community health center reported approximately 20 nPEP requests, while 1 hospital reported approximately 40 nPEP requests. Providers prescribing nPEP reported that they generally provide 28-day regimens rather than 3 or 7-day regimens. The starter packs of less than 28 days were generally provided by emergency departments and other providers who do not follow HIV patients regularly.

B. Goal Setting

Goal 4.1: Physicians and populations at highest risk of HIV transmission are aware of the benefits of post-exposure prophylaxis and use it appropriately as an HIV prevention tool.

One critical challenge to expanding nPEP in Philadelphia is funding shortfalls for the antiretroviral (ARV) medicines nPEP requires. Although providing ARVs for nPEP is considered a clinical HIV prevention intervention, this important intervention is not currently eligible for funding by HRSA, nor is it currently funded by PDPH with CDC resources.

Low nPEP uptake is likely attributable to several factors. First, many sites do not yet have nPEP protocols (but will likely adopt the proposed PDPH nPEP guidelines). Second, funding shortfalls for nPEP programs may limit access to nPEP to those with health insurance; many providers do not have a way to fund nPEP for patients and therefore may be reluctant to promote this intervention. Third, there may be limited patient knowledge about the benefits of nPEP, which may result in limited demand. The nPEP work group has discussed the need for expanding the access, knowledge, and use by training clinics to assess and refer quickly eligible patients. Several providers commented that several of the patients requesting nPEP did not ultimately

meet clinical criteria for nPEP provision. Lastly, a few providers also reported in the survey that they only provide clinical services to HIV-positive patients; this suggests that it may be necessary to train a wider range of HIV clinical providers in nPEP provision in order to expand nPEP citywide.

While PEP uptake was generally low, providers also generally agreed about the importance of the intervention and were enthusiastic about efforts to try to expand PEP provision.

Goal 4.2: Determine the feasibility and cost-effectiveness of a formal program to make nPEP available and accessible.

Pending PDPH approval of the work group's draft nPEP guidelines, the next step is to develop the policies and procedures, criteria and eligibility, and financing mechanisms to provide nPEP as a new prevention strategy. Because the Cost Utility Ratio ($:Quality of Life Year Saved) is most sensitive to the per-exposure transmission probability, although each exposure varies based on the partners' act/role and cannot be known with sufficient certainty to calculate cost effectiveness. Further complicating nPEP cost-effectiveness are the variables of patient and partner factors that can affect the risk of transmission, including stage of disease, viral load, genetics, and facilitation (or not) by concurrent sexually transmitted disease. Although not yet studied, reducing community viral load through test-and-treat models may render nPEP not cost-effective. Pending new information on the comparative cost-effectiveness of nPEP, this plan proposes to design and test a small nPEP demonstration project to develop policies, core program elements, and reporting processes.

Intervention 5: Implement Efforts to Change Existing Structures, Policies, and Regulations that are Barriers to Creating an Environment for Optimal HIV Prevention, Care, and Treatment

A. Situational Analysis

As discussed in Intervention 1, State Act 148 of 1990 presents the most significant challenge to routinizing HIV testing activities in Philadelphia because it mandates specific, written informed consent and face-to-face counseling as required elements of any HIV testing services. Act 148 contributes to both actual and perceived barriers to routine testing. For example, the law requires written informed HIV specific consent and pre-test counseling, both of which supplant CDC recommendations.

1. <u>What activities did the PDPH conduct to support this activity?</u>

Since 2007, the grantee has worked with the State Department of Health (DOH) in its process to change the Act. In 2008, the State DOH convened a series of stakeholders' advisory group meetings to address the issues and the grantee medical director participated in these meetings.

In September 2010, PDPH and the AIDS Law Project of Pennsylvania developed a strategy to address the issue of perceived barriers to HIV testing.

2. **What was the PDPH's 2009 budget for this activity?** PDPH does not budget for this activity.

3. **What structures, policies, and regulations did the PDPH address in 2009?**

Among multiple efforts undertaken to address Act 148-related barriers, PDPH developed and disseminates protocols that fully comply with the law, streamline the consent process, and are appropriate for each clinical setting providing routine testing.

4. **What accomplishments occurred during 2009?**

In January 2009, the State Department of Health drafted language to amend Act 148 to reflect CDC revised recommendations for HIV testing. In 2009, the legislature introduced a bill (Senate Bill 291) to amend Act 148 but no further legislative action has been taken.

5. **What funding outside of the CDC can be used to support this activity?**

City General Funds may be used to provide information to State legislators regarding the impact on the health of the public resulting from existing or proposed State laws.

B. Goal Setting

Goal 5.1: Change actual and perceived barriers to routine HIV screening imposed by State Act 148 of 1990.

Until Act 148 is changed, the law contains clear requirements for HIV testing – pre-testing counseling, written informed consent and face-to-face post-test counseling – that, when implemented properly, are *not* barriers to testing. Expanding and streamlining HIV testing can easily be accomplished through the development of three efforts consistent with existing law.

- Encourage health-care providers to offer HIV testing for all patients, consistent with sound professional judgment. Offering the test to all patients will reduce the stigma of being targeted for testing on the basis of risk or demographics.

- Develop consent forms that contain sufficient pre-testing counseling information so that the patient can make an informed decision and a signature line that proves the patient consented. The Family Planning Council (FPC), a network of 27 family planning provider agencies throughout southeastern Pennsylvania, has developed a streamlined HIV testing protocol, including a consent form, which provides information about the test and is signed by the patient. PDPH will consult with other providers, including hospital administrators, to review the institution's current testing protocols and procedures to determine how streamlined consent and counseling may be implemented based on the FPC model. The

protocol would be disseminated through a Health Advisory, with appropriate follow up training.

- Facilitate provision of post-test counseling by trained counseling rather than medical providers.

A complete legal, legislative, and policy analysis is needed in order to address the real and perceived barriers to routine testing associated with State Law 148 and to assess legislative action in 2011 to change it. PDPH will develop new HIV testing guidelines based any new law, disseminate them through a Health Advisory, and provide appropriate follow up training. This goal will contribute significantly to this plan by mitigating, or even entirely removing, actual and perceived barriers to HIV testing. With fewer barriers, more people who are unaware of their status will be identified and linked to care and services.

Intervention 6: Implement Linkage to Care, Treatment, and Prevention Services for Persons Testing HIV Positive and Not Currently in Care

A. Situational Analysis

For more than 20 years, PDPH has implemented policies, services, and quality management activities to ensure linkage to care, treatment, and prevention services for persons testing HIV positive and not linked to care. In 2011, PDPH will maintain and expand a diverse and coordinated portfolio of services so that HIV screening is routinely available in clinical settings and so that individuals in high risk groups routinely come into contact with HIV screening programs operated in clinical and nonclinical settings. Significant resources are directed to a range of activities that are intended to:

A. Ensure that all PDPH HIV testing programs (clinical and non-clinical) provide linkage to care services as a component of the HIV testing process;
B. Ensure that persons are connected to care upon release from the City Jail System and State Correctional system;
C. Provide linkage to care for persons unconnected to medical case management; and
D. Enhance linkage to care for youth through a collaborative project with the Children's Hospital of Philadelphia.

Each of these strategies discussed below, beginning with linkage to care from PDPH-funded HIV testing programs.

A. ENSURE THAT ALL PDPH HIV TESTING PROGRAMS (CLINICAL AND NON-CLINICAL) PROVIDE LINKAGE TO CARE SERVICES AS A COMPONENT OF THE HIV TESTING PROCESS

1. Does the PDPH have written policy and procedures on linkage to HIV care, treatment, and prevention for those testing positive and not currently in care?

Linkage to care for all newly diagnosed HIV-positive individuals is a priority of all HIV testing programs funded by PDPH. Providers are responsible for actively referring all individuals who test HIV-positive into Ryan White funded medical care. All providers must offer CRCS or early intervention services and accompany newly identified HIV-positive persons to their initial medical visit. If providers do not offer such services themselves, they are required to establish formal working relationships with written MOUs with organizations that do. All referrals must provide the last known address for the individual being tested, which is shared with the medical site where the referral is being made. Providers must actively follow up with each individual and document any efforts made to ensure the client's linkage to care services. Providers ensure that any consumer receiving a reactive HIV antibody test result and wishing to be enrolled in HIV case management services is immediately linked to PDPH's central MCM intake unit for PLWHA.

Ryan White Part A funded Early Intervention Services (EIS) provide HIV testing and enhance linkage to care. EIS providers are required to follow the client through three medical visits to ensure that care is effectively established. Ryan White EIS funding is targeted to larger HIV testing programs to provide this enhanced linkage. For example, Mazzoni Center (which receives CDC and State funding through PDPH and direct CDC funding for HIV testing) uses a RW EIS grant to support a full-time early intervention specialist who works with all newly diagnosed clients identified through any of its funded HIV testing programs. Another EIS program (St. Christopher's Hospital for Children) works with private physicians who diagnose youth with HIV and connects them to the infectious disease clinic in the hospital. Overall the RW EIS program in the first nine months of 2010 served 208 newly diagnosed persons and linked 143 to HIV medical care, for a rate of about 70%.

2. Did grantees receive training on the policy and procedures?

Linkage to care from HIV testing programs has been a focus of recent efforts with HIV testing providers funded by PDPH. In 2010, several provider meetings were held to clarify and emphasize these requirements. Individual providers with difficulties linking to care have received provider specific technical assistance either directly from PDPH or, in the case of clinical providers, through the local AIDS Education Training Center.

3. What data do the PDPH use to track HIV-positive persons not currently in care, treatment, and prevention services?

PDPH uses the HIV testing database to track linkage to a first medical appointment, linkage to partner services, and linkage to prevention services for all newly identified HIV-positive

persons. This data is used to develop system-wide and provider specific improvement plans. PDPH also uses surveillance data to estimate the numbers of persons in need of HIV medical care. In addition, laboratories are required to report all CD4 and viral load data to PDPH, which is then matched with HIV surveillance data to measure the duration of time between diagnosis and linkage to care. Linkage to care after HIV diagnosis is measured as the duration of time between HIV diagnosis and receipt of a CD4 count and/or an HIV viral load using local HIV surveillance data reported to the PDPH. An analysis of linkage to care is shown in Appendix 3. Of the 984 new diagnoses of HIV in 2009 included in this analysis, 55.5% were linked to care within 3 months of their diagnosis while 41.9% were not linked to care within 12 months. Being female, young, heterosexual, or IDU was associated with no care linkage after 12 months. Meanwhile, Blacks, Hispanics, and White are equally likely to be linked or not linked to care over time.

4. How many PLWHA reside in Philadelphia?

Currently, 11,362 people living with HIV/AIDS reside in Philadelphia.

5. What is the estimated number of PLWHA in need of treatment?

PDPH estimates that approximately 5,000 PLWHA are in need of HIV treatment. Unmet need for HIV related primary care has increased from 22% in 2007 to 27% in 2009 with the greatest increases being seen in PLWH not AIDS. Although unmet need was slightly lower for whites compared to Blacks and Latinos, no other characteristics distinguish persons who are in and out of care. In 2011, PDPH will use surveillance data to evaluate linkage on a population basis.

6. How many publicly funded HIV/infectious disease treatment facilities exist?

A total of 39 PDPH-funded medical agencies exist in Philadelphia.

7. What funding outside of the CDC is available for care and HIV prevention for PLWHA?

For HIV medical care and supportive services, PDPH administers more than $23 million in Ryan White Part A funds and $4 million in Part B funds in the region. This is supplemented by Ryan White Part C and D grantees in Philadelphia. In addition, CDC prevention funding, PDPH administers State and local funding for HIV prevention services.

8. What was the PDPH's 2009 budget for prevention for persons living with HIV?

Ryan White-funded care programs in Philadelphia offer prevention for positives as a component of the service (e.g. medical care and medical case management – see Interventions 8, 9, 10, 12, 13, and 14). For programs specifically addressing prevention for persons living with HIV through evidence based interventions (Intervention 13) the budget is $800,000 – from a combination of CDC, HRSA, State, and local funds.

B. LINKAGE TO CARE FOR HIV-POSITIVE PERSONS RELEASED FROM CORRECTIONAL FACILITIES

City Jails. A significant number of newly diagnosed persons are identified in jail, while other inmates enter jail already knowing they are HIV-positive. Incarceration disrupts care for those who know their HIV status and these persons must be linked again to care upon release. Each year, approximately 1,700-1,800 PLWHA are released from federal, state or local jails in Philadelphia. PDPH's MCM intake data, moreover, show that 36% of all intakes report a history of incarceration. As mentioned above in Intervention 1, jail-based testing is an opportunity to provide HIV testing to a priority population of high risk, out of care, African American heterosexual men. Inmates who test HIV-positive or identify themselves at medical intake at City jails receive standard HIV care while in the system under the care of the jail's HIV medical director, Debra D'Aquilante MD, an infectious disease specialist.

Each episode of re-entry requires re-establishment of eligibility for Medicaid for the more than 50% of persons released from incarceration who are not insured at the time of release. The net impact of these re-entry episodes is a significant demand for benefits counseling, intensive case management, drug and alcohol treatment, and outreach services. Persons released from jail also pose a number of medical complexities in treatment. While federal, state and local jails offer medical care, including HIV treatment, many prisoners do not avail themselves of these services because either they do not know their HIV status or they fear disclosure of their HIV status among jail populations. Some people leave incarceration without having received HIV treatment while in jail, and some who leave jail having received treatment are subsequently lost to the care system upon release. PDPH has mitigated lost to care events by stationing medical case managers in the Philadelphia jail system to coordinate linkage to care upon release. Even so, many people incarcerated in the Philadelphia jail system are released with little or no advanced notice or planning and are subsequently lost to care until a medical crisis brings them into the HIV care system.

With a combination of RWP Part F Special Projects of National Significance (SPNS) funding and RW Part A and MAI funding, ActionAIDS and Philadelphia FIGHT (both well-established PDPH-funded CBOs) collaborate on a project to link HIV-positive inmates to care and services upon release from the Philadelphia Jail system. Six prison case managers are stationed at the jails to work directly with inmates prior to their discharge, and for an additional 3-4 months post-discharge to assure that those who are released get securely linked to medical care and other needed services. Clients are transferred to the community-based system of medical case management after participation in this program. An estimated 60% of HIV-positive inmates in the City jails are successfully linked to treatment and care services upon release; 30% (some of whom are commercial sex workers) opt out of treatment and care services; the remaining 10% are unknown. As of January 2011, 35 individuals are on a waiting list for this prison case management program.

Prison case management is complemented by the activities of outreach workers from Philadelphia FIGHT: one worker is stationed at the City jails and two others at the Institute for

Community Justice, a drop-in center for recently released persons that provides a range of HIV services including TEACH outside (an adherence program) and Safety Counts. The outreach workers add support beyond what the case managers can provide to reconnect recently released persons to medical and community services. A final component of this program is that FIGHT has a designated re-entry medical care provider who provides same or next day appointments to persons released from the jail system along with incentives for attending medical appointments.

State prisons. HIV-positive clients in care in the State prison system are released with a 30 day supply of medications. Beginning in 2004, the Transitional Planning Initiative (TPI) was developed to ensure effective linkage to care and services in the community post-release from State correctional institutions. Infection control nurses at State prison facilities identify HIV-positive inmates scheduled to be released and provide information directly to them on the importance of continuing medical care and risk reduction. The infection control nurse also links the individual to the PDPH MCM central intake unit, which conducts intake with the inmate and schedules the first HIV medical appointment and medical case management session with an assigned provider. The case manager works with the client to develop discharge plans and ensure linkage into medical care and other community services. Inmates are given priority for MCM. This program serves an average of 70 inmates a year.

C. ENHANCED LINKAGE TO CARE FOR YOUTH WITH NEWLY DIAGNOSED HIV

PDPH and The Children's Hospital of Philadelphia (CHOP), as a clinical site of the Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) are working collaboratively to link youth 14-24 who have tested positive for HIV to care as part of an NIH-funded program initiative (SMILE). The project ensures linkage of youth receiving HIV testing at Health Center 1 which houses the STD screening program and is centrally located in Philadelphia. Through this project other Health Centers in the system will be identified that may benefit from increased linkage efforts and are located in medically under-served residential neighborhoods throughout the City. Additional testing venues include other AACO contracted agencies. To provide direct linkage into care for youth identified to be HIV-positive through any of the program's points of entry for early intervention, the CHOP Outreach Worker will work with testing venues and the CHOP clinical team to meet with the adolescent at the time of post-test counseling to ensure a direct link into care. This project began in March 2010; as of October 2010, approximately 30 youth were enrolled. Although referrals can be received from any agency, the official community partners for SMILE are the Mazzoni Center, Health Center 1, Safeguards, The COLOURS Organization, Gay and Lesbian Latino AIDS Initiative (GALAEI), the Women's Anonymous Test Site (WATS) and BEBASHI. Additional referrals have been received from ActionAIDS, Job Corps, and the Family Planning Council's Circle of Care program (the Part D grantee). To date the number of cases opened under the SMILE project is 62, with 5 of these youth considered repeats, i.e. they are on their second linkage to care attempt. Currently, 31 have been linked (1st medical visit within 42 days), 23 have been engaged in care (2nd medical visit within 4 months of 1st medical visit), 11 have accepted linkage to care but are not linked yet, 3 are newly engaged, and 1 patient refused linkage to care. The SMILE project receives

approximately $85,000 in National Institutes of Health funding to support 1.5 FTEs (1.0 FTE outreach worker and 0.5 FTE data manager), as well as incentives for participants such as meals, tokens, and child care for visits.

D. LINKAGE TO HIV CARE AND PREVENTION SERVICES THROUGH MEDICAL CASE MANAGEMENT

As mentioned earlier, PDPH maintains a central intake system in its Client Services Unit (CSU) for medical case management that serves over 2,200 people with HIV/AIDS a year. Although many persons seeking medical case management are already in medical care and need only help in retention, adherence, and connection to supportive services, some of those seeking medical case management have not been linked to care. In 2009, 367 people with HIV who were not recently in medical care sought services. Of those, 93% who received MCM also received medical care within 10 weeks of intake. The PDPH Client Services Unit has special protocols to address the needs of these persons. If a person contacting the CSU is not currently in medical care, CSU staff makes an appointment with a medical provider and follow-up after the appointment to ensure it has been kept. In addition, all medical case management providers are required to ensure clients are enrolled in HIV medical care. A significant gap in linkage to care processes relates to HIV diagnoses made by private physicians who may not know where to refer newly diagnosed persons.

Intervention 14, below, provides additional details about how persons with HIV are linked to other medical and social services, including housing assistance.

B. Goal Setting

Goal 6.1: Improve initial entry into HIV medical care for people testing HIV-positive not currently in care.

Diagnosing HIV itself is not sufficient to reduce new HIV infections. This intervention will ensure newly diagnosed persons are connected to care, and as a consequence both individual and community viral load can be reduced. The intervention also supports linkages to secondary prevention services.

This plan includes strategies to improve linkages to care from clinical settings (Intervention 1) and non-clinical settings (Intervention 2). Disparities in access to care by minority populations is addressed by geographic analysis of testing settings in Interventions 1 and 2, and through the jail and youth linkage programs described above, which serve predominately minority populations. Linkage through the City jail system is a unique opportunity to address the needs of heterosexual HIV-positive men who in Philadelphia are overwhelmingly African American and Latino. The NIH-funded SMILE linkage program specifically targets minority youth MSM, a population at great risk for not being linked to care.

Intervention 7: Implement Interventions or Strategies Promoting Retention in or Re-engagement in Care for HIV-Positive Persons

A. Situational Analysis

Retention in care is a primary focus of PDPH Quality Management (QM) activities for HIV medical care. The rationale is that none of the other quality measures for persons in care can be improved if patients are not retained in care. In 2009, more than 11,000 HIV-positive persons were served with PDPH-funded medical care. Of that number, 80% were retained in care from the previous year. In addition, 80% of patients seen in these sites in 2009 had at least 2 medical visits 3 months apart. These are two retention-related performance measures for PDPH-funded HIV medical care providers (see Intervention 9 for further discussion of the performance measure process).

PDPH also measures unmet need for medical care for persons with diagnosed HIV. Persons are categorized as having unmet need if there is no evidence of receipt of viral load or CD4 testing or ART in the measurement year. Approximately 5,000 HIV-positive persons in Philadelphia are estimated to have unmet need for medical care. Some of these people were never linked to medical care while others have fallen out of care. The PDPH HIV surveillance unit will further analyze retention patterns in 2011.

1. **In what ways, if any, do you work with healthcare providers to promote retention or re-engagement in care?**

PDPH works with healthcare providers to promote retention and re-engagement in care in several ways.

- In PDPH-funded medical settings, QM requires two performance measures for retention in care. Providers track retention and use this data to develop improvement projects.

- PDPH funds an extensive medical case management (MCM) program to support retention and re-engagement in care. MCM providers are required by contract to track attendance at medical visits along with receipt of laboratory testing to ensure that clients are retained in medical care. MCM is designed to work with clients to overcome barriers to retention in HIV medical care. One of the key activities is the coordination of medical care. (See Intervention 14 for more discussion of MCM.)

- PDPH funds 18 organizations for care outreach activities focused on retention in medical care. The program model for care outreach is to follow-up on clients who have not been seen for a medical visit in 100 days, work with the clients to overcome barriers to care, and facilitate re-entry into care. Care outreach programs are required by contract to actively track clients who previously have fallen out of care through three medical visits. In 2009, PDPH-funded Ryan White care outreach programs provided services to 1,557 clients, linked 854 clients to a first medical appointment, and linked 470 to a third medical visit.

- HIV testing programs may encounter persons who already know their HIV-positive status and have fallen out of care. Program staff works to connect these people to care.

2. <u>Do you provide funding to agencies or organizations to promote retention or re-engagement in care?</u>

PDPH funds providers to promote retention and re-engagement in care as part of HIV medical care and HIV MCM programs as well as care outreach programs whose sole focus is retention in care.

a. How many agencies were funded in 2009?

PDPH-funded 18 agencies in 2009 for care outreach to promote retention or re-engagement in care.

b. What types of agencies were funded?

Twelve of the organizations funded for care outreach were HIV medical programs. These programs received funding for care outreach workers to work with patients to retain them in care. Four of the organizations were large case management agencies. The local syringe access program and a youth outreach program were also funded to provide retention services through the care outreach program model. In addition, one of the funded programs works with the jail population to ensure continuity in medical care upon release. (This program is discussed in Intervention 6.)

c. What was the PDPH's 2009 budget for this activity?

The PDPH budget for this activity in 2009 was $985,091 for care outreach programs.

3. What funding outside of the CDC is available for interventions or strategies to promote retention in care?

Ryan White and Minority AIDS Initiative funds from HRSA are available for interventions or strategies to promote retention in care.

4. How many agencies implemented interventions or strategies to promote retention in or re-engagement in care?

In 2009, 18 agencies implemented interventions to promote retention and re-engagement in care. All PDPH-funded medical and MCM providers also provided retention services.

B. Goal Setting

Goal 7.1: Retain HIV-positive persons in care and re-engage in care HIV-positive persons unconnected to care or who have been lost to follow-up.

Efforts to retain HIV-positive people in care and re-engage them in care are embedded in all PDPH-funded care and prevention programs. Ryan White funded care outreach programs have retention in care as their goal. Retention and reengagement are critical for all prevention with positives activities which are ineffective if people are not retained in care. This goal leverages HRSA funds and other retention in care programs. Improvements in retention in care will support other clinical interventions such as adherence to ART (Intervention 9), STD screening (Intervention 10), risk screening (Intervention 13), and others. Retention in care is critical for meeting objectives such as increasing the proportion of clients in the HIV continuum of care and increasing proportion of MSM, Blacks, Latinos, and IDUs with undetectable viral load by improving adherence to treatment plans. Outreach activities and retention improvement plans will target disproportionately affected populations and will be cost effective by decreasing morbidity due to treatment interruptions.

Intervention 8: Implement Policies and Procedures That Will Lead to the Provision of Antiretroviral Treatment in Accordance with Current Treatment Guidelines for HIV-Positive Persons

A. Situational Analysis

PDPH administers Ryan White Part A and Part B funds and coordinates with all other RW Parts. All Ryan White Part D medical providers are also funded by Parts A and B as are all but 1 of 7 Part C grantees. PDPH funds HIV medical care at 31 clinical sites in the City. These clinics serve over 9,000 HIV-positive people, or nearly half of the persons diagnosed with HIV in Philadelphia and nearly two thirds of all persons with HIV/AIDS in care in Philadelphia.

The figure below summarizes populations served by the Ryan White medical care programs. Rows in **bold** highlight under-represented populations in which the number of persons living with HIV/AIDS are under-represented in Ryan White medical care, which in most cases is related to the prevalence of private health insurance in the population. Whites, males and people in the prime employment ages of 20-44 and 45 and older are more likely to have jobs and private insurance and thus would be expected to be underrepresented in the service utilization data compared to their prevalence in the population of people with HIV disease. Only injection drug users are underrepresented to any significant degree. This may in part be accounted for by some misclassification of former IDU into the heterosexual transmission category who are overrepresented in the system of care.

PDPH ensures appropriate use of PHS guidelines for ART primarily through its Clinical Quality Management (CQM) program. The vision and mission of the program is to ensure that PLWHA receive the highest quality clinical care services, that the system of HIV/AIDS care is accessible for hard to reach populations, and that services respond to local epidemiological trends. The

program is comprehensive: all resources managed by PDPH, including Part A, Part B, MAI, CDC prevention services funds, as well as state and local funded activities are included. CQM is coordinated with all community planning and administrative activities, including the procurement and monitoring of PDPH's large multi-agency care and prevention services system.

CQM goals for 2011 are to: (1) assure PLWHA receive medical care that meets or exceeds Public Health Service guidelines and standards of care, (2) ensure access to and maintenance in medical care and MCM for hard-to-reach and out-of-care PLWH/A, (3) enhance integration of medical care with MCM, (4) improve collection, analysis, and reporting of quality management data, (5) expand use of CQM data to inform future program and policy decisions, particularly those regarding access to and quality of care for PLWHA.

Demographic Group/ Exposure Category	Living with HIV/AIDS in the EMA N=25,563	Ryan White Medical CAREWare Data Report N=12,255
RACE/ETHNICITY		
White, not Hispanic	**24.9%**	**17.2%**
Black, not Hispanic	61.0%	66.5%
Hispanic	12.0%	12.8%
Asian/Pacific Islander	0.6%	0.7%
Other/Unknown	1.5%	2.8%
GENDER		
Male	**68.4%**	**63.9%**
Female	31.6%	35.0%
Transgender	NA	1.2%
AGE AT DIAGNOSIS (YEARS)		
<13 years	0.5%	4.0
13 - 19 years	1.4%	2.4
20 - 44 years	**45.9%**	**44.1**
45+ years	**52.2%**	**49.4**
ADULT/ADOLESCENT AIDS EXPOSURE CATEGORY		
Men who have sex with men	**31.3%**	**29.7%**
Injection drug users	**25.9%**	**14.6%**
Men who have sex with men and inject drugs	**3.5%**	**1.6%**
Heterosexuals	35.2%	43.8%
Other/Hemophilia/blood transfusion	0.2%	5.6%
Risk not reported or identified	3.9%	4.8%

Demographic Group/ Exposure Category	Living with HIV/AIDS in the EMA N=25,563	Ryan White Medical CAREWare Data Report N=12,255
INSURANCE STATUS		
Private		16.7%
Medicare		13.4%
Medicaid		51.0%
Other public		0.6%
None		16.9%
Unknown		1.3%

Figure 5. Populations in Philadelphia Part A EMA Ryan White Programs

CQM implements quality assurance, outcomes monitoring and evaluation, and continuous quality improvement activities. Quality assurance is the degree to which providers adhere to contract provisions addressing administrative and programmatic requirements for each service category for which that provider is funded. These requirements are based on PHS guidelines and standards of care for primary medical care for PWLH/A, other federal guidance such as CDC's guidance for prevention with positives, professional guidelines, and locally developed standards of care.

Quality assurance also includes the local consumer grievance mechanism, operated by the PDPH Client Services Unit. Through this mechanism, any consumer of PDPH-funded services has the right to confidentially report problems with the services they receive. The grievance process provides individual consumers and providers with a uniform mechanism for resolving specific incidents. It also provides PDPH with important, real-time consumer satisfaction data and with data to improve planning and inform corrective actions. Outcomes monitoring and evaluation tracks client- and provider-related performance of PHS guidelines and professional standards.

Every Part A-funded provider is required by contract to establish and implement internal continuous quality improvement (CQI) processes aimed at identifying and solving problems, improving processes, and ensuring delivery of quality services and high customer satisfaction. In addition, the CQM program monitors system outcomes such as access to services by racial/ethnic and sexual minority populations, the uninsured, and other populations of concern. Continuous quality improvement (CQI) focuses on solving specific high-priority quality problems and improving processes in the overall system. CQI enables delivery of high quality clinical services and customer satisfaction.

1. **Does the PDPH collect data on the treatment regimens persons living with HIV are prescribed and the treatment they receive?**

PDPH collects client-level data on treatment regimens persons living with HIV are prescribed and on the treatment they receive. For example, to assess the provision of ART in accordance with guidelines, PDPH reviewed data collected through the quality management process for 2009. When stratified by CD4 category, high levels of achievement of clinical guidelines for ART were seen, as indicated in the Figure 6, below.

For all PDPH-funded medical care providers, the percent of patients with AIDS receiving ART is a required performance measure. In 2009, 94% of AIDS patients in PDPH-funded medical care sites received ART based on the HRSA-defined performance measure for adults and adolescent patients. Data on this measure is reported to PDPH every two months.

PDPH also collects data on the provision of ART through its Medical Monitoring Project, a randomized stratified sample of all persons with HIV in care in Philadelphia.

CD4 range	Percent on ART
Below 350 cells/µL	85.5%
Between 351 – 500 cells/µL	77.5%
Above 500 cells/µL	81.4%

Source: PDPH Quality Management Data

Figure 6. Ryan White Clients on ART by CD4

2. **Does the PDPH have written policy and procedures or its own guidance on the use of antiretroviral treatment in accordance with current guidelines?**

PDPD develops and implements policies to promote provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons, and requires all funded agencies to follow current USPHS guidelines for care of persons with HIV including the provision of anti-retroviral medications.

3. **What funding outside of the CDC is available to support this activity?**

Ryan White funding is available to support this activity.

4. **How many agencies/organizations addressed this activity in 2009?**

All agencies funded for medical care and MCM are mandated by contract to participate in all PDPH required CQM-related activities.

B. Goal Setting

Goal 8.1: Ensure appropriate use of PHS guidelines for ART.

Appropriate use of ART will lower community viral load and decrease transmission of HIV. This goal also supports efforts to reduce risky behavior of persons with HIV by lowering relative risk of transmission on a population basis.

Disparities in care are analyzed for client-level clinical indicators reported through PDPH's quality management program, described above. Data are reported by race, gender, risk, age, and insurance status. These data show that the PDPH-funded system of care reaches a predominately minority population that is reflective of the HIV/AIDS epidemic in Philadelphia. This goal leverages HRSA funding of Ryan White quality management activities to ensure appropriate use of ART and equitable access to it regardless of demographic characteristics.

Intervention 9: Implement Interventions or Strategies Promoting Adherence to Antiretroviral Medications for HIV-Positive Persons

A. Situational Analysis

PDPH promotes adherence to ART for HIV-positive persons through adherence counseling as a required component of MCM, and through Project TEACH (Treatment Education Activists Combating HIV), a local intervention. The Medical Monitoring Project, a representative sample of people in care, provides self-reported information on unmet need for adherence support. Local MMP data indicates that 11% persons interviewed reported a need for adherence support. Of those with a need, 89% had the need met. Medical case managers use the CASE Adherence Index to target resources to persons most in need of adherence support. In addition, the Quality Management program provides a flow of information to monitor adherence needs, and adherence rates, and to identify opportunities for adherence-related improvement projects. For example, quality management CAREWare data from 2009 indicate that 75% of patients on ART are virally suppressed. Because such data are required to be reported, this information can be used over time to target adherence interventions and resources.

1. **Does the PDPH have written policy and procedures on adherence to antiretroviral medications?**

Yes. Adherence counseling is a required component of PDPH-funded HIV medical care providers. In 2009, 51% of patients had documented adherence counseling, which increased to 68% in 2010. In addition, PDPH-funded MCM providers are required to implement standard procedures promoting adherence to ART, including adherence counseling to patients on ART. By contract, MCM providers must communicate with clients' medical care providers and maintain records of the medications clients are prescribed. Medical case managers are

required by contract to assess and report data to PDPH on adherence of clients using the CASE Adherence Index at intake and quarterly thereafter. Medical case managers deliver adherence counseling or refer clients to other programs such as Project TEACH, or both. Clients who have scores that indicate adherence issues are identified and adherence interventions are implemented by case managers as part of the client's service care plans.

2. Did you fund any agencies or organizations to conduct interventions or strategies to promote adherence in 2009?

PDPH funded numerous adherence activities in 2009.

a. What was the PDPH's 2009 budget for this activity?

PDPH's budget in 2009 for Project TEACH was $250,000. The budget for MCM was $5,848,485.

b. What kinds of agencies were funded?

Funded agencies include community based organizations, CHCs, medical care facilities, and hospital based clinics.

c. How many agencies were funded?

In 2009, PDPH-funded Philadelphia FIGHT (for Project TEACH). In addition, 39 PDPH-funded medical agencies and 21 MCM agencies were funded to conduct adherence activities as part of their contracted services.

d. What interventions or strategies were used?

In addition to the contractually required adherence counseling by PDPH-funded medical and MCM providers, Project TEACH is a local health program developed and implemented by Philadelphia FIGHT, a major AIDS service provider. Project TEACH strongly emphasizes self-management of HIV especially adherence. In biweekly sessions over a 9-week period, TEACH participants learn about secondary HIV prevention, treatment education, outreach and advocacy. TEACH learning objectives include health promotion for HIV-positive individuals through assertive use of health care, pharmaceutical therapy and adherence to ART, prevention and early treatment of infections, nutrition, clinical trials, stress reduction, and peer support. Adaptations of TEACH are also offered for monolingual Spanish speakers (Latino TEACH) and for jail populations (TEACH Outside).

e. How many PLWHA were served?

In 2009, 155 HIV-positive persons completed Project TEACH and 6,000 patients received adherence counseling as part of medical care. Also in 2009, 7,000 MCM clients were served.

f. What funding outside of the CDC is available to promote treatment adherence?

Funding outside CDC to promote treatment adherence is from the Ryan White Program. In addition, funding from the Pennsylvania AIDS Drug Assistance Program (the Special Pharmaceuticals Benefits Program, or SPBP) will support a significant new multi-faceted adherence effort, to be initiated in 2011 in collaboration with PDPH. Note that because Pennsylvania does not have an ADAP waiting list, ADAP funding can be used (at the State's discretion) to support adherence-related activities.

g. How many agencies delivered interventions or strategies to promote treatment adherence in 2009?

In 2009, all PDPH-funded 39 medical providers, 21 MCM providers, and Philadelphia FIGHT (through Project TEACH) delivered adherence counseling and patient education.

h. How many PLWHA received interventions for medical adherence beyond standard clinical care?

In 2009, 7,000 PLWHA received adherence counseling as part of the MCM process and 155 PLWHA graduated from Project TEACH.

B. Goal Setting

Goal 9.1: Increase adherence to antiretroviral therapies.

Adherence to ART improves health outcomes of the individual and lowers community viral load. In Philadelphia, adherence services are a mandatory component of all PDPH-funded HIV medical care and MCM services. This results in a wide penetration of consistent adherence supports, particularly during the period of initiation of ART, while switching therapies, or re-engaging in ART after a treatment interruption. A special adherence program, Project TEACH, is an important part of these efforts because it trains peer leaders who frequently become a part of the staffing of the care and prevention system. While documentation of adherence counseling is improving, the reported unmet need for adherence support is relatively low among all needs identified by a representative sample of people with HIV/AIDS in Philadelphia. This goal leverages multiple Part of the Ryan White Program and cost-effectively reduces morbidity and prevents costly treatment interruptions.

Intervention 10: Implement STD Screening According to Current Guidelines for HIV-Positive Persons

A. Situational Analysis

The PDPH strategy to ensure STD screening according to current guidelines for HIV-positive persons is through the provision of comprehensive HIV care at PDPH-funded HIV medical care

sites. The strategy does not rely on referrals to STD programs, but rather provision of STD screening in the course of regular HIV medical care at the HIV care site.

1. **Does the PDPH have written policy and procedures on linkages of HIV-positive persons to STD screening and treatment?**

Providers are required by contract to follow PHS guidelines for treatment of persons with HIV. As part of the PDPH quality management program for HIV medical care, HRSA-defined performance measures have been implemented for syphilis, chlamydia, and gonorrhea screening. (Performance measures for chlamydia and gonorrhea were implemented in 2010, the baseline data collection year for those measures.) In addition, PDPH implemented its own performance measure for syphilis screening of MSM. Many of the PDPH-funded clinics include syphilis screening as a standing order on lab orders to ensure that screening occurs. In 2009, 72% of MSM received at least one syphilis screening in the measurement year; 61% of all patients were screened for syphilis. (Note that data collection does not include a variable for whether patients are sexually active, which is one reason for less than 100% performance on these measures.)

2. **Does the PDPH have its own guidelines on STD screening and treatment?**

PDPH creates guidelines based on CDC recommendations. PDPH Health Advisories are issued as needed to advise the medical community of changes in guidelines.

3. **In what ways does the PDPH monitor its STD clinics to assure screening and treatment take place in accordance with the 2006 STD Treatment Guidelines?**

The PDPH STD Control Program verifies treatment of reportable STDs to ensure that appropriate care has been provided.

4. **How many PDPH-funded agencies referred HIV-positive persons to STD screening in 2009?**

Screening is integrated into comprehensive HIV medical care, not by referral to STD programs.

   a. **How many of these persons kept their first appointments?**

Data on first kept STD appointments are not available, although in 2009, 68% of persons receiving medical care at PDPH-funded HIV medical sites received syphilis screening. Data on the percent of patients screened for gonorrhea and chlamydia will be available in Spring 2011.

5. **What funding outside of the CDC is available to promote referral of PLWHA to STD screening?**

HRSA Ryan White funding for outpatient/ambulatory medical care is available for this purpose.

6. **How many agencies referred PLWHA to STD screening in 2009?** Data not available.

    a. **How many PLWHA kept their first appointments?** Data not available.

B. Goal Setting

Goal 10.1: HIV-positive persons will access STD screening at PDPH-funded medical sites.

The PDPH promotes STD screening for HIV-positive individuals by providing comprehensive HIV medical care in its funded HIV medical care sites. The emphasis is on access and retention in medical care as a strategy to ensure patients are provided standard of care in relation to STD screening and treatment. Note that STD screening for HIV-positive individuals is a part of Intervention 21, below, which prioritizes partner services for persons co-infected with HIV and STDs.

Intervention 11: Implement Prevention of Perinatal Transmission for HIV-Positive Persons

A. Situational Analysis

1. **Does the PDPH have written policies and procedures for perinatal prevention and treatment?**

PDPH has collaborated with all six labor and delivery hospitals in Philadelphia to develop written policies to promote prevention of perinatal transmission. To ensure that all HIV infected women and HIV-exposed infants have access to appropriate prevention interventions, all women in Philadelphia County's six delivering hospitals are offered HIV tests before delivery as well as linkage to appropriate care and treatment services for themselves and their exposed infants. There is an even greater focus on offering these services to women delivering in or from areas of high prevalence of substance abuse, sexually transmitted diseases or infections, and HIV/AIDS. No law or regulation currently exists to require reporting of HIV testing provided to pregnant women; the HIV counseling, testing and reporting form captures information only on positive test results of a pregnant woman. Negative results are not included. PDPH and its primary partners (Family Planning Council/Circle of Care and the AETC) conduct trainings for local obstetrician/ gynecologists on the American Congress of Obstetricians and Gynecologists and CDC guidelines for HIV testing of pregnant women, including third trimester testing.

2. **What specific activities were funded by the PDPH for perinatal prevention 2009?**

In 2009, PDPH contracted with the Family Planning Council (FPC) of Southeastern Pennsylvania to implement perinatal prevention activities through its RWP Part D-funded Circle of Care program. The following is a summary of activities.

- Voluntary HIV testing is available to pregnant women, especially those at high risk for HIV through counseling and testing services through Circle of Care subcontractors. In 2009, 87 pregnant women were tested and 231 women of child bearing age were tested.

- Rapid testing is available in labor and delivery in all six delivering hospitals in Philadelphia. In 2009, nearly 3,000 rapid HIV tests were performed in labor and delivery.

- FPC/Circle of Care, in collaboration with the local AIDS Education and Training Center (AETC) conducted provider trainings and held three perinatal expert panels to ensure implementation of HHS/HRSA, CDC and Public Health Service guidelines regarding HIV counseling and testing for women and to ensure the proper management of HIV-positive pregnant women from pregnancy to postpartum management.

- FPC/Circle of Care provided through two subcontracts enhanced perinatal case management to 102 HIV-positive pregnant and parenting women to link HIV-positive mothers to HIV medical care, specialty prenatal care, and supportive services through the pregnancy and guarantee quality medical and supportive services are available for HIV-positive mothers and their exposed infants. This was supplemented with peer counseling support provided at four locations.

- PDPH's HIV Surveillance Unit completed the perinatal evaluation protocol, which collects and reports data on HIV testing of pregnant women, receipt of appropriate prophylaxis, and other aspects of perinatal HIV transmission as outlined in the perinatal HIV prevention program evaluation protocol.

3. <u>What was the PDPH's 2009 budget for this activity?</u>

In 2009, PDPH provided $279,354 for programs to support perinatal HIV prevention programs. In 2010, an additional $15,000 supported Fetal Infant Mortality Review/HIV (FIMR/HIV), a collaboration between CDC, American College of Obstetricians and Gynecologists (ACOG), CityMatCH (a national membership organization of city and county health departments' maternal and child health programs and leaders representing urban communities) and the National Fetal Infant Mortality Review (NFIMR). The goal of the FIMR/HIV is to improve perinatal HIV prevention systems by using the FIMR case review and community action process. The methodology provides an in-depth look at the health, social, economic, cultural, safety and education systems that result in a perinatal HIV exposure or transmission by collecting comprehensive quantitative and qualitative data, by way of medical record abstraction and maternal interview.

4. <u>How many agencies carried out perinatal prevention activities in 2009?</u>

PDPH contracts with the Family Planning Council of Southeastern Pennsylvania to coordinate perinatal prevention activities in Philadelphia. FPC is also the local RW Part D grantee, which greatly facilitates perinatal prevention activities carried out through its network of providers.

Other partners are the City's six delivery hospitals. Additional technical assistance is provided by the local AIDS Education and Training Center.

5. How many pregnant women were tested for HIV during 2009?

Negative HIV results are not reportable to PDPH. Data on the number of pregnant women testing is not known due to lack of funding to collect this data from each delivering hospital. The most recent data available are from 2006, when 71% of women were tested during pregnancy.

a. How many were newly diagnosed with HIV? Data not available.

6. How many HIV exposed infants were born in 2009?

In 2009, a total of 90 HIV exposed infants were born in Philadelphia.

7. How many infants were born with HIV in 2009?

In 2009, no infants were born with HIV in Philadelphia.

8. What funding outside of the CDC is available to promote perinatal prevention?

As mentioned above, PDPH receives $15,000 for FIMR/HIV and the Family Planning Council is the local Ryan White Part D grantee, which funds activities related to perinatal transmission. Although there were no perinatal transmissions in 2009, gaps in perinatal prevention exist in Philadelphia. For example a recent study which included Philadelphia (SK Whitmore et al. Missed Opportunities to Prevent Perinatal Human Immunodeficiency Virus Transmission in 15 Jurisdictions in the United States During 2005-2008) found that 60% of women did not receive all of the recommended perinatal prevention interventions: timely diagnosis of HIV (before labor), prenatal care (before labor), prescription of ART, a cesarean delivery, and recommendation to avoid breast feeding. Other local data indicate that only half of HIV care providers are consistently engaging in pre-conceptual counseling with their new female patients. Other Enhanced Perinatal Surveillance data indicate that women have not received prenatal care and are not receiving all three arms of ART, and FIMR/HIV reviews indicate several cases of potential exposures that might have occurred but did not merely by chance.

B. Goal Setting

Goal 11.1: Eliminate perinatal transmissions of HIV in Philadelphia.

PDPH's strategy to test and provide prophylactic ART to all HIV-positive pregnant women has had dramatic impacts on perinatal transmission of HIV; in 2009, with data analysis conducted to date, no infants exposed to HIV perinatally have seroconverted. However, as recently as 2005, five infants were diagnosed with perinatally transmitted HIV. Further, each year between 2005

and 2008, between 110-120 infants were exposed to HIV perinatally. In 2009, this number decreased to 92 infants, largely due to reporting delays. PDPH proposes a redesign of its provision of perinatal transmission activities which are outlined in the objectives in Workbook 2.

Intervention 12: Implement Ongoing Partner Services for HIV-Positive Persons

A. Situational Analysis

1. Does the PDPH have its own policy and procedures for partner services that comply with the 2008 recommendations?

PDPH promotes partner notification services for all individuals testing HIV-positive. In 2010, to promote greater uptake of partner notification services, PDPH amended contract Service Provision Guidelines for all HIV testing contracts to ensure that partner services staff are present at the delivery of confirmatory HIV-positive test results and that each client has the opportunity to speak to Partner Services staff at the time of receiving an HIV diagnosis.

In addition, PDPH has written policies for ongoing partner services for persons in its funded system of care. All RW funded HIV medical providers are required to refer newly diagnosed patients, patients with STD diagnoses, and patients with high viral loads and reported high risk behavior to PDPH partner services. A performance measure of the number and percent of newly diagnosed patients referred to partner services was implemented in 2009 (baseline performance at the initiation of this program was 18%).

Partner Services are delivered in a collaborative effort between the PDPH AIDS Activities Coordinating Office (AACO) and the PDPH STD Control Program.

a. Do grantees receive training on the policy and procedures?

Training has been provided to grantees on the policies and procedures through provider meetings and on-site technical assistance. All PDPH-funded HIV medical care sites and HIV testing sites have been assigned to work with either AACO or STD Control partner services programs. Provider agencies develop protocols and/or MOUs with the assigned partner services program to delineate how the services will be offered to clients. In 2010, the required training for new HIV testing staff was extensively revised, in part, to emphasize and explain policies and procedures related to partner services.

2. How many FTEs were devoted to partner services in 2009?

The STD Control Program has 2.0 FTE staff devoted to HIV partner services and AACO has an additional 2.0 FTE staff for HIV partner services. Provider agencies are assigned to work with either STD Control or AACO staff. These services are coordinated through monthly partner services meetings between STD Control and AACO.

3. What was the PDPH's 2009 budget for partner services?

The PDPH spent $248,979 on partner services in 2009 – this includes 2 FTE partner services specialists funded by the CDC and 2 FTEs funded with State prevention resources.

4. How many newly identified, confirmed HIV positive tests were reported in 2009?

In 2009, 985 individuals were newly diagnosed with HIV in Philadelphia.

5. How many partners were contacted by PDPH staff?

From all PDPH funded HIV testing sites (clinical and non-clinical), 52% of new positives were referred to Partner Services. A total of 299 newly diagnosed persons agreed to participate in partner services (32% of all new diagnoses reported to PDPH – this includes new diagnoses made outside of the PDPH funded system), and from that number, 497 partners were elicited. Among those individuals, 253 partners of HIV-positive individuals were notified of exposure to HIV.

6. How many partners received HIV tests?

Of the partners of HIV-positive individuals informed of exposure to HIV through partner services, 164 individuals received HIV tests.

a. How many tests were newly identified, confirmed positive tests?

As a result of partner services, 36 individuals were diagnosed with HIV in 2009.

B. Goal Setting

Goal 12.1: Implement utilization of partner services by persons testing positive for HIV.

Partner services is an effective means to reach people with HIV who are unaware of their status. In 2009 in Philadelphia, 14% of partners notified were newly diagnosed with HIV through the efforts of partner services. This is an area of growth for PDPH. In recent years, PDPH has focused on increasing utilization of partner services and revised training curricula for HIV test counselors. Efforts to meet clients at medical care in addition to the time of HIV diagnosis have expanded the utilization of partner services and show coordination between the HIV care and prevention systems. This goal also relates to Intervention 21 discussed below, in which use of surveillance data to better target partner services is planned.

The major gap in partner services is that the HIV case reports are not used to trigger partner services activities; rather, all partner services activities are the result of referrals from PDPH-funded providers. Since most HIV diagnoses are made outside of the PDPH-funded system, many opportunities for partner services are missed. To address this, PDPH requires all newly

diagnosed HIV-positive patients at funded HIV medical sites be referred to partner services. This plan includes an objective to use the surveillance database for initiating partner services and assessing the completeness of referrals to partner services.

Intervention 13: Implement Behavioral Risk Screening Followed by Risk Reduction Interventions for HIV-Positive Persons (Including Those for HIV-Discordant Couples) at Risk of Transmitting HIV

A. Situational Analysis

PDPH-funded behavioral risk screening is required by Comprehensive Risk Counseling and Services (CRCS) and Health Education/Risk Reduction (HERR) providers with prevention funding (which served about 800 positive people in 2009), and by MCM providers funded by RW (which served 7,000 positive people in 2009). For the purposes of this plan, this intervention focuses on CRCS and HERR, while Intervention 14 (below) focuses on MCM. PDPH has written contractual requirements for CRCS (in place currently) and HERR (implemented in January 2011) that require behavioral risk screening for HIV-positive persons prior to enrollment in risk reduction interventions. In addition, PDPH-funded medical providers (see description of system in Intervention 8) and MCM providers (see description of the MCM system in Intervention 14) are required by contract to assess risk behaviors and make appropriate referrals and/or provide risk reduction planning with clients. Local MMP data indicate that almost half of persons in medical care in Philadelphia discussed HIV prevention with their health care provider in the last 12 months.

1. **Do grantees receive training on the policy and procedures?**

All CRCS and HERR providers receive regular training through the PDPH Prevention Training Institute; medical case management staff are trained through the Case Management Coordination Project.

2. **How many agencies did you fund in 2009 to implement interventions for HIV-positive persons?**

In 2009, 8 agencies were funded to provide interventions for HIV-positive persons.

3. **What was the PDPH's 2009 budget for this activity?**

The PDPH budget in 2009 was $816,029, which served 793 persons ($1,029 per person per year).

a. How many agencies were funded?

In 2009, 8 agencies were funded.

b. Did the agencies conduct behavioral risk screenings before HIV-positive persons enrolled in risk reduction interventions?

For CRCS the agencies conducted risk screening, a new requirement for all PDPH-funded group-level prevention interventions.

c. What interventions or strategies were implemented?

CRCS for HIV-infected individuals is provided at six agencies: two community-based sites that are also large RW funded medical case management sites and four HIV clinic-based sites (two of which serve youth). Other prevention interventions for HIV-infected individuals that are supported with CDC funds include:

- *Protect and Respect*, (a locally developed intervention) at the Drexel University/Hahnemann Hospital Partnership Clinic (a Ryan White Funded HIV clinic),
- *Healthy Relationships* at Mazzoni Center (a RW funded HIV clinic) and at the Pennsylvania School for the Deaf,
- *Teens Linked to Care* at St. Christopher's Hospital for Children,
- *Protocol Based Counseling* at The Children's Hospital of Philadelphia, and
- *Safety Counts* at BEBASHI, a RW funded MCM site.

d. How many PLWHA were served?

In 2009, 793 PLWHA were served.

4. What funding outside of the CDC is available for risk reduction interventions for HIV-positive persons?

PDPH uses City, State and Ryan White Part B funding for prevention interventions with HIV-positive individuals.

In addition, by contract, funded medical providers (see description of system in Intervention #8) and medical case management providers (see description of the system in Intervention #14) are required to assess risk behaviors and make appropriate referrals and/or provide risk reduction planning with clients. Risk reduction activities provided by medical providers and medical case management providers are not included in the funding amount above which refers only to CRCS and HERR evidence based activities. HIV risk reduction counseling is a requirement for all clients in MCM.

5. **How many agencies implemented risk reduction interventions for HIV-positive persons in 2009?**

In addition to the agencies cited above, there are 21 medical case management agencies in Philadelphia which provide risk reduction activities to 7,000 persons enrolled in medical case management.

Local data from the MMP, a representative sample of persons receiving HIV medical care in Philadelphia (and includes non-PDPH-funded agencies), indicate that 34% of people in care reported discussing prevention with a prevention program worker in the past 12 months and 21% reported discussing prevention with peers in an organized session. This plan proposes expanding the availability of prevention interventions for HIV-positive persons in the care system.

B. Goal Setting

Goal 13.1: Screen HIV-positive persons in PDPH-funded medical care and medical case management sites for risk behaviors.

In order to ensure that HIV-positive people are appropriately referred to prevention interventions, PDPH utilizes its extensive network of funded HIV medical and medical case management providers to screen HIV-positive individuals for risk behaviors.

Goal 13.2: Provide HIV-positive persons in need of risk reduction with appropriate risk reduction interventions.

In combination, these goals will enable PDPH to continue currently available behavioral risk screening at medical care and MCM sites, improve its quality by site and system-wide, and increase the availability of CRCS in PDPH-funded medical sites.

The rationale is that a combination of behavioral risk screening and intervention opportunities are needed to reduce the incidence of behaviors of HIV-positive persons, including youth, associated with HIV transmission.

Reducing behavioral risk among the population of HIV-positive people avoids harm to the positive individual and enables people with HIV to reduce behaviors that risk transmission of HIV to HIV-negative behavior partners. It is important that appropriate prevention resources be available for HIV-positive persons. This plan envisions expanding the resources available for referral/on-site prevention interventions in the HIV care system.

Resources for the expansion of evidence-based interventions for HIV-positive individuals will initially come from ECHPP funding, but will in Year 2 reflect a decrease in funding for EBIs for high risk negative individuals.

This intervention leverages Intervention 12 in which ongoing referrals to partner services for HIV-positive individuals screened for high risk behaviors is described.

Intervention 14: Implement Linkages to Other Medical and Social Services for HIV-Positive Persons

A. Situational Analysis

PDPH provides $5.85 million for medical case management through a highly decentralized yet highly coordinated network. Currently, PDPH supports 21 community-based organizations to provide medical case management, a uniformly defined service that promotes linkage to other medical and social services for HIV-positive persons. These agencies include clinical care providers, ASOs and other CBOs. This system serves 7,000 persons living with HIV in the city.

Across the system, MCM services encompass a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are one component of MCM. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members' needs and personal support systems. MCM includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

MCM activities required by PDPH include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. MCM also requires client-specific advocacy and review of utilization of services. To facilitate quick and easy access to these services, PDPH operates a central intake unit for HIV-positive persons seeking MCM.

At enrollment, PDPH's central intake unit makes an initial benefits eligibility assessment. In addition, needs for other medical and social services are documented. This provides system-wide data, reduces mistakes in subsequent applications for benefits, and speeds the process for eventual eligibility for benefits. The following table shows the needs for various services and for select sub-populations. Housing and benefits assistance were by far the most frequently reported needs at intake.

Figure 7: Initial MCM Service Needs at PDPH Central Intake, 2009						
Service Category Needed	**All clients**	**African American Women**	**African American MSM**	**Youth 13-24**	**Recently Released from Jail**	**Late Presenters**
Number of persons	*2,316*	*602*	*385*	*162*	*60*	*146*
Medical Care	26%	20%	27%	41%	65%	43%
Dental Care	5%	6%	6%	7%	5%	5%
Mental Health Counseling	33%	34%	34%	35%	32%	42%
Emergency Financial Assistance	9%	11%	8%	6%	2%	2%
Housing Assistance	59%	62%	58%	43%	57%	38%
Food Bank	19%	18%	18%	9%	12%	10%
Medical Transportation	23%	24%	19%	12%	35%	28%
Legal Services	6%	6%	4%	6%	2%	5%
Benefits Assistance	51%	50%	44%	46%	73%	65%
Risk Counseling	8%	10%	7%	21%	12%	38%
Medical Insurance	28%	20%	35%	39%	73%	58%
HIV Medications	23%	16%	22%	28%	65%	31%
Support Group	32%	36%	33%	28%	35%	34%
Substance Abuse Counseling	10%	13%	5%	5%	15%	10%

1. **Does PDPH have written policy and procedures on screening for mental and social services and linkage to other medical and social services for PLWHA?**

By contract and through PDPH MCM policy standards, a comprehensive bio-psychosocial assessment is required at the time of MCM agency intake along with a service care plan based on that assessment. Medical case managers are provided with current service inventories to assure that appropriate linkages to other medical and social services are made.

   a. **Did grantees receive training on the policy and procedures?**

The PDPH provides a structured ongoing training curriculum (the Case Management Coordination Project) for medical case managers to ensure that funded agencies are able to assess and refer clients to needed services. All case managers and supervisors must complete a required curriculum each year. Sample topics include how to coordinate benefits, reduce duplication of services, and ensure that Ryan White Program funds are the payer of last resort.

2. **What funding outside of the CDC is available for other medical and social services for PLWHA?**

The funding for this system is RWP funding.

3. **How many publicly funded mental health treatment facilities exist?**

The Philadelphia Department of Behavioral Health (with City, State, SAMHSA, and other funding) connects adults, adolescents, and children to a network of mental health treatment

facilities. There are different levels of mental health treatment to meet individual needs. There are five Crisis Response Centers to meet the needs of those individuals in acute psychiatric distress who need immediate attention. Inpatient services are available at 22 area hospitals for individuals experiencing a mental health crisis. Over 50 mental health providers offer outpatient services in the Philadelphia region. Outpatient services include acute partial programs requiring attendance five days per week and based in hospital settings, traditional partial day programs, after-school programs, and intensive outpatient treatment for individuals addressing substance abuse issues. SAMHSA directly funds five mental health programs in Philadelphia: Children's Hospital of Philadelphia's Center for Pediatric Stress, Horizon House, Mental Health Association of Southeastern Pennsylvania, Philadelphia Department of Public Health's Department of Behavioral Health and Mental Retardation, and Public Health Management Corporation.

4. How many publicly funded substance abuse treatment facilities exist?

As with mental health treatment, the Philadelphia Department of Behavioral Health connects adults, adolescents, and children to a network of substance abuse treatment facilities. There are different levels of substance abuse treatment to meet individual needs. Inpatient substance abuse treatment involves individuals being placed in one of 56 inpatient facilities in order to address a drug and/or alcohol problem. Outpatient services are offered at over 50 sites. In addition, SAMHSA funds three substance abuse treatment programs in Philadelphia: Mazzoni Center, Project H.O.M.E., and Urban Affairs Coalition.

5. How many publicly funded organizations provide housing assistance?

Housing assistance is provided by a myriad of organizations. The Philadelphia Housing Authority, the nation's fourth largest public housing authority, provides rental assistance and housing to over 80,000 individuals and families in Philadelphia. The Philadelphia Office of Supportive Housing offers housing to the homeless and special needs populations, such as the chronically mentally ill. The Office of Housing and Community Development administers a variety of housing assistance including HOPWA (Housing Opportunities for People with AIDS). Housing assistance for individuals and families living with HIV is centralized through the AIDS Activities Coordinating Office.

In 2009, 59% of the more than 2,300 new clients were in need of housing assistance at the time of intake into the MCM system. PDPH's Client Services Unit works with the City's Office of Housing and Community Development (OHCD) to process applications for rental assistance programs for people who have an AIDS diagnosis or are disabled due to HIV disease. These federally funded programs pay 70% of the monthly rent, including a utility allowance. PDPH also supports a hospice for people living with AIDS, a specialized personal care facility, and two transitional housing programs for medically needy persons with HIV, one for women and one for men. Currently, 84.5% of Ryan White clients in Philadelphia have stable or permanent housing.

In 2010, HUD awarded entitlement funding to the City under the Community Development Block Grant (CDBG) and HOME Investment Partnership (HOME) programs totaling $55.3 million and $16.4 million, respectively. In addition, the City qualified for $2.3 million in Emergency Shelter Grants. These programs limit activities to those benefiting low- and moderate-income persons. CDBG funds support a broad range of affordable housing, economic, and community development activities. HOME funds are limited to housing development and rental assistance. In addition, the City applies annually to HUD for funding available from the McKinney Homeless Assistance Program. This program supports housing development, rental assistance, and support services for homeless persons. In Philadelphia, rental assistance through the McKinney Act has been set aside for persons with HIV or AIDS who are homeless.

In 2010, Philadelphia's HOPWA funding was $8.9 million. OHCD, the City's HOPWA administrator, contracts with seven well-established community-based and AIDS service organizations to administer rental assistance programs, including ActionAIDS, Asociación de Puertorriqueños en Marcha, Inc., Congreso, and Mazzoni Center, all of which are PDPH-funded for HIV-related services. The OHCD-funded 1260 Housing Development Corporation is exclusively for HIV-positive individuals with an AXIS I mental health diagnosis. OHCD also funds Public Health Management Corporation, ActionAIDS, and Mazzoni Center to implement HOPWA-funded housing counseling, and emergency financial assistance grants. Private foundations and individual giving support many of the organizations that carry out HOPWA-funded activities.

Using HOPWA and other funding in 2010, 1,346 households affected by AIDS or HIV received direct housing services, including rental assistance, emergency grants, or residence in a HOPWA-funded facility. This exceeded by 40% the City's goal for its Housing and Urban Development-mandated Year 35 Consolidated Plan, the equivalent of nearly 400 households affected by AIDS or HIV.

Other Federal housing-related funding is provided through the City's Office of Supportive Housing and the Philadelphia Housing Authority, both of which provide rental assistance and project-based housing for low income individuals and special needs populations, including HIV-positive persons.

6. How many publicly funded organizations provide social services (e.g., domestic violence agencies)?

Hundreds of organizations in Philadelphia provide social services. In order to assist persons to access a particular service, the first step is usually connecting to one of the service hotlines such as First Call for Help, a United Way program that facilitates access to social services. The PDPH-funded Health Information Helpline provides information and referral services to approximately 150 agencies for persons at risk or living with HIV. The Domestic Violence Hotline also provides referral services.

7. How many agencies were funded in 2009 to deliver this activity?

In 2009, 21 agencies were funded to provide medical case management.

a. **What programs/interventions were implemented (e.g., CRCS, Healthy Relationships, Partnership for Health)?**

See Intervention 13.

8. How many PDPH-funded agencies referred PLWHA to other medical and social services?

All 21 medical case management agencies referred persons to other medical and social services. Referrals are also made by medical providers and prevention services providers.

a. **How many PLWHA kept their first appointments?**

In 2009, 2,316 PLWHA were provided with MCM intake and services. Note that client-level data on initial appointments to HIV medical care are tracked, but not for other medical and social services that clients receive through the MCM linkage system.

B. Goal Setting

Goal 14.1: HIV-positive persons are linked to other needed medical, social services, and housing assistance.

This goal provides for continuation of the PDPH system of access and linkage to MCM, which is designed to assure that HIV-positive persons receive medical, social services, and housing assistance.

The rationale is that reported needs of clients decline over time once MCM services are received. Recent data from the Medical Monitoring Project (a representative sample of persons receiving HIV care in Philadelphia) indicate that 42% of persons interviewed had a need for case management. Of those in need of MCM, 86% had that need met.

The goal is necessary for this plan because it provides HIV-positive people with expeditious resolution of immediate needs such as housing and benefits assistance, and subsequently to other medical and social service needs that can be barriers to accessing and maintaining primary care. Further, retention in care plays a role in lowering community viral load and reducing potential new transmissions of HIV.

As shown above in Figure 7, housing assistance is among the highest needs of people living with HIV/AIDS at MCM intake (59%). Housing assistance at intake is most needed by African American women, African American MSM, and persons recently released from incarceration. In response, PDPH's MCM system is designed to expeditiously link Ryan White clients to both HIV medical care and non-medical support services, including housing assistance. To accomplish this, PDPH co-locates its centralized MCM intake and AIDS housing placement services in the

PDPD/AACO Client Services Unit. Linkages to all types of services needed by new intakes are highly coordinated and effective. Currently, 84.5% of Ryan White clients in Philadelphia have stable or permanent housing, well within reach of the national target of 86%.

This goal leverages Intervention 6, which emphasizes linking HIV-positive MSM, Blacks, Latinos, and IDUs to care, including inmates released from jail, enhanced linkage to care for youth with newly diagnosed HIV, and linkage to care and prevention services through medical case management.

Intervention 15: Target Condom Distribution to HIV-Negative Persons in the General Population Who Are At Risk of HIV Infection

A. Situational Analysis

Most PDPH condom distribution efforts target high-risk populations and HIV-positive persons. Local data from the National HIV Behavioral Surveillance (NHBS) study indicates that a large proportion of those who received condoms used them. NHBS asks if respondents had gotten free condoms in the last 12 months (Heterosexual - 16.3%, IDU - 46.6%, MSM - 28.2%) and, if so, had they used any free condoms (Heterosexual - 63.3%, IDU -52.6%, MSM - 79.2%).

On the other hand, local data from the Youth Risk Behavioral Surveillance System (YRBSS) indicates that 37% of Philadelphia High School students did not use a condom at last sexual intercourse. YRBSS for 2009 shows very high rates of risk behaviors for youth in Philadelphia:

- 63% ever had sexual intercourse
- 15% had sexual intercourse for the first time before 13 years of age
- 26% had sexual intercourse with four or more persons during their life
- 46% had sexual intercourse with at least one person during the 3 months before the survey.

Syphilis is increasing in youth in Philadelphia which also has high rates of Chlamydia (3.5 times the national rate) and gonorrhea (3 times the national rate) among 15-19 year olds. A local data match of HIV and STD surveillance databases showed that youth 11-19 years of age with a positive STD test for gonorrhea, chlamydia, or syphilis are at greater risk of having subsequent HIV infection (2.5- to 3.0-fold increase). Youth 13- 24 years of age represent 5% of all PLWHA in Philadelphia. Rates are disproportionate for minorities, especially for young African American MSM. PDPH estimates a 3% prevalence of HIV among black MSM 13 – 19. To address these issues, PDPH is focusing on condom accessibility for at-risk youth.

1. <u>What was PDPH's 2009 funding for the activity?</u>

PDPH funds condom distribution through the Philadelphia School System's school-based Health Resource Centers (HRC). Currently, 13 (of 61) public high schools have HRCs and distribute nearly over 90,000 condoms per year. The HRC program costs $219,760 and includes a counseling component.

PDPH District Health Centers routinely provide condoms free of charge to their patients. These distribution points are City-sponsored and independently managed by each site. On occasion, the CDP will provide these sites with additional supplies of condoms on an as-needed basis.

2. How many agencies were funded?

In 2009, 13 Philadelphia high school Health Resource Centers were funded.

3. What did the agencies accomplish?

Over 90,000 condoms were distributed to high school students

4. What other funding is available for the activity?

No other funding is identified.

5. What was PDPH's 2009 funding for the activity?

PDPH funding for this activity in 2009 was $356,760.

B. Goal Setting

Goal 15.1: Free condoms are available and accessible to the general population at risk of HIV infection.

Condoms accessibility has been shown to be an effective structural intervention. Under Intervention 3, this plan will distribute condoms in high prevalence areas to high risk individuals.

Goal 15.2: Increase the use of condoms among in- and out-of-school youth.

As shown above, youth represent a population with many HIV risk behaviors. Although overall, youth have relatively low HIV prevalence, some subgroups (e.g. young Black MSM) have very high rates of HIV. It is therefore important to ensure youth adopt consistent condom use. This plan therefore proposes a broad condom distribution program targeting youth to increase accessibility and (over time) change norms around condom use among youth. This will be accomplished in an effort coordinated between the PDPH STD Control program and PDPH AIDS Activities Coordinating Office, in collaboration with the Philadelphia School District.

Intervention 16: HIV and Sexual Health Communication or Social Marketing Campaigns Targeted to Relevant Audiences

A. Situational Analysis

PDPH funds two HIV and sexual health communications and social marketing programs: "Get Texted" is a new media project that targets all risk populations, and the Prison AIDS Project, which delivers HIV prevention education to Philadelphia Jail system inmates.

"Get Texted" was initiated in June 2009 in collaboration with OraSure, Inc. and Rip Road Technologies on a small scale as part of PDPH's broader effort to enhance promotion of National HIV Testing day. "Get Texted" is designed for cell phone users to find local HIV test sites by texting their zip code to 36363. Individuals using this free service receive a series of options allowing them to further delineate the type of test sites about which they would like to receive more information. Examples are sites serving women, Spanish speakers, youth, and LGBT populations. All test sites in Philadelphia are included in the service. Users are provided with adjacent test sites if none are available within their immediate zip code.

PDPH's Prison AIDS Project delivers HIV prevention education to inmates in the Philadelphia Jail system. The project's primary focus is to lessen the fear associated with HIV disease and to promote HIV prevention and AIDS awareness education to the incarcerated population. In addition, PDPH serves as an internal information and training resource for all jail staff.

Ten educational presentations and workshops are delivered to Philadelphia Jail system inmates: HIV/AIDS 101, Sexually Transmitted Diseases, Women's Reproductive Health, Men's Reproductive Health, Birth Control, Self Esteem, Nutrition and Health, Stress Management, Healthy Relationships, and Domestic Violence. Presentation topics for jail staff include: AIDS, a Public Health Issue, HIV and Incarcerated Population, Defining HIV, Defining AIDS. The Immune System and AIDS, HIV Transmission, Prevention of HIV Transmission, HIV Antibody Test, Jail Staff Concerns, and Legal Issues (State Act 148).

1. <u>What was PDPH's 2009 funding for the activity?</u>

PDPH's 2009 funding for "Get Texted" was $36,000 and for the Prison AIDS Project was $255,000.

2. <u>How many agencies were funded?</u>

Both programs are implemented by PDPH.

3. <u>What did the agencies accomplish?</u>

As of 9/30/10, "Get Texted" served 888 unique individuals. The first six months of the campaign (July-December 2009) focused on distribution of campaign promotional materials at community events and through provider outreach.

Through the Prison AIDS Project, 12,258 inmates received HIV prevention education in 399 presentations; training and technical assistance was provided to 206 jail staff.

4. What other funding is available for the activity?

No other funding is available for these activities.

B. Goal Setting

Goal 16.1: Information about where to get tested is easily obtained by the general population.

This plan proposes to continue and expand "Get Texted" with media placement and promotion in order to reach more general and targeted populations in need of access to testing. In January 2010, PDPH launched a six month public transit campaign to promote and diffuse "Get Texted" within neighborhoods with high HIV/AIDS prevalence. Transit posters were strategically placed on the Broad Street Line (which traverses the City north to south) and on bus routes that cover almost the entire city, including many high-risk neighborhoods. With additional supplemental funds from the CDC, this public transit effort was repeated during the last three months of 2010. The plan also provides for development of a targeted media campaign for high-risk youth, leveraging the condom campaign described in Intervention 15.

Goal 16.2: HIV and sexual health information is available to persons entering Philadelphia jail system.

Philadelphia jail system inmates are an especially high risk population. This goal will enhance HIV screening of all incoming inmates as well as condom distribution in the jail. Health literacy is low among most inmates, and this goal aims to increase awareness of and knowledge of fundamental HIV-related topics, including but not limited to HIV risk, the benefits of knowing one's status, and how people with HIV can achieve health and wellness.

Intervention 17: Support Clinic-Wide or Provider-Delivered Evidence-Based HIV Prevention Interventions for HIV-Positive Patients and Patients at Highest Risk of Acquiring HIV

A. Situational Analysis

Currently, no formal program is implemented to support clinic-wide or provide-delivered evidence-based HIV prevention for HIV-positive patients and persons at highest risk of acquiring HIV.

1. What was PDPH's 2009 funding for the activity?

No funding was budgeted in 2009 for this activity.

2. How many agencies were funded?

None.

B. Goal Setting

Goal 17.1: HIV-positive persons receive evidence-based HIV prevention interventions during their clinic or provider visits. (ECHPP YEAR 2)

To improve risk reduction activities conducted by PDPH-funded medical providers and MCM providers, this plan proposes to review and select appropriate interventions for later implementation. The criteria will be to identify low cost, easy to deliver, low threshold activities appropriate to different clinical settings such as Safe in the City for the STD clinic, the HIV Intervention for Providers intervention (Rose, Courtenay-Quirk, et al. 2010), and Partnership for Health. Another criterion is the ability to provide ongoing training to the clinicians in the PDPH system of HIV medical care. This activity will further strengthen the risk reduction activities already underway in PDPH RW funded care settings, by implementing formal, evidence-based programs.

In the current ECHPP year, PDPH will conduct formative work to identify intervention(s) to be implemented in ECHPP Year 2. The availability of these relatively low-cost interventions will complement the more expensive evidence-based interventions described above in Intervention 13 (behavioral risk screening and EBIs). Because of cost constraints, this goal targets high risk HIV-positive persons, ensuring that risk reduction interventions are available to a wider patient population following risk screening (Intervention 13).

Intervention 18: Conduct Community Interventions that Reduce HIV Risk

A. Situational Analysis

1. What was PDPH's 2009 funding for the activity?

PDPH provides $366,439 in funding for evidence based community level interventions.

2. How many agencies were funded?

The PDPH supports three ASOs to implement *Community Promise* targeting MSM. *Community Promise* is a community-level intervention to promote progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk reduction supplies.

PDPH also supports one agency to provide *Mpowerment* for young MSM. In 2009, 348 persons were reached with this intervention.

3. What did the agencies accomplish?

In 2009, a total of 1,570 persons were reached.

4. What other funding is available for the activity?

CDC directly funds The Philadelphia AIDS Consortium (TPAC) to implement *Popular Opinion Leader* in faith-based organizations. TPAC plans to reach 300 people in 2010, including provision of HIV testing through faith-based organizations and at the agency's main site.

CDC directly funds Mazzoni Center for *Community Promise* to target MSM of color. Mazzoni's plan is to create 8 new role model stories per year along with HIV testing.

Two additional HIV prevention programs are funded directly by CDC. The Family Planning Council of Southeastern Pennsylvania and Public Health Management Corporation, which collaborate with the other directly-funded agencies as a group and with PDPH-funded providers, target African American MSM and African American heterosexuals, respectively.

B. Goal Setting

Goal 18.1: Provide coordinated community level interventions.

This plan will continue the 4 currently PDPH-funded community level interventions, and will identify one community in 2011 for implementation of a CLI in 2012. Currently, four *Community Promise* projects are available in Philadelphia, each of which targets MSM. In light

of a recent MSM needs assessment discusses duplication of services and lack of coordination among providers regarding HIV prevention interventions targeting MSM. This goal maximizes existing resources and focuses these efforts to better mobilize this high risk community (Public Health Management Corporation, 2010).

This goal optimizes resources by shifting from an uncoordinated combination of isolated community-level interventions to a fully coordinated and comprehensive approach to resource allocations. Although service contracts with CLI providers are in place for the existing programs, formative work during the first ECHPP year will select one community or population and develop an implementation process for allocation of resources to maximize reduction in HIV incidence.

Intervention 19: Support Behavioral Risk Screening Followed by Individual and Group-Level Evidence-Based Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV; Particularly those in an HIV-Serodiscordant Relationship

A. Situational Analysis

Local data from the National HIV Behavioral Surveillance (NHBS) study provides information about exposure to prevention activities for different high risk groups. The National HIV Behavioral Surveillance asks high risk people if they have spoken to a health educator in the last 12 months about HIV prevention activities. Many Philadelphia respondents had spoken to a health educator in the last 12 months, including 3.8% of heterosexuals, 21.8% of IDU, and 7.3% of MSM. NHBS also asks if respondents had participated in a group session about HIV prevention in the last 12 months. Philadelphia NBHS respondents also participated in group sessions about HIV prevention, including 2.2% of heterosexuals, 9.7% of IDUs, and 3.6% of MSM.

1. What was PDPH's 2009 funding for the activity?

The Health Department's funding for this intervention is $1,656,959 from a combination of CDC, State, and City funds. Delivering evidence-based interventions (EBIs) is comparatively expensive on a per client per year basis.

2. How many agencies were funded?

In 2009, 15 agencies served 2,387 high-risk HIV negative individuals. This amounts to approximately $881 per client per year.

3. What did the agencies accomplish?

PDPH-funded agencies served 2,387 high-risk negatives in 2009 with the following individual and group interventions:

Individual and Group Level Interventions	# served in 2009
BART for African American and other high-risk minority adolescents	292
Be Proud be Responsible for African American and other high-risk minority adolescents	548
Comprehensive Risk Counseling Services	321
Many Men Many Voices	298
Preventing AIDS through Live Movement and Sound (PALMS) for African American adolescents	109
Project Respect	46
RAVE, a local innovation	38
Safety Counts for Injecting Drug Users	264
Video Opportunities for Innovative Condom Education and Safer Sex (VOICES) for African American and Latinos	471
Total	**2,387**

4. What other funding is available for the activity?

In addition, the CDC funds several community based organizations directly:

- PHMC serves approximately 100 African American women aged 14-18 with *Sihle;*
- Mazzoni Center's CRCS reaches approximately 70 individuals per year;
- Family Planning Council serves approximately 310 African American MSM and heterosexual men with its D-UP and NIA programs.
- The Philadelphia AIDS Consortium implements Popular Opinion Leader targeting faith-based organizations.

B. Goal Setting

Goal 19.1: High-risk HIV-negative persons get appropriate EBIs based on results of behavioral screening.

While bringing EBIs to the scale needed to assure long-term behavior change is cost-prohibitive, targeting resources to persons at very high risk is appropriate and feasible. PDPH proposes to better target high risk populations, and to shift emphasis and funding to HIV prevention interventions for HIV-positive persons. Contracts are currently in place, so the changes will made in 2012. In the meantime, ECHPP funds will support a new evidence-based pilot program for high-risk adolescents identified through school-based STD screening, as described in Intervention 15.

Intervention 20: Integrate Hepatitis, TB, and STD Testing, Partner Services, Vaccination, and Treatment for HIV-Infected Persons, HIV-Negative Persons at Highest Risk of Acquiring HIV, and Injection Drug Users According to Existing Guidelines

A. Situational Analysis

Soon after CDC released national guidance on Program Collaboration and Service Integration (PCSI), PDPH initiated a PCSI Workgroup to develop and implement projects and initiatives across programs in order to provide comprehensive services to their clients, and better serve their shared at-risk populations. The Workgroup is comprised of representatives from the principal City agencies (AIDS Activities Coordinating Office, the STD Control Program, the Tuberculosis Control Program, the Viral Hepatitis Prevention Program, and the Office of Addiction Services (OAS). Other internal PDPH programs closely involved with the initiative include the Acute Communicable Disease (ACD) Program, and the Immunization Program. The local AETC performance site and the Drexel School of Public Health also participate.

1. What was PDPH's 2009 funding for the activity?

No funding was available in 2009. In September 2010, PDPH was funded by CDC for $336,054 per year for 3 years to continue to develop and promote PCSI initiatives.

2. How many agencies were funded?

This is a PDPH program.

3. What did the agencies accomplish?

The Philadelphia PCSI Workgroup was formally established in May 2008, and has served as a forum for disease programs to discuss and address areas for increased program collaboration and service integration. Projected Philadelphia PCSI Strategies and Activities as of October 2010 are:

- Cross systems provider training
- Integrated screening and case finding
- Shared planning and data analysis
- Collaborative surveillance and data activities
- Support for community providers
- Integrated risk assessment
- Expanded linkage and referral resources
- Integrated consumer materials

4. What other funding is available for the activity?

No other funding PCSI is available.

B. Goal Setting

Goal 20.1: Promote the provision of integrated services to clients for maximum public health benefit.

A variety of PCSI-related projects have been developed and will be implemented throughout the funding period. PCSI is a structural intervention that aims to reshape the context in which programs and services for HIV/AIDS, STD, viral hepatitis, and tuberculosis are provided, acknowledging that each disease-specific service system varies in its history and development, funding source, and programmatic aims. The Philadelphia PCSI Initiative aims to create an environment where programs can identify opportunities for program collaboration and service integration, and use surveillance and programmatic data to provide comprehensive and appropriate services to at-risk clients. PCSI also aims to ensure that resources are used appropriately and that provision of comprehensive services is acceptable to both clients and programs.

The Philadelphia PCSI Initiative considers cross systems provider training, integrated screening and case finding, shared planning and data analysis, collaborative surveillance and data activities, increased support for community providers, expanded linkage and referral resources, and integrated comprehensive prevention materials.

Intervention 21: Target Use of HIV and STD Surveillance Data to Prioritize Risk Reduction Counseling and Partner Services for Persons with Previously Diagnosed HIV Infection with a New STD Diagnosis and Persons with a Previous STD Diagnosis who Receive a New STD diagnosis

A. Situational Analysis

In 2010, 171 new syphilis cases among persons with known HIV infection were reported in Philadelphia. These are currently considered priority cases. However, the HIV diagnosis in these cases is based on self-report or HIV testing of new syphilis cases. Potentially, many additional cases of co-infection are not identified. Data is currently not shared between the HIV surveillance program and the STD Control Program. In the past year, PDPH has initiated efforts to standardize security and confidentiality policies between HIV and STD surveillance programs. A Memorandum of Understanding between the two PDPH units enables data sharing for the purposes of identifying priority cases for referral to partner services.

B. Goal Setting

Goal 21.1: Identify and test for HIV and STDs the partners of persons with known HIV infection and a new syphilis diagnosis.

PDPH currently is unaware of the full extent of HIV and syphilis co-infection and is unable to track co-infection with other STDs. This goal will initiate the process for use of HIV and STD surveillance data sharing to identify high priority cases for partner services. Following implementation of data sharing, PDPH will develop a plan for prioritizing cases for referral to partner services with co-infection of HIV and other STDs. PDPH disease investigators will locate co-infected persons to offer partner services and identify partners for testing and treatment. The impact of these efforts will increase the number of people with HIV who are aware of their HIV status.

Interventions Not Included

- **Intervention 22: For HIV-negative Persons at Highest Risk of Acquiring HIV, Broadened Linkages to and Provision of Services for Social Factors Impacting HIV Incidence such as Mental Health, Substance Abuse, Housing, Safety/Domestic Violence, Corrections, Legal Protections, Income Generation, and Others.**
- **Intervention 23: Brief Alcohol Screening and Interventions for HIV-Positive Persons and HIV-Negative Persons at Highest Risk of Acquiring HIV.**
- **Intervention 24: Community Mobilization that Create Environments that Support HIV Prevention by Actively Involving Community Members in Efforts to Raise HIV Awareness, Building Support for and Involvement in HIV Prevention Efforts, Motivating Individuals to Work to End HIV Stigma, and Encouraging HIV Risk Reduction Among Their Family, Friends, and Neighbors.**

Intervention 25: Syringe Access Services

A. Situational Analysis

PDPH has provided City General Revenue Funds for syringe access services for many years, under the authority of the Philadelphia Board of Health's determination of the presence of a public health emergency among IDUs. Prevention Point Philadelphia (PPP), one of the nation's first syringe exchange programs (SEPs), is supported with City General Revenue Funds. The SEP model is based on NIDA's *Principles for Effective HIV Prevention Outreach with Injection Drug Users*, which calls for services to be provided to individuals in their own neighborhoods and to be available at a variety of locations at a range of times, and to provide a comprehensive range of services.

The Philadelphia SEP distributes sterile syringes to registered clients using a standard protocol of exchanging syringes one for one. In addition to syringes, PPP provides safer injecting and safer sex supplies such as bleach, water, cotton balls, alcohol pads, antiseptic toilettes, antibiotic ointment, and Band-Aids. Safer sex supplies include condoms, female condoms, lubrication, dental dams, and sanitary disposable gloves. Clients are informed of services available through the SEP and PPP's Harm Reduction Services Center (HRSC) and receive information regarding the risks associated with injection drug use and sex work, and are provided with skills and strategies for reducing drug-related harm. PPP has several sites serving the distinct needs associated with each geographic location's drug culture, including the Center City neighborhood with a strong presence of gay and lesbian residents and business establishments, and the heroin, coke and crack users of North Philadelphia.

1. What was PDPH's 2009 funding for the activity?

Funding for this activity in 2009 was $232,413 through the City's Office of Addiction Services.

2. How many agencies were funded?

One agency, Prevention Point Philadelphia (PPP), has received funding for this activity.

3. What did the agencies accomplish?

In 2009, PPP made 10,952 contacts with 3,307 unique clients, dispensed 1.5 million syringes, and disposed of 1.5 million used syringes through nearly 11,000 contacts with 3,300 unique exchangers. In total, PPP served more than 4,000 unduplicated clients, including 557 clients within the mobile Street-side Health Project (SHP), which provides PPP clients with medical consultations, health screening, and wound care. PPP provided 1,020 rapid HIV tests, identified 63 individuals as HIV-positive, and linked them to medical care. PPP also provided 1,621 service referrals to link clients with public benefits assistance, primary and specialty medical care, family planning services, legal services, behavioral health care, housing assistance, domestic violence services, food and clothing, and many other social services. PPP's mobile unit visits six

fixed locations citywide. These services are provided by volunteer physicians and medical students from Philadelphia's four medical schools.

4. What other funding is available for the activity?

In 2009, PPP received $77,180 directly from corporations and foundations to support the organization and its services.

B. Goal Setting

Goal 25.1. Intravenous drug users always use clean equipment.

Syringe access services supported by PDPH are believed to have contributed to the remarkable decline in the number of IDUs contracting HIV/AIDS in Philadelphia. PPP's services have also helped many individuals resolve criminal justice system barriers to care (such as outstanding bench warrants) so that they can access medical assistance, tested thousands of hard-to-reach individuals, and reduced the number of unnecessary emergency room visits through our free mobile medical unit. In 2010, PPP further expanded its capacity as a bridge to treatment through a pilot program to provide its clients access to buprenorphine medications as an alternative to active drug users who seek opiate addiction treatment.

Process Information

This section provides information on who participated in developing this plan, the data that were used, and the decision-making process that was followed. All plan strategies are cost-effective and efficacious public health approaches that will work together to maximize their intended impact, address the need in Philadelphia, and leverage other resources, including coordination across funding streams.

Step 1: Situational Analysis

Meetings

To develop the Situational Analysis, ECHPP planners met with:

Donald F. Schwarz MD MPH, Deputy Mayor for Health and Opportunity and Commissioner of Health
PDPH Chief of Staff, Nan Feyler JD MPH
PDPH AACO Director, Jane Baker MA
PDPH AACO Program Administrator, Coleman Terrell
PDPH AACO Medical Director/Medical Epidemiologist, Kathleen A. Brady MD
PDPH AACO Client Services Unit Manager, Evelyn Torres MSW
PDPH AACO Information Services Unit Manager, Marlene Matosky, RN MPH
PDPH AACO Education Unit Manager, Philip DiBartolo MPH
PDPH AACO HIV Prevention Coordinator/CPG Governmental Co-Chair, David Acosta
PDPH AACO HIV Prevention Evaluation Coordinator, Patricia A. Jones MPA
PDPH AACO Consultants, Amy Nunn PhD, Jerry Macdonald PhD, and Matthew McClain
PDPH STD Control Program Manager Melinda Salmon
PHPH STD Control Program Special Projects Coordinator Andrew de los Reyes
PDPH STD Control Program Epidemiologist, Lt. Commander USPHS Felicia M. T. Lewis MD
PDPH PSCI Coordinator Marcelo Fernandez-Viña
PA Department of Public Welfare SPBP Coordinator (ADAP Program) Cheryl Henne
PA DOH HIV Prevention Section Chief Kenneth McGarvey
CDC Project Officers Angie Alvarado MHS and Cari Courtenay-Quirk PhD

The ECHPP team, led by PDPH/AACO Program Administrator Coleman Terrell, jointly developed the Situational Analysis. Members include PDPH/ AACO Medical Director/Medical Epidemiologist, HIV Prevention Coordinator, HIV Prevention Evaluation Coordinator, Information Services Unit Coordinator, and consultants.

ECHPP planners held two meetings with Deputy Mayor for Health and Opportunity and Commissioner of Health Donald F. Schwarz and PDPH Chief of Staff Nan Feyler. In the first meeting, the ECHPP process was reviewed and principles for guiding the process were developed. A second meeting was held with the Deputy Mayor and Chief of Staff upon

completion of the draft plan that contained consensus recommendations for goals and objectives for review and comment.

In addition, AACO met with the City of Philadelphia Board of Health, a departmental body of the Philadelphia Department of Public Health. The Board is composed of the Health Commissioner, who serves as President, and seven Mayoral appointees. The Board is responsible for promulgating the health regulations of the Department of Public Health. These regulations establish public health standards for administration and practice that effectively control public health hazards and preserve and promote the health of the people of Philadelphia. Board members review scientific, technical, and administrative advances in the field of public health to ensure that the City's health regulations reflect best possible practices. In November 2010, the Board reviewed data from the Philadelphia Youth Risk Behavioral Survey and an update on HIV/AIDS among youth. Subsequently, Deputy Mayor Schwarz convened two meetings with administrative and program staff from AACO and STD Control to initiate a focused collaboration to expand PDPH activities addressing HIV and STD youth risk behaviors in Philadelphia.

Further, PDPH attended meetings of the Philadelphia Community Planning Group and Ryan White Planning Council to provide updates on the ECHPP process.

Available Data

In addition to information provided to ECHPP grantees by CDC, data from numerous sources form the evidentiary basis for the plan. These include local epidemiologic data, information on current resources, organizational partners, and funding streams, as well as efficacy, cost, and cost effectiveness data. We also utilized public data sets such as those of CDC, the U.S. Census, and other sources.

However, the preponderance of information used to develop this plan was derived from local sources, listed below. The primary source is PDPH itself, whose data capacity has expanded and improved in partnership with CDC and HRSA for over 20 years, including robust HIV/AIDS, STD, TB, and Hepatitis surveillance, regular special studies, and ongoing client- and population-level quality management data on persons receiving PDPH-funded services.

Surveillance and Survey Data

- Core HIV/AIDS Surveillance
- Medical Monitoring Project
- Enhanced Perinatal Surveillance
- Fetal Infant Mortality Review HIV
- Test, Link to Care Plus
- National HIV Behavioral Surveillance
- Youth Risk Behavioral Surveillance Survey

Program and Performance Data

- Ryan White Program Part A and Part B CAREWare Quality Management Program, including clinical performance data on the entire population of persons with HIV/AIDS (>9,000) receiving PDPH-funded HIV medical care in Philadelphia (about 66% of people in care) and program performance data on clients served by PDPH-funded services for persons living with HIV/AIDS.
- PEMS, including data on all publically funded HIV testing in Philadelphia and data on all PDPH-funded prevention interventions.
- PDPH/AACO Fiscal Unit cost data
- PDPH/AACO Program Unit program monitoring and site visit data

Unavailable Data

Even with substantial levels of available data that directly informed the study of ECHPP interventions, the planning process would have benefitted from acquiring:

- Data on HIV testing in settings not funded by PDPH such as private physicians and other payers.
- Data on persons testing negative for HIV screened outside of the publicly funded system.
- Data on persons living with HIV/AIDS receiving care outside of the Ryan White system that is comparable in depth and quality to the data on persons served by RW funding through PDPH to compliment data on this population available from MMP, a representative sample of all people with HIV/AIDS.

Step 2: Goal Setting

ECHPP is a rare opportunity for the City of Philadelphia to implement significant policy changes and program enhancements to reduce new HIV infections, increase access to care while improving health outcomes for people living with HIV, and reduce HIV-related disparities. Deputy Mayor of Health and Opportunity and Health Commissioner Donald Schwarz (a pediatrician with over 25 years of clinical, administrative, and research experience) strongly advocates for and promotes preventive approaches to public health and wellness, particularly with respect to HIV. The goals of this plan reflect the core principles of health and wellness for all Philadelphians as envisioned by Dr. Schwarz and his senior staff, who are fully committed to and will be actively engaged in guiding PDPH and the community through the ECHPP process.

The most useful sources of data were PDPH ongoing and special surveillance studies (such as MMP), NHBS, local Ryan White quality management data, and program monitoring data from PDPH-funded HIV prevention services.

In addition, new modeling was conducted to further inform the plan. PDPH performed geo-mapping to overlay HIV/AIDS prevalence data with clinical sites offering HIV testing, condom distribution sites, and HIV care and treatment sites. Further, Ryan White CAREWare data were

extracted to identify disparities in access and linkage to HIV care. Analysis of STD diagnoses in relation to subsequent HIV infection was also conducted. PDPH will continue to use these and other methods to target resources to meet local and national objectives.

In addition to the unavailable data listed above, a longer amount of time to develop the plan would have been helpful to support goal setting. The lack of time meant that planning activities that typically occur in distinct steps instead overlapped or were concurrent. Additional time would have allowed for a fuller consideration of the ECHPP planning tools, more use of available data sets, more of an opportunity to consider such questions as how the various interventions will (or will not) link together and what might be the potential unintended consequences of a planned activity or its timing.

Goal setting was an iterative process based on CDC guidance, direction from the Commissioner of Health, available data, and literature reviews (including commentaries and editorials), along with the use of guiding principles developed specifically for ECHPP; these are listed in the Guide to Readers. Preliminary goals evolved during two all-day sessions in which the planning team and key PDPH personnel used a facilitated nominal group process to develop consensus recommendations.

The Pennsylvania Department of Health, which administers Ryan White Part B and CDC HIV Prevention Cooperative Agreement funds, was provided a draft of the planned interventions and its comments were incorporated into the plan. PDPH also planned specific activities for ECHPP implementation with the State's HIV prevention and ADAP staff. ECHPP will be discussed at quarterly meetings between PDPH and the City's Office of Addiction Services, which administers the local portion of the SAMHSA Community Block Grant for Pennsylvania.

Finally, Deputy Mayor for Health and Opportunity Schwarz reviewed the preliminary goals resulting from this process, and gave his approval.

Appendix 1: Primary Data Sources

Primary data for this Workbook are from two primary internal sources: the Surveillance Unit and the Information Services Unit of the PDPH AIDS Activities Coordinating Office:

Surveillance Unit Datasets

- Core Surveillance (CS)
- Enhanced Perinatal Surveillance (EPS)
- Fetal Infant Mortality Review (FIMR) for HIV-related cases
- Medical Monitoring Project (MMP), a representative sample of HIV-positive persons in care
- National HIV Behavioral Surveillance (NHBS) for IDU, heterosexual, and MSM data
- Test, Link to Care Plus (TLC Plus)
- Youth Risk Behavioral Surveillance Survey (YRBSS)

Information Services Unit Datasets

- PEMS/CTR Data, includes all publically funded HIV testing in Philadelphia
- PEMS Data, includes PDPH-funded prevention interventions other than CTR
- Ryan White Program CAREWare Program Data, client-level data for all PDPH-funded RW services
- Ryan White Program CAREWare Quality Management Data, clinical population data on >9,000 persons in PDPH-funded HIV medical care in Philadelphia (about 66% of all people with HIV/AIDS in care)

Shared Datasets

Through the ECHPP plan, AACO and the PDPH STD Control Program's Disease Control Monitoring System will share data for the identification of undiagnosed cases of HIV infection and other purposes, including defining and describing the patterns of STD and HIV co-infections, program design, and program monitoring.

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Appendix 3: Additional Local Data

The source for all data shown below is the Philadelphia Department of Public Health. This data reflects PDPH-funded testing only.

HIV-positive Persons Identified by HIV Screening in Clinical Settings and Linked to Care and Services, 2009									
Number of Tests	New Positives	Sero-positivity Rate	Received Result	Return Rate	Referred to Care	Linked to Care	Linkage Rate	Referred to Partner Services	Partner Services Rate
53,166	**326**	**0.61%**	**183**	**56%**	**171**	**148**	**45%**	**146**	**45%**

HIV Screening in Clinical Settings and Linkage to Care and Services, by Gender, 2009										
Gender	Tests	New Positives	Sero-positivity Rate	Received Result	Return Rate	Referred to Care	Linked to Care	Linkage Rate	Referred to Partner Services	Partner Services Rate
Female	26,137	88	0.34%	65	74%	65	51	58%	55	63%
Male	26,689	235	0.88%	115	49%	105	95	40%	89	38%
Trans-F2M	3	0	0.00%	0	-	0	0	-	0	-
Trans-M2F	28	3	10.71%	3	100%	1	2	67%	2	67%

HIV Screening in Clinical Settings and Linkage to Care and Services, by Age Group, 2009										
Age Group	Tests	New Positives	Sero-positivity Rate	Received Result	Return Rate	Referred to Care	Linked to Care	Linkage Rate	Referred to Partner Services	Partner Services Rate
>12	628	2	0.32%	2	100%	2	2	100%	1	50%
13-24	22,075	87	0.39%	35	40%	33	31	36%	26	30%
25-44	21,308	163	0.76%	97	60%	90	76	47%	77	47%
44+	8,535	74	0.87%	49	66%	46	39	53%	42	57%

HIV Screening in Clinical Settings and Linkage to Care and Services, by Race/Ethnicity, 2009										
Race/ Ethnicity	Tests	New Positives	Sero-positivity Rate	Received Result	Return Rate	Referred to Care	Linked to Care	Linkage Rate	Referred to Partner Services	Partner Services Rate
Asian	1,197	4	0.33%	2	50%	1	1	25%	1	25%
Black/AA	37,646	262	0.70%	146	56%	138	119	45%	119	45%
DK/Declined	3,786	21	0.55%	8	38%	8	8	38%	7	33%
Hispanic	2,984	13	0.44%	10	77%	8	6	46%	7	54%
Other	653	4	0.61%	3	75%	2	2	50%	2	50%
White	6,335	20	0.32%	12	60%	12	10	50%	10	50%

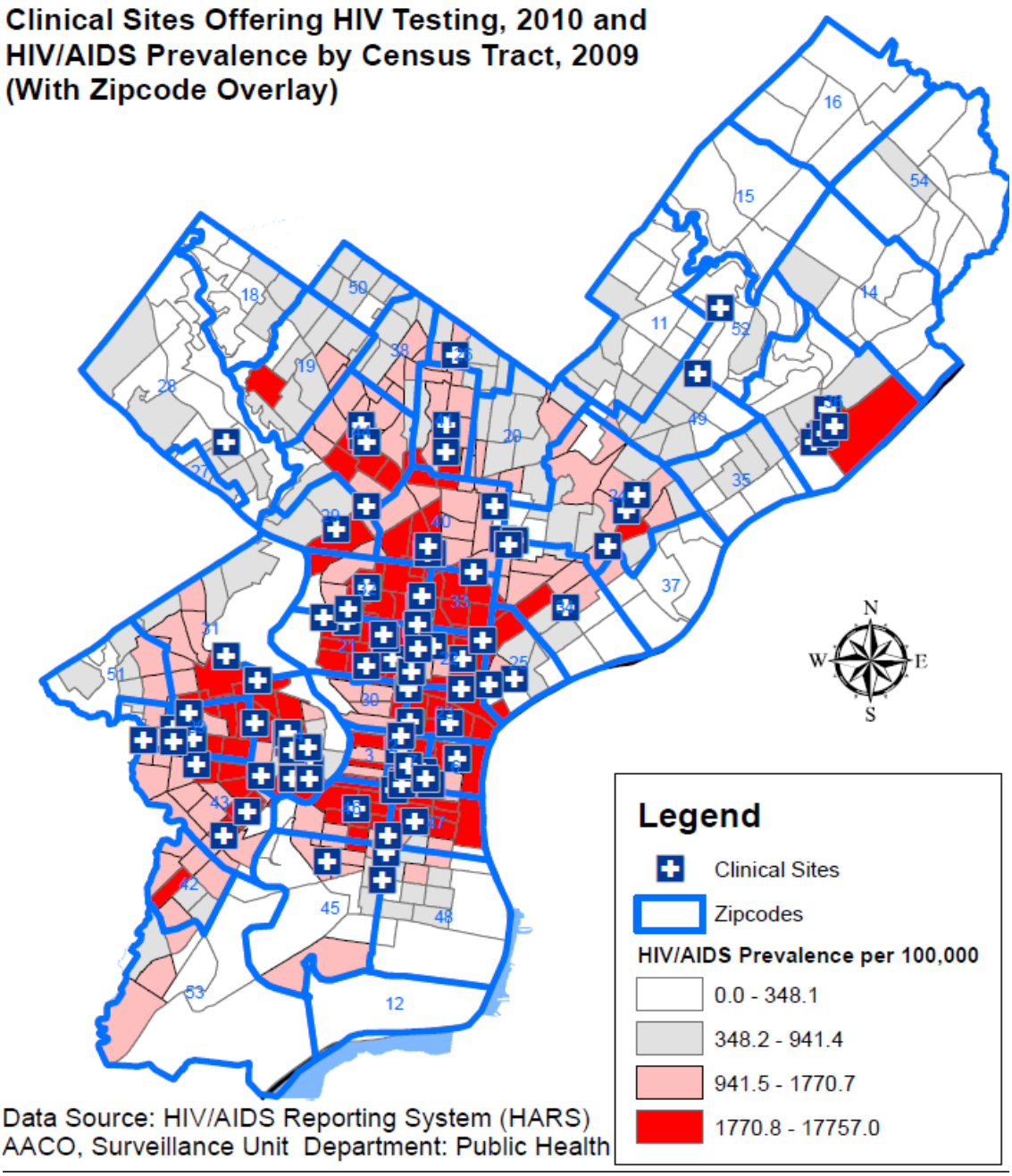
HIV Screening in Clinical Settings and Linkage to Care and Services, by Risk Group, 2009										
Risk Group	Tests	New Positives	Sero-positivity Rate	Received Result	Return Rate	Referred to Care	Linked to Care	Linkage Rate	Referred to Partner Services	Partner Services Rate
HET	31,255	87	0.28%	77	89%	73	61	70%	58	67%
IDU	1,366	17	1.24%	8	47%	7	3	18%	5	29%
MSM	5,440	109	2.00%	39	36%	36	37	34%	33	30%
NIR	5,100	18	0.35%	11	61%	9	6	33%	7	39%
Unknown	4,507	49	1.09%	35	71%	34	33	67%	33	67%
Other	4,701	42	0.89%	11	26%	10	7	17%	9	21%

Linkage to Care for 2009 HIV Diagnoses
All Cases Reported to PDPH Regardless of Funding Source

	Link to Care (in months)										Total	
	CD4/VL in 3		CD4/VL in 4-6		CD4/VL in 7-12		CD4/VL in gt 12		No Care Linkage			
	N	Row %	N	Row %	N	Row %	N	Row %	N	Row %	N	Col %
Total	519	55.5 %	7	0.7 %	11	1.1 %	*	0.5 %	392	41.9 %	934	100.0 %
Race												
Black	352	56.4 %	*	0.6 %	*	0.8 %	*	0.1 %	262	41.9 %	624	66.8 %
White	85	55.1 %	*	0.6 %	*	1.2 %	*	1.9 %	63	40.9 %	154	16.4 %
Hispanic	73	52.5 %	*	1.4 %	*	2.8 %	*	0.7 %	59	42.4 %	139	14.8 %
Asian	*	41.6 %	0	0	0	0	0	0	7	58.3 %	12	1.2 %
Multi-race	*	100.0 %	0	0	0	0	0	0	0	0	*	0.4 %
Other/Unk	0	0	0	0	0	0	0	0	*	100.0 %	*	0.1 %
Gender												
Female	136	53.9 %	*	0.3 %	*	0.7 %	*	0.3 %	112	44.4 %	252	26.9 %
Male	383	56.1 %	6	0.8 %	9	1.3 %	*	0.5 %	280	41.0 %	682	73.0 %
Age at HIV												
< 13	*	100.0 %	0	0	0	0	0	0	0	0	*	0.2 %
13-24	120	53.0 %	0	0	*	0.8 %	0	0	104	46.0 %	226	24.1 %
25-34	136	56.4 %	*	0.8 %	*	0.4 %	*	0.8 %	100	41.4 %	241	25.8 %
35-44	122	56.4 %	*	1.3 %	*	1.3 %	*	1.3 %	85	39.3 %	216	23.1 %
45-54	97	55.4 %	*	0.5 %	*	2.2 %	0	0	73	41.7 %	175	18.7 %
55+	42	56.7 %	*	1.3 %	*	1.3 %	0	0	30	40.5 %	74	7.9 %
Exposure												
MSM	216	60.6 %	*	0.2 %	*	0.5 %	*	0.5 %	135	37.9 %	356	38.1 %
IDU	49	46.6 %	*	1.9 %	*	4.7 %	*	1.9 %	47	44.7 %	105	11.2 %
Heterosexual	130	54.6 %	*	0.8 %	*	0.8 %	*	0.4 %	103	43.2 %	238	25.4 %
MSM/IDU	*	33.3 %	0	0	0	0	0	0	6	66.6 %	9	0.9 %
Pediatric	*	100.0 %	0	0	0	0	0	0	0	0	*	0.2 %
No Risk Reported	119	53.1 %	*	0.8 %	*	0.8 %	0	0	101	45.0 %	224	23.9 %

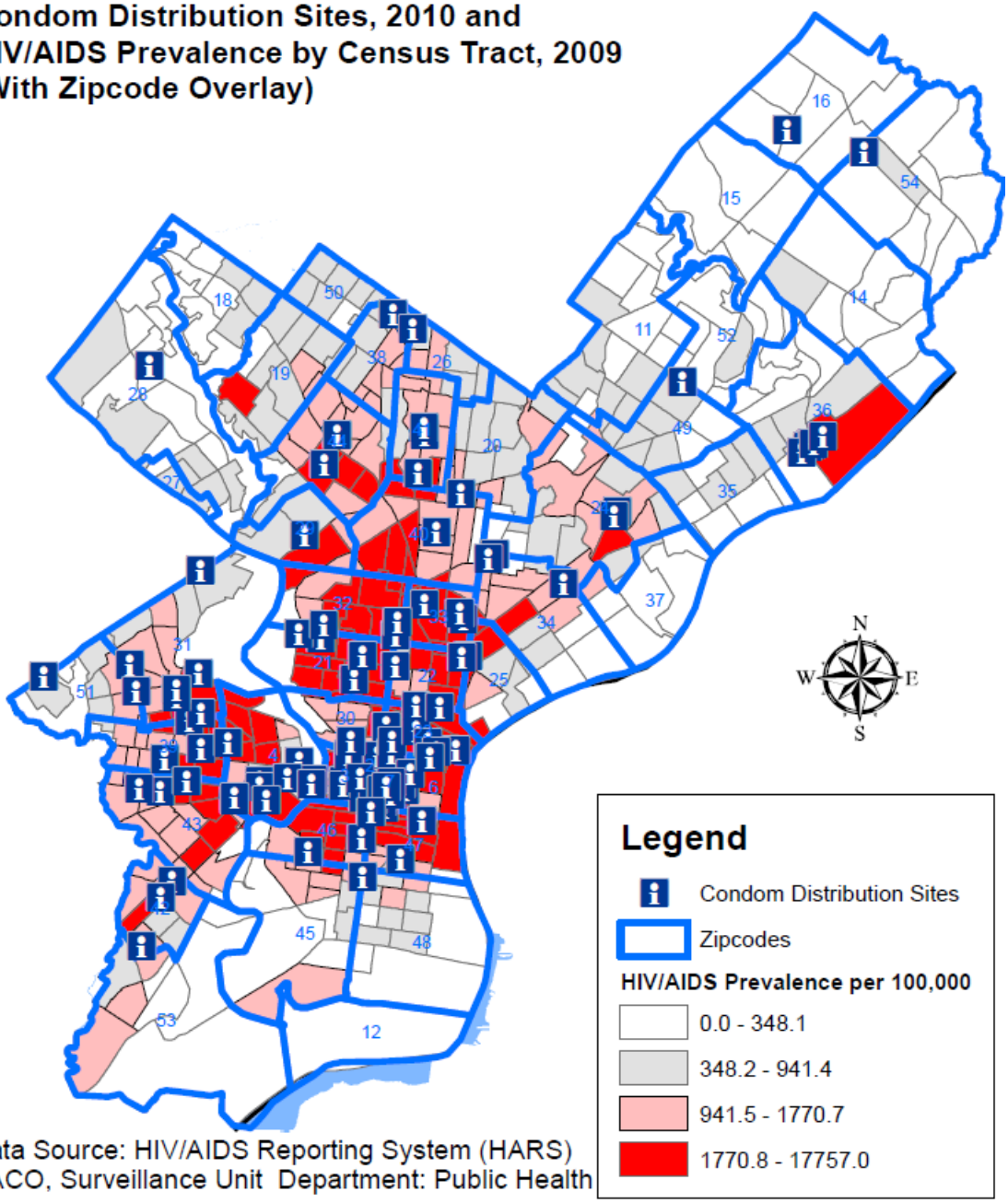
***Counts less than 6 are not reported.**
Note that cases with "No Risk Reported" are considered to be predominately Heterosexual.

Appendix 4: Maps

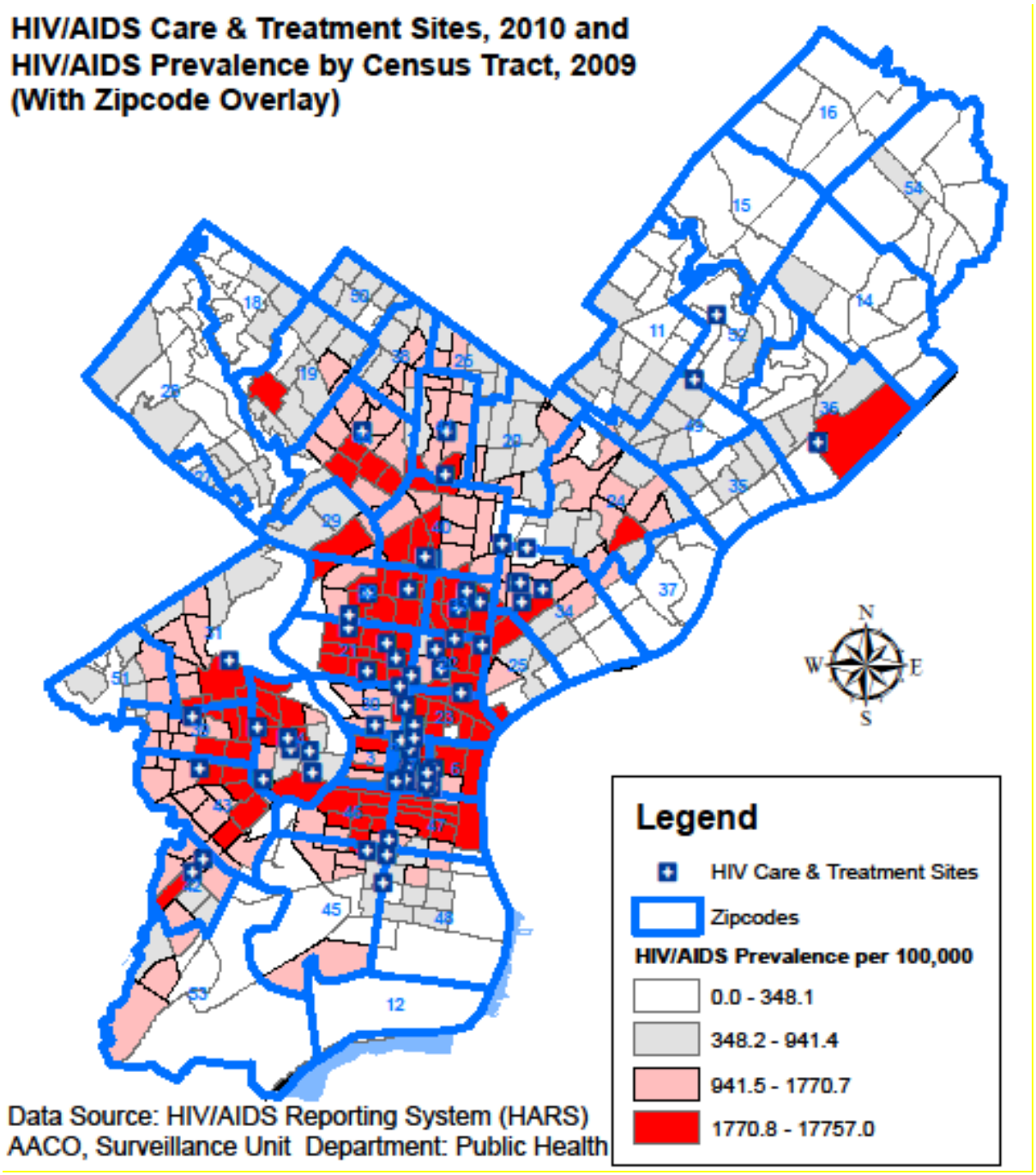


For comparison purposes, the most recent estimated national HIV/AIDS prevalence rate is 447.8 per 100,000.

Condom Distribution Sites, 2010 and HIV/AIDS Prevalence by Census Tract, 2009 (With Zipcode Overlay)



Data Source: HIV/AIDS Reporting System (HARS)
AACO, Surveillance Unit Department: Public Health


HIV/AIDS Care & Treatment Sites, 2010 and
HIV/AIDS Prevalence by Census Tract, 2009
(With Zipcode Overlay)
N
W
E
S
Legend
HIV Care & Treatment Sites
Zipcodes
HIV/AIDS Prevalence per 100,000
0.0 - 348.1
348.2 - 941.4
941.5 - 1770.7
1770.8 - 17757.0
Data Source: HIV/AIDS Reporting System (HARS)
AACO, Surveillance Unit Department: Public Health

Appendix 5: Glossary

A

AACO:

See AIDS Activities Coordinating Office.

ADAP:

See AIDS Drugs Assistance Programs.

AETC:

See AIDS Education and Training Centers.

AFFECTED COMMUNITY:

This includes HIV-positive people, persons living with AIDS and other individuals, including their families, friends and advocates, directly impacted by HIV infection and its physical, psychological and sociological ramifications.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR):

An agency of the Public Health Service that supports activities to enhance health care services and improve access to them.

AIDS ACTIVITIES COORDINATING OFFICE (AACO):

AACO is a division of the Philadelphia Department of Public Health. Its mission is to develop, monitor and evaluate all HIV/AIDS-related care and prevention services in the eligible metropolitan area (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties in Pennsylvania; Burlington, Camden, Glouster, and Salem counties in New Jersey).

AIDS DRUGS ASSISTANCE PROGRAMS (ADAP)

State-based programs funded in part by Part B of the Ryan White Program that provide therapeutics (including devices necessary to administer pharmaceuticals) to treat HIV disease or prevent the serious deterioration of health, including treatment of opportunistic infections. ADAP formularies and eligibility criteria are determined state-by-state with a focus on serving low-income individuals with HIV disease. In Pennsylvania, ADAP is administered by the Department of Public Welfare as the Special Pharmaceuticals Benefits Program (SPBP).

AIDS EDUCATION AND TRAINING CENTERS (AETC):

The Health Resources and Services Administration supports a network of regional and national centers that serve as resources for educating health professionals in prevention, diagnosis and care of HIV-infected patients. The centers train primary caregivers to incorporate HIV prevention strategies into their clinical priorities, along with diagnosis, counseling and care of HIV-infected persons and their families.

AIDS SERVICE ORGANIZATION (ASO):

A health association, support agency or other service active in the prevention and treatment of AIDS.

ANTIRETROVIRAL THERAPY

A substance or process that destroys a virus or suppresses its replication.

ART:

See Antiretroviral Therapy.

ARV:

See Antiretroviral Therapy.

ASO:

See AIDS Service Organization.

ASYMPTOMATIC:

Without symptoms. Usually used in AIDS literature to describe a person who has a positive reaction to one of several tests for HIV antibodies, but who shows no clinical symptoms of the disease.

B

BASELINE:

1. Information gathered at the beginning of a study from which variations found in the study are measured. 2. A known value or quantity with which an unknown is compared when measured or assessed.

C

CBO:

See Community-Based Organization.

CDC:

See Centers for Disease Control and Prevention.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC):

A Public Health Service agency responsible (among others) for assessing the status and characteristics of the AIDS epidemic and the prevalence of HIV infections. CDC supports the design, implementation and

evaluation of prevention activities, and maintains various HIV/AIDS information services, such as the CDC National AIDS Clearinghouse.

COMMUNITY-BASED ORGANIZATION (CBO):

A locally based service organization that provides social services at the community level.

COMMUNITY HEALTH CENTER (CHC):

See Federally Qualified Community Health Center.

COMMUNITY PLANNING GROUP (CPG):

Community planning groups are responsible for developing comprehensive HIV prevention plans that are directly responsive to the epidemics in their jurisdictions. The goal of HIV Prevention Community Planning is to improve the effectiveness of HIV prevention programs. Together in partnership, representatives of affected populations, epidemiologists, behavioral scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, determine their priority intervention needs, and identify interventions to meet those needs.

COMPREHENSIVE RISK COUNSELING AND SERVICES (CRCS):

Comprehensive Risk Counseling and Services (formerly Prevention Case Management) is an intensive, individual-level client-centered counseling for adopting and maintaining HIV risk-reduction behaviors. CRCS is designed for HIV-positive and HIV-negative individuals who are at high risk for acquiring or transmitting HIV and STDs and struggle with issues such as substance use and abuse, physical and mental health, and social and cultural factors that affect HIV risk. CRCS consists of seven core required elements, although CRCS programs may vary to suit the target population, resources, and agency mission.

CPG:

See Community Planning Group.

CRCS:

See Comprehensive Risk Counseling and Services.

D

DATABASE:

An organized compilation of information, usually maintained in a computer system.

DIAGNOSIS:

The determination of the presence of a specific disease or infection, usually accomplished by evaluating clinical symptoms and laboratory tests.

E

ECHPP:

See Enhanced Comprehensive HIV Prevention Planning.

Enhanced Comprehensive HIV Prevention Planning (ECHPP):

Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS is to facilitate the development and implementation of Enhanced Comprehensive HIV Prevention Plans (ECHPPs) for MSAs most affected by the HIV epidemic in order to reduce HIV risk and incidence in those areas. This program will be conducted in two phases. In Phase I, which will be supported under this program and will have a one year project period, grantees will develop focused ECHPPs for the targeted MSAs and begin the implementation of those plans. The plans will be guided by the best available evidence and tailored by the jurisdiction with intensive guidance from HHS/CDC. ECHPP addresses gaps in scope, reach of HIV prevention interventions and strategies among relevant populations, and coordination of HIV prevention, care and treatment services as it complements, but does not negate, the agreed upon HIV Prevention Comprehensive Plans for community planning. ECHPP is limited to 12 entities in specific Metropolitan Statistical Areas (MSAs) or specified Metropolitan Divisions (MDs) that have the highest estimated AIDS prevalence at the end of 2007,and together comprise 44% of the total estimated persons living with AIDS in the United States, including the City of Philadelphia. ECHPP is administered by the CDC's National Center for HIV/AIDS, Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention.

F

FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS (FQHCs)

Public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). Community Health Centers serve a variety of underserved populations and areas. Migrant Health Centers serve migrant and seasonal agricultural workers. Healthcare for the Homeless Programs reach out to homeless individuals and families and provide primary care and substance abuse services. Public Housing Primary Care Programs serve residents of public housing and are located in or adjacent to the communities they serve. Federally Qualified Health Center Look-Alikes are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

H

HAART:

Highly Active Antiretroviral Therapy.

HEALTH AND HUMAN SERVICES (HHS):

The U.S. government's principal agency for protecting the health of all Americans and providing essential health services, especially for those who are least able to help themselves. HHS includes hundreds of programs, administered by operating divisions such as CDC, HRSA, NIH, and SAMHSA. HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees.

HEALTH EDUCATION/RISK REDUCTION (HERR):

Health education and risk reduction (HERR) is one element of comprehensive HIV prevention. HERR activities are individual- or group-level interventions that target persons at increased risk of becoming infected with HIV or, if already infected, of transmitting the virus to others. HERR includes street and community outreach, comprehensive risk counseling and services, community-level interventions, and public information. Individual level interventions provide ongoing health communications, health education, and risk reduction counseling to assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Health communications, health education, and risk reduction interventions for groups provide peer education and support, promote and reinforce safer behaviors, and provide interpersonal skills training in negotiating and sustaining appropriate behavior change. Community-level interventions seek to reduce risk behaviors by changing community attitudes, norms, and practices through health communications, prevention marketing, community mobilization/ organization, and community events. Public information programs for the general public seek to dispel myths about HIV transmission, support volunteerism for HIV programs, reduce stigma and discrimination toward persons with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community. HERR also facilitates linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices which prevent transmission of HIV, and they help clients make plans to obtain these services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA):

A Public Health Service agency that administers (among others) education and training programs for health care providers and community service workers who care for AIDS patients. HRSA also administers programs to demonstrate how communities can organize their health care resources to develop an integrated, comprehensive system of care for those with AIDS and HIV infection. See also Public Health Service.

HEPATITIS:

An inflammation of the liver caused by certain viruses and other factors such as alcohol abuse, some medications and trauma. Although many cases of hepatitis are not a serious threat to health, the disease can become chronic and can sometimes lead to liver failure and death. There are four major types of viral hepatitis: (a) hepatitis A, caused by infection with the hepatitis A virus; (b) hepatitis B, caused by infection with the hepatitis B virus (HBV), which is most commonly passed on to a partner during intercourse, especially during anal sex, as well as through sharing drug needles; (c) non-A, non-B hepatitis, caused by the hepatitis C virus, which appears to be spread through sexual contact as well as through sharing drug needles (another type of non-A, non-B hepatitis is caused by the hepatitis E virus, principally spread through contaminated water) (d) delta hepatitis occurs only in people who are already infected with HBV and is caused by the HDV virus; most cases of delta hepatitis occur among people who are frequently exposed to blood and blood products such as people with hemophilia.

HERR:

See Health Education/Risk Reduction.

HIV DISEASE:

Characterized by a gradual deterioration of immune function. During the course of infection, crucial immune cells called CD4+ T cells are disabled and killed, and their numbers progressively decline. CD4+ T cells play a crucial role in the immune response, signaling other cells in the immune system to perform their special functions. See also Acquired Immunodeficiency Syndrome; CD4 (T4) or CD4+ Cells; Human Immunodeficiency Virus Type 1.

HOPWA:

See Housing Opportunities for People with AIDS.

HOUSING AND URBAN DEVELOPMENT (HUD):

The U.S. government's principal agency to create strong, sustainable, inclusive communities and quality affordable homes for all. HUD works to strengthen the housing market, to bolster the economy, and protect consumers; meet the need for quality affordable rental homes; utilize housing as a platform for improving quality of life; and build inclusive and sustainable communities free from discrimination. HUD administers the Housing Opportunities for People with AIDS (HOPWA) program.

HOUSING OPPORTUNITIES FOR PEOPLE WITH AIDS (HOPWA):

HOPWA is a Federal program funding provides housing assistance and related supportive services for a wide range of housing, social services, program planning, and development costs for housing for people with HIV/AIDS. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services. HOPWA is administered by the Department of Housing and Urban Development (HUD).

HRSA:

See Health Resources and Services Administration.

HUD:

See Housing and Urban Development.

I

IDU:

Injection Drug Use or Injection Drug User.

INCIDENCE:

The number of new cases occurring in a given population over a certain period of time.

INFECTION:

The state or condition in which the body (or part of the body) is invaded by an infectious agent (e.g., a bacterium, fungus or virus), which multiplies and produces an injurious effect (active infection). As related to HIV: Infection typically begins when HIV encounters a CD4+ cell. The HIV surface protein gp120 binds tightly to the CD4 molecule on the cell's surface. The membranes of the virus and the cell fuse, a process governed by gp41, another surface protein. The viral core, containing HIV's RNA, proteins and enzymes, is released into the cell. See CD4 (T4) or CD4+ Cells; gp41; gp120.

INFECTIOUS:

Capable of being transmitted by infection, with or without actual contact. See also Infection.

INFORMED CONSENT:

Type of protection available to people considering entering a drug trial. Before entering the trial, participants must sign a consent form that contains an explanation of: (a) why the research is being done, (b) what researchers want to accomplish, (c) what will be done during the trial and for how long, (d) what risks are in the trial, (e) what benefits can be expected from the trial, (f) what other treatments are available, and (g) the participant's right to leave the trial at any time. See also Clinical Trial.

M

MINORITY AIDS INITIATIVE:

The Minority AIDS Initiative (MAI) was created in 1998 by the U.S. government to respond to growing concern about the impact of HIV/AIDS on racial and ethnic minorities. It provides funding to strengthen organizational capacity and expand HIV-related services in minority communities.

MSM:

Men who have sex with men.

N

NEONATAL:

Concerning the first four weeks of life after birth.

NON-OCCUPATIONAL PRE-EXPOSURE PROPHYLAXIS (nPEP)

Daily oral antiretrovirals (tenofovir disoproxil fumarate [TDF] and emtricitabine [FTC]) to prevent acquisition of HIV infection among uninfected but exposed persons.

O

OHP:

See Office of HIV Planning.

OFFICE OF HIV PLANNING

OHP supports the activities of two decision-making bodies, the Philadelphia EMA Ryan White Part A Planning Council and the Philadelphia Prevention Community Planning Group (CPG), that plan HIV care and prevention services in the Philadelphia area. OHP also assists the Positive Committee, a group that supports and enhances the participation of people living with HIV in the community planning process through educational activities and outreach. OHP conducts needs assessment activities, produces literature reviews, organizes community outreach and educational activities, completes comprehensive plans, records and monitors official processes (including meeting minutes), collaborates with the AIDS Activity Coordinating Office (AACO) and other community and governmental organizations, and provides all logistical and administrative support for the planning bodies.

OPPORTUNISTIC INFECTION:

1. An illness caused by an organism that usually does not cause disease in a person with a normal immune system. People with advanced HIV infection suffer opportunistic infections of the lungs, brain, eyes and other organs. 2. Opportunistic infections common in AIDS patients include Pneumocystis carinii pneumonia, Kaposi's sarcoma, shigellosis, histoplasmosis and other parasitic, viral, and fungal infections, and some types of cancers. See also Histoplasmosis; Kaposi's Sarcoma; Pneumocystis carinii Pneumonia.

P

PDPH:

See Philadelphia Department of Public Health.

PERINATAL:

Events that occur at or around the time of birth.

PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH (PDPH):

The mission of the Department of Public Health is to protect the health of all Philadelphians and to promote an environment that allows us to lead healthy lives. We provide services, set policies, and enforce laws that support the dignity of every man, woman and child in Philadelphia.

PHS:

See Public Health Service.

PREVALENCE:

A measure of the proportion of people in a population affected with a particular disease at a given time.

PROPHYLAXIS:

Treatment that helps to prevent a disease or condition before it occurs or recurs.

PUBLIC HEALTH SERVICE (PHS):

A multi-agency organizational component of the US Department of Health and Human Services. See also Centers for Disease Control and Prevention; Health Resources and Services Administration; National Institutes of Health.

R

RYAN WHITE PROGRAM:

The Ryan White Program works with cities, states, and local community-based organization to provide HIV-related services to more than half a million people each year. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources. Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic. Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated Jurisdictions. Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease. Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS. Part F provides funds for a variety of programs: the Special Projects of National Significance Program grants fund innovative models of care and supports the development of effective delivery systems for HIV care; AIDS Education and Training Centers Program supports a network of 11 regional centers and several National centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. The Dental Programs provide additional funding for oral health care for people with HIV. The Minority AIDS Initiative provides funding to evaluate and address the disproportionate impact of HIV/AIDS on African Americans and other minorities. Ryan White is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts, as outlined below.

S

SEROCONVERSION:

The development of antibodies to a particular antigen. When people develop antibodies to HIV or an experimental HIV vaccine, they "seroconvert" from antibody-negative to antibody-positive. See also Antibodies; Antigen.

SEROPREVALENCE:

As related to HIV infection: The proportion of persons who have serologic (i.e., pertaining to serum) evidence of HIV infection at any given time. See also Serum.

SEROSTATUS:

Results of a test for specific antibodies. See also Antibodies.

SEXUALLY TRANSMITTED DISEASE (STD):

Also called venereal disease. A contagious disease usually acquired by sexual intercourse or genital contact. Historically, the five venereal diseases were: gonorrhea, syphilis, chancroid, granuloma inguinale and lymphogranuloma venereum. To these have been added scabies, herpes genitalis and anorectal herpes and warts, pediculosis, trichomoniasis, genital candidiasis, molluscum contagiosum, nonspecific urethritis, chlamydial infections, cytomegalovirus and AIDS. See also Herpes Simplex Virus II; Molluscum Contagiosum.

SPECIAL PHARMACEUTICALS BENEFITS PROGRAM (SPBP)

See AIDS Drugs Assistance Programs.

STANDARDS OF CARE:

Treatment regimen or medical management based on state-of-the-art patient care.

STD:

See Sexually Transmitted Disease.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA):

An agency of the Department of Health and Human Services, with the mission to assure that quality substance abuse and mental health services are available to the people who need them, and to ensure that prevention and treatment knowledge used more effectively in the general health care system.

SURVEILLANCE:

Close or continuous observation or testing (e.g., serosurveillance), used, among others, in epidemiology. Immunological surveillance, or immunosurveillance, is a monitoring process of the immune system that detects and destroys neoplastic (e.g., cancerous) cells and that tends to break down in immunosuppressed individuals. See also Epidemiologic Surveillance.

SYMPTOMS:

Any perceptible, subjective change in the body or its functions that indicates disease or phases of disease, as reported by the patient.

SYNDROME:

A group of symptoms and diseases that together are characteristic of a specific condition.

SYPHILIS:

A disease (usually sexually transmitted) resulting from infection with the spirochete (a bacterium) Treponema pallidum.

SYRINGE SERVICE PROGRAM (SSPs)

Syringe services programs encompass a range of services, including the exchange of used syringes for new sterile syringes in an effort to decrease the spread of HIV/AIDS, hepatitis C and other blood-borne pathogens. In addition to providing new, sterile syringes, many programs provide health education and counseling, immunizations, access to substance abuse and mental health treatment, screening for tuberculosis, hepatitis and HIV, and condom distribution, as well as referrals for social and medical programs. In December 2009, President Obama signed the Consolidated Appropriations Act of 2010, which modified provisions regarding the use of funds for needle exchange programs. This modification allows states to fund syringe services programs using federal funds, although no specific federal funds were appropriated for this purpose. Syringe service programs provide clean needles to injection drug users at no cost. In February 2011, the Surgeon General of the United States determined that a demonstration needle exchange program (NEP) or syringe services program (SSP) would be effective in reducing drug abuse and the risk of infection with the etiologic agent for acquired immune deficiency syndrome. This determination permits the expenditure of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds for SSPs.

T

TRANSMISSION:

In the context of HIV disease: HIV is spread most commonly by sexual contact with an infected partner. The virus can enter the body through the mucosal lining of the vagina, vulva, penis, rectum or, very rarely, the mouth during sex. The likelihood of transmission is increased by factors that may damage these linings, especially other sexually transmitted diseases that cause ulcers or inflammation. Studies of SIV infection of the genital membranes of nonhuman primates suggest that the sentinel cells known as mucosal dendritic cells may be the first cells infected. Infected dendritic cells may migrate to lymph nodes and infect other cells. HIV also is spread through contact with infected blood, most often by the sharing of drug needles or syringes contaminated with minute quantities of blood containing the virus. Children can contract HIV from their infected mothers either during pregnancy or birth, or postnatally, via breastfeeding. Current research indicates that the AIDS virus may be 100 to 1000 times more contagious during the first two months of infection, when routine AIDS tests are unable to tell whether people are infected. See also Lymph Nodes; Simian Immunodeficiency Virus.

TUBERCULOSIS (TB):

A bacterial infection caused by Mycobacterium tuberculosis. TB bacteria are spread by airborne droplets expelled from the lungs when a person with active TB coughs, sneezes or speaks. Repeated exposure to these droplets can lead to infection in the air sacs of the lungs. The immune defenses of healthy people usually prevent TB infection from spreading beyond a very small area of the lungs. If the body's immune system is impaired because of infection with HIV, aging, malnutrition or other factors, the TB bacterium may begin to spread more widely in the lungs or to other tissues.

V

VIRAL LOAD:

The amount of HIV virus in the circulating blood. Monitoring a person's viral burden is important because of the apparent correlation between the amount of virus in the blood and the severity of the disease: sicker patients generally have more virus than those with less advanced disease. A new, sensitive, rapid test-called the branched DNA assay for HIV-1 infection-can be used to monitor the HIV viral burden. In the future, this procedure may help clinicians to decide when to give anti-HIV therapy. It may also help investigators determine more quickly if experimental HIV therapies are effective.

VIRUS:

Organism composed mainly of nucleic acid within a protein coat, ranging in size from 100 to 2000 angstroms (unit of length; 1 angstrom is equal to 10-10 meters); they can be seen only with an electron microscope. During the stage of their life cycle when they are free and infectious, viruses do not carry out the usual functions of living cells, such as respiration and growth; however, when they enter a living plant, animal or bacterial cell, they make use of the host cell's chemical energy and protein- and nucleic acid-synthesizing ability to replicate themselves. Viral nucleic acids are single- or double-stranded and may be DNA (deoxyribonucleic acid) or RNA (ribonucleic acid). After viral components are made by the infected host cell, virus particles are released; the host cell is often dissolved. Some viruses do not kill cells but transform them into a cancerous state; some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more severe, form of disease. Viruses, known to cause cancer in animals, are suspected of causing cancer in humans. Viruses also cause measles, mumps, yellow fever, poliomyelitis, influenza and the common cold. Some viral infections can be treated with drugs. See also DNA; Nucleic Acid; Ribonucleic Acid.

W

WESTERN BLOT:

A laboratory test for the presence of specific antibodies, more accurate than the ELISA test. See also Antibodies; ELISA.