



**Pennsylvania Department of Health**

**Comprehensive HIV Care Service Plan**

**2012**

## Table of Contents

<b>I.</b>	<b>Integrated HIV Planning Council Information</b>	<b>Page 3</b>
	<b>A. Council Background and Purpose</b>	<b>Page 3</b>
	<b>B. Current Subcommittee Structure and Process</b>	<b>Page 4</b>
	<b>C. Integrated Planning Council Workplan</b>	<b>Page 5</b>
	<b>D. Membership</b>	<b>Page 13</b>
<b>II.</b>	<b>Where Are We Now?</b>	<b>Page 15</b>
	<b>A. Description of local HIV/AIDS Epidemic</b>	<b>Page 15</b>
	<b>B. Description of Current Continuum of Care</b>	<b>Page 17</b>
	<b>C. Description of Needs</b>	<b>Page 23</b>
	<b>D. Description of Priorities for the Allocation of Funds</b>	<b>Page 28</b>
	<b>E. Description of Gaps in Care</b>	<b>Page 28</b>
	<b>F. Description of Prevention and Service Needs</b>	<b>Page 30</b>
	<b>G. Description of Barriers to Care</b>	<b>Page 33</b>
	<b>H. Evaluation of 2009 Comprehensive Plan</b>	<b>Page 33</b>
<b>III.</b>	<b>Where Do We Need To Go?</b>	<b>Page 42</b>
	<b>A. Plan to meet 2009 challenges</b>	<b>Page 42</b>
	<b>B. 2012 Proposed Care Goals</b>	<b>Page 43</b>
	<b>C. Goals regarding individuals Aware of their HIV status, but are not in care</b>	<b>Page 44</b>
	<b>D. Goals regarding individuals Unaware of their HIV status</b>	<b>Page 45</b>
	<b>E. Proposed Solutions for closing gaps in care</b>	<b>Page 45</b>
	<b>F. Proposed solutions for addressing overlaps in care</b>	<b>Page 45</b>
	<b>G. Description detailing the proposed coordinating efforts with providers</b>	<b>Page 45</b>
<b>IV.</b>	<b>How Will We Get There?</b>	<b>Page 51</b>
	<b>A. Introduction</b>	<b>Page 51</b>
	<b>B. Strategy, plan, activities, and timeline to close gaps in care</b>	<b>Page 57</b>
	<b>C. Strategy, plan, activities, and timeline to address needs of individuals who are aware of their HIV status</b>	<b>Page 57</b>
	<b>D. Strategy, plan, activities, and timeline to address needs of individuals who are Unaware of their HIV status</b>	<b>Page 59</b>
	<b>E. Strategy, plan, activities, and timeline to address needs of special populations</b>	<b>Page 60</b>
	<b>F. Description detailing the activities to implement the proposed coordinating efforts of providers</b>	<b>Page 61</b>
	<b>G. How the plan addresses Healthy People 2020 objectives</b>	<b>Page 61</b>
	<b>H. How the plan reflects the Statewide Coordinated Statement of Need</b>	<b>Page 61</b>
	<b>I. How this plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act</b>	<b>Page 62</b>
	<b>J. Describe how the comprehensive plan addressed the goals of the National HIV/AIDS Strategy, as well as which specific NHAS goals are addressed</b>	<b>Page 62</b>
<b>V.</b>	<b>How will we monitor progress?</b>	<b>Page 63</b>
<b>VI.</b>	<b>Appendices</b>	
	<b>A. SPNS Project – A Critical Phase Interventions Project (CPI)</b>	<b>Page 69</b>
	<b>B. Unmet Needs for Primary Medical Care Chart</b>	<b>Page 75</b>
	<b>C. Supplements to the Epidemiologic Profile</b>	<b>Page 78</b>

## **I. HIV Integrated Planning Council Information**

- A. Council Background and Purpose:** Pennsylvania's response to the HIV/AIDS epidemic is the result of collective wisdom gained through decades of experience in health and human services. Much of this experience has been HIV-specific, from those on the front lines since the beginning of the HIV/AIDS epidemic, to those who have since joined in the efforts to respond to the spread of the disease. Reflective of this experience, is the response in Pennsylvania evolving over time from the earliest efforts in HIV education and care.

The experience began in Pennsylvania in 1991, with the implementation of the Ryan White CARE Act. In 1992, the Department of Health teamed up with the regional planning coalitions to focus on establishing a statewide planning effort for care and support services. This collaboration produced the HIV Planning Council in its infancy. The first efforts of this group utilized a Needs Assessment and Strategic Planning subcommittee to develop the "State AIDS Plan" which was put into draft form by 1994. This draft covered primary needs assessment information specific to epidemiology, prevention, and care. Even in these early days, the care planning body found it important to be inclusive of prevention planning efforts and therefore used the Center for Disease Control (CDC)-mandated, HIV Community Prevention Planning Groups' activities as a resource.

Over the next several years, there were significant changes in leadership at the state and federal level, as well as the re-authorization of the Ryan White CARE Act. The re-authorization now mandated a cross-Parts effort known as the Statewide Coordinated Statement of Need (SCSN). In response to this mandate, Pennsylvania chose to dismantle the HIV Planning Council and create a more inclusive and representative statewide PA Integrated HIV Planning Council which included Parts A-D as well as other health and human services providers and community stakeholders.

In addition to the Statewide Coordinated Statement of Need, the Division was also responsible for the development of a Statewide Comprehensive Plan. Through the combined efforts of the Integrated HIV Planning Council, the advisory body to the Department, and the work of the HIV Community Prevention Planning Committee, also convened by the Department, the development of a strategic planning document was initiated. This document included new focus areas such as, unmet need, quality management, joint care and prevention planning efforts, and the outcomes of the Consumer Input Project. The Consumer Input Project was a successful needs assessment activity conducted through a contract with the PA Mid Atlantic AIDS Education and Training Center. The updated submission of the Statewide Coordinated Statement of Need and the new Comprehensive Plan took place in 2003.

Over the next several years the PA Integrated HIV Planning Council struggled with identifying its purpose due to constantly adjusting to produce various documents. The group was focusing more on the production of a specific document rather than conducting an on-going planning process. This led to the Division on several occasions, producing documents which did not enlist the efforts of the Council and focused only on the Part B service delivery system.

In 2009, the Council re-established a subcommittee structure which would look at established goals over time. Each subcommittee would work to gather information on those goals from all Parts around the State, report on where the State is at in progress toward those goals and develop recommendations for future action. With the development of the current subcommittee structure, the emphasis was realigned to focus on the planning process. Due to the fact that this Council is comprised of individuals who are actively employed at organizations receiving one or more Parts of Ryan White funding or other human service organizations there is little ability to conduct thorough needs assessment activities on behalf of the Council. For needs assessment information the subcommittee structure gathers information from the regional planning Coalitions as well as any needs assessments conducted by any other Parts. In order for the Council to fully conduct a needs assessment it would be necessary to contract with an outside organization. Realizing this was very important to the group, as the only way in which to accomplish planning activities in this group is to collect completed needs assessments and the results and determine what information could be applied statewide and establish recommendations. Any information or activities selected to be recommended for application statewide would be in an effort to improve the overall quality of service in Pennsylvania.

Development of this document reflects a collaborative effort to identify significant issues related to the needs of persons living with HIV/AIDS, examine the current service delivery system, and identify possible improvements to the service delivery system. All Ryan White grantees are asked to contribute to the process in the hope that it will “maximize coordination, integration, and effective linkages across the various CARE Act Parts.” The Integrated HIV Planning Council created this document with the following general purposes in mind:

1. To improve coordination of Ryan White Program grantees within Pennsylvania and to build upon existing planning activities of the individual grantees and other interested stakeholders.
2. To monitor the changing statewide epidemiological profile, and to identify common gaps in care, unmet needs and barriers for persons within the Commonwealth living with HIV disease.
3. To promote cooperation and collaboration to develop a shared vision for effective planning and coordination of care services across the Commonwealth.
4. To evaluate the current CARE Act service delivery structure and plan for the Statewide implementation of suggested improvements.

- B. **Current Subcommittee Structure and Process:** The Pennsylvania Department of Health, as the Ryan White Program Part B Grantee, is charged with obtaining the input of consumers, providers and grantees of the CARE Act in preparing this Comprehensive Plan which is inclusive of the Statewide Coordinated Statement of Need. The Integrated HIV Planning Council is the official advisory body to the Departments of Health and Public Welfare on HIV care related issues. The Planning Council additionally serves as a forum for exchange of information among Ryan White Parts, consumers, and HIV/AIDS service organizations. A new subcommittee structure was established in July of 2009 to more effectively produce the required documentation and more actively engage participants of the Council. Membership of the group includes individuals from all Ryan White Parts and these individuals are active participants during subcommittee work. If further information is needed from one of the Parts additional contacts are made in an effort to gain more input. Current membership also includes individuals from the Mid-Atlantic AIDS Education and Training Center. These members are also active participants in subcommittee work. The Integrated Planning Council strives to have very active consumer participation. In 2009 there was an existing

consumer advisory group named the Greater Alliance of Pennsylvania Consumer Advisory Body. This group was fully incorporated into membership of the Integrated Planning Council. Therefore active participation is gained through this group which includes at least two consumers representing leadership roles within all seven regions of the State. In addition to these participants, numerous providers are also members of the Council and actively participate in subcommittee work.

The Council also produced a Work Plan to keep the Council on target for completing its goals within the two year planning process. The Work Plan is included below. Apart from the Council activities, the state's HIV/AIDS Epidemiologist, Dr. Benjamin Muthambi, was charged with creating a comprehensive, integrated epidemiological profile. Dr. Muthambi's methodology is described and justified in detail in the Integrated Epidemiological Profile (see Section II. A.1.).

#### **Subcommittees:**

**Steering subcommittee:** Chairs of each subcommittee meet at the conclusion of each meeting to provide an update on subcommittee work, plan the agenda for the next meeting, and discuss any issues.

**Data/Needs Assessment subcommittee:** Gather regional information from all Parts, review epidemiological profile for suggested target populations and identify needs to be addressed.

**Barriers and Gaps subcommittee:** Identify critical barriers and gaps existing in PA, review met and unmet need data, and brainstorm ways in which to address identified barriers and gaps.

**Implementation subcommittee:** Research best strategies on successful needs assessments conducted, research best strategies on ways to address identified barriers and gaps, and develop recommendations for implementing best strategies.

**Membership subcommittee:** Meets as necessary at the conclusion of the meeting to review membership applications.

**Consumer Advisory subcommittee:** Meets the evening before each meeting to discuss consumer issues which then feed into the work of all other subcommittees.

#### **C. Integrated Planning Council Workplan:**

##### **Integrated Planning Council - Planning Cycle -Summary**

(Based on 2-year HRSA cycle: 2011 - 2013)

<b>PA Integrated Planning Council</b>	<b>Products to be developed:</b>	<b>Due Dates</b>
<b>2-year</b>		
	Comprehensive Plan & State Wide Coordinated Statement of Need	November 2011

#### **Goals Referenced Throughout Plan:**

##### **Broad Goals from SCSN 2009:**

- 1. Strengthen communication and/or explore new collaborations with federal, state, and local partners or agencies.**
- 2. Establish a statewide model for medical case management.**
- 3. Integrate the HRSA performance measures into service delivery systems and quality improvement programs.**
- 4. Improve case findings and facilitate linking individuals to care and treatment.**

##### **HRSA Program Guidance Goals:**

1. Improve Access to Health Care
2. Improve Health Outcomes
3. Improve Quality and Health Care
4. Eliminate Health Disparities

### IPC Meeting Schedule & Work Plan for 2010

March 2010– September 2011

#### 9 March 2010 (1 day)

II.	III. Objective	Presenter		Status
IV.	V. Welcome New Members (if applicable)	Joe/Melissa		✓
	Quality Management Report	Marie Stokes		✓
	Orient members to key products <ul style="list-style-type: none"> <li>Epi profile</li> <li>Resource Inventory (connection to prevention planning process)</li> <li>Gathering of statewide planning activities and developing ways in which to enhance those activities</li> <li>Participation in the exchange of information between all Ryan White parts</li> </ul>	Joe/Melissa		✓
	Suggestions for roundtable discussions/presentations	All		✓
	SPBP Update	Cheryl Henne/John Haines		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal To Address</b>	<b>Status</b>
	Elect co-chairs of each committee	All subcommittees	N/A	Complete
	Note any suggestions for changes to the 2010-2011 Work Plan	All subcommittees	N/A	Complete
	Provide update on progress toward Broad Goal 2 and list additional actions needed	Implementation	Broad Goal 2 (SCSN)	Complete
	<b>VI. Steering Committee meets to:</b>			
	Set agenda for next meeting: Intro/Announcements Epi Presentation Medical Case Management Presentation Update on Broad Goals 1 and 3 Subcommittee work	Steering Committee	N/A	Complete
	Requested presentations for May: Epi Profile Medical Case Management	Joe to arrange	N/A	Complete

**18 May 2010 (1-day)**

<b>VII.</b>	<b>VIII. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>IX.</b>	X. Update on the progress toward Broad Goal 1 and list additional actions needed (SCSN 2009)	PA Dept. of Health		✓
<b>XI.</b>	XII. Quality Management Update <ul style="list-style-type: none"> <li>Update on the progress toward Broad Goal 3 and list additional actions needed (SCSN 2009)</li> </ul>	Marie Stokes		✓
	Medical Case Management	E. Torres		✓
	Unmet Need Project Presentation	Dr. Muthambi		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Discuss and develop methods for utilization and a distribution matrix for the documents	Implementation	N/A	In progress
	<b>XIII. Steering Committee meets to:</b>			
	Set agenda for next meeting: Intro/Announcements Membership and QM Update Epi Profile Presentation Coordinated Care Network Presentation Subcommittee work	Steering Committee	N/A	Complete

**13 July 2010 (1-day)**

<b>XIV</b>	<b>XV. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>XVI</b>	XVII. Quality Management Update	Marie Stokes		✓
	Epi Profile	Dr. Muthambi		✓
	Coordinated Care Network	Dave Giannangeli		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Identify and describe barriers to accessing health care	Barriers	HRSA Goal 1	Complete
	Discuss action steps for a statewide medical case management model	Implementation	Broad Goal 2	Complete
	<b>XVIII. Steering Committee meets to:</b>			
	Set agenda for next meeting: Intro/Announcements QM Update Expanded Testing Initiative Vocational Development and Employment Needs Survey Subcommittee work	Steering Committee	N/A	Complete

**14 September 2010 (1 day)**

<b>XIX</b>	<b>XX. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>XXI</b>	XXII. Quality Management Update	Marie Stokes		✓
	Expanded Testing Initiative	Dr. Crook		✓
	Vocational Dev. & Employment Needs Survey	Liz Conyers, PhD		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Select (x) barriers able to be addressed during 2011-2013	Barriers	HRSA Goal 1	Complete
	<b>XXIII. Steering Committee meets to:</b>			
	Set agenda for next meeting: Intro/Announcements Quality Management Update Subcommittee Work	Steering Committee	N/A	Complete

**9 November 2010 (1 day)**

<b>XXIV</b>	<b>XXV. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>XXV</b>	XXVII. Quality Management Update	Marie Stokes		
	No presentations – subcommittee work only			
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	<ul style="list-style-type: none"> <li>Determine what information is/data is available regarding those accessing RW health care and establish a way in which to compile this information (prior to meeting)</li> <li>Discuss any potential data available regarding health outcomes and compile (prior to meeting)</li> <li>Review the compiled data regarding health outcomes and summarize</li> <li>Discuss and identify 2 or 3 health outcomes to target during 2011-2013</li> </ul>	Data/Needs Assessment	<ul style="list-style-type: none"> <li>HRSA Goal 1</li> <li>HRSA Goal 2</li> <li>HRSA Goal 2</li> <li>HRSA Goal 2</li> </ul>	Complete
	<ul style="list-style-type: none"> <li>Conclude selection of barriers to address during 2011-2013</li> <li>Identify and describe barriers specifically impacting each targeted outcome (communicate with Data/Needs for targeted outcomes)</li> </ul>	Barriers	<ul style="list-style-type: none"> <li>HRSA Goal 1</li> <li>HRSA Goal 2</li> </ul>	Complete
	<ul style="list-style-type: none"> <li>Identify and describe existing</li> </ul>	Implementation	<ul style="list-style-type: none"> <li>HRSA</li> </ul>	Complete



	strategies to address those barriers impacting access to health care <ul style="list-style-type: none"> <li>• Develop a plan to distribute the existing successful strategies for consideration statewide</li> <li>• Complete the discussion and development of utilization and a distribution matrix for the documents</li> </ul>		Goal 1 <ul style="list-style-type: none"> <li>• HRSA Goal 2</li> <li>• N/A</li> </ul>	
	<b>XXVIII. Steering Committee meets to:</b>			
	Set agenda for next meeting			

**8 March 2011 (1 day)**

<b>XXI</b>	<b>XXX. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>XXX</b>	XXXII. Welcome New Members (if applicable)			
	Follow-up/conclude reporting on Broad Goal 1 (SCSN 2009)	PA Dept. of Health		✓
	Quality Management Report <ul style="list-style-type: none"> <li>• Follow-up/conclude reporting on Broad Goal 3 (SCSN 2009)</li> </ul>	Marie Stokes		✓
	Presentation on Successful Prevention for Positives program	Anthony Stroble		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	<ul style="list-style-type: none"> <li>• Gather information/data regarding health disparities across the State (prior to meeting)</li> <li>• Summarize data collected regarding health disparities</li> </ul>	Data/Needs Assessment	<ul style="list-style-type: none"> <li>• HRSA Goal 4</li> <li>• HRSA Goal 4</li> </ul>	Complete
	Research and summarize statewide progress toward Broad Goal 4	Barriers	Broad Goal 4	Complete
	<ul style="list-style-type: none"> <li>• Conclude follow-up on Broad Goal 2</li> <li>• Identify and describe existing successful strategies impacting health outcomes</li> </ul>	Implementation	<ul style="list-style-type: none"> <li>• Broad Goal 2</li> <li>• HRSA Goal 2</li> </ul>	Complete
	<b>XXXIII. Steering Committee meets to:</b>			
	Set agenda for next meeting			

**10 May 2011 (1 day)**

XXX	XXXV. Objective	Presenter		Status
XXX	XXXVII. Quality Management Presentation <ul style="list-style-type: none"> <li>• Overview of all QM initiatives</li> <li>• Actively collected performance measures</li> <li>• Preliminary data/status of measures</li> </ul>	Marie Stokes	HRSA Goal 3	✓
	Bristol, Myers, Squibb – Adherence Outcomes	Ron Poppel		✓
	Internet Interventions	University of Pittsburgh		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Conduct a broad assessment of need on the following topics: <ul style="list-style-type: none"> <li>• Medical/support services</li> <li>• Prevention needs (link to CPG)</li> </ul>	Data/Needs Assessment	N/A	Complete
	Identify barriers which are perpetuating these health disparities (using data/needs committee information)	Barriers	HRSA Goal 4	Complete
	Continue work from previous meeting	Implementation	HRSA Goal 2	
	<b>XXXVIII. Steering Committee meets to:</b>			
	Set agenda for next meeting			

**12 July 2011 (1 day)**

XXXI	XL. Objective	Presenter		Status
XLI.	XLII. Quality Management Update	Marie Stokes		✓
	Update on Unmet Need/Disparities	Dr. Muthambi		✓
	National HIV/AIDS Strategy	S. Wyche		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Review and summarize unmet need data and activities/strategies currently conducted in the State	Data/Needs Assessment	N/A	Complete
	Select those barriers which may be addressed statewide	Barriers	HRSA Goal 4	Complete
	Collect established methods for decreasing/eliminating specific health disparities from nationwide or statewide sources	Implementation	HRSA Goal 4	Complete
	<b>XLIII. Steering Committee meets to:</b>			
	Set agenda for next meeting			

**13 September 2011 (1 day)**

<b>XLIV</b>	<b>XLV. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>XLV</b>	XLVII. Unmet Need	<b>B. Muthambi</b>		✓
	CPG Presentation	S. Flaherty		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Create a summary of needs of special populations including: adolescents, IDUs, homeless, and transgender	Data/Needs Assessment		Complete
	Create a description on any shortfalls in the healthcare workforce	Barriers		Complete
	<ul style="list-style-type: none"> <li>Review and summarize established methods for decreasing/eliminating specific health disparities from nationwide or statewide sources</li> <li>Work on Healthy People 2020 Objective</li> </ul>	Implementation	HRSA Goal 4	Complete
	<b>XLVIII. Steering Committee meets to:</b>			
	Set agenda for next meeting			

**8 November 2011 (1 day)**

<b>XLI</b>	<b>L. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>LI.</b>	LII. Act 59 presentation	Ken McGarvey		✓
	Subcommittee Updates	Subcommittee chairs		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Address the following items: <ul style="list-style-type: none"> <li>How the service continuum has been affected by budget cuts</li> <li>Description of Care Needs</li> <li>Description of Prevention/Service Needs</li> <li>Goals regarding individuals aware of their HIV status but not in care</li> <li>Goals regarding individuals unaware of their HIV status</li> </ul>	Data/Needs Assessment subcommittee		Complete
	Address the following: <ul style="list-style-type: none"> <li>Refine description of barriers to care</li> <li>Proposed solutions for closing gaps</li> <li>Proposed solutions for</li> </ul>	Barriers subcommittee		Complete

	overlaps in care			
	Address the following: <ul style="list-style-type: none"> <li>• Description detailing proposed coordinating efforts with specific programs</li> <li>• Description detailing the activities to implement the proposed coordinating efforts</li> </ul>	Implementation subcommittee		Complete
	<b>LIII. Steering Committee meets to:</b>			
	Discuss progress towards document completion	Subcommittee chairs		

### 13 March 2012 (1 day)

<b>LIV.</b>	<b>LV. Objective</b>	<b>Presenter</b>		<b>Status</b>
<b>LVI.</b>	<b>LVII. Subcommittee updates</b>	Subcommittee chairs		✓
	Statewide Data review (webportal)	Jewish Healthcare Foundation		✓
	Establishment of 2012 Care Goals	All		✓
	<b>Subcommittees meet to:</b>	<b>Subcommittee</b>	<b>Goal to Address</b>	<b>Status</b>
	Address the following items: <ul style="list-style-type: none"> <li>• How the service continuum has been affected by budget cuts</li> <li>• Description of Care Needs</li> <li>• Description of Prevention/Service Needs</li> <li>• Goals regarding individuals aware of their HIV status but not in care</li> <li>• Goals regarding individuals unaware of their HIV status</li> </ul>	Data/Needs Assessment subcommittee		Complete
	Address the following: <ul style="list-style-type: none"> <li>• Refine description of barriers to care</li> <li>• Proposed solutions for closing gaps</li> <li>• Proposed solutions for overlaps in care</li> </ul>	Barriers subcommittee		Complete
	Address the following:	Implementation subcommittee		Complete

	<ul style="list-style-type: none"> <li>• Description detailing proposed coordinating efforts with specific programs</li> <li>• Description detailing the activities to implement the proposed coordinating efforts</li> </ul>			
	<b>LVIII. Steering Committee meets to:</b>			
	Discuss progress towards document completion	Subcommittee chairs		

**D. Membership (Participants)** Membership on the Integrated HIV Planning Council consists of grantees from all Ryan White Parts, consumers, and various government partners. Below is a list of all members of the Council updated as of October 2011. Participation of the Coalition President and/or Executive Director at the Integrated HIV Planning Council meetings is part of each coalition's contract with the Department of Health.

**AACO (Philadelphia region)**

Aramide Ayorinde  
Alicia Beatty  
Karen Coleman  
Jerry Coleman  
Mark Corbin  
Ronald Ford  
Omar Galloway  
Bernard Griffith  
Derick Wilson  
Ana Lapp  
Howell Strauss/Anne Ferguson

**AIDSNET region**

Jean D'Aversa  
Anthony Strobel  
Ann Stuart Thacker  
Susan Rubinstein

**North Central region**

Sarah Emel  
Joseph Swisher

**North East region**

Dan Champion

Melissa Davis  
Wayne Fenton  
Elidoro Primero

**North West region**

David Brosius  
Michael Cole  
Susan Boland  
Donna Woodman  
Erika Freeman

**South Central region**

Amy Collins,  
Michael Dolatoski  
Deborah Garlock  
Regina King  
Richard Klick  
Shannon McElroy  
Daniel Sole  
Tamara Wurst  
Laura Brubaker

**South West region**

Kathi Boyle  
Doyin Desalu  
Mary Gallagher  
Ronald Lane  
Ralph Pence  
Justin Smith

**Commonwealth of Pennsylvania**

Shirley Black - Department of Education  
John Haines - PA Department of Public Welfare, Special Pharmaceutical Benefits Program  
Lynn Heitz - Bureau of Long Term Care  
Cheryl Henne - PA Department of Public Welfare, Special Pharmaceutical Benefits Program  
Tracina Crooper - PA Department of Health, Division of TB/STD  
Daniel Fox - PA Department of Community and Economic Development  
Benjamin Muthambi - PA Department of Health, Division Epidemiology  
Ted Danowski - PA Department of Health, Division of HIV/AIDS  
Ken McGarvey - PA Department of Health, Division of HIV/AIDS  
Julia Montgomery - PA Department of Health, Division of HIV/AIDS  
Tanecia Richardson - PA Department of Health, Division of HIV/AIDS  
Joanne Valentino - PA Department of Health, Division of HIV/AIDS

**II. Where Are We Now?** The purpose of this section is to identify populations in most need of HIV care and services as well as barriers to care, provide an overview of the current state of HIV healthcare and service delivery, and identify progress and shortfalls. (Please note: All information included in this section meets the requirements for elements listed in the Statewide Coordinated Statement of Need Guidance as well as the “Where are we now?” section of the Comprehensive Plan Guidance.)

**A. Description of local HIV/AIDS epidemic:**

1. Integrated Epidemiological Profile – The executive summary of the profile is provided below, for the complete profile please follow the link provided below. Appendix C contains supplements to the current profile.

[http://www.portal.state.pa.us/portal/server.pt/community/hiv\\_aids/14241/integrated\\_epidemiologic\\_profile\\_of\\_hiv\\_aids\\_in\\_pa/557190](http://www.portal.state.pa.us/portal/server.pt/community/hiv_aids/14241/integrated_epidemiologic_profile_of_hiv_aids_in_pa/557190)

The Pennsylvania Department of Health (PADOH) is presenting the 2009/10 Summary Report of the Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania providing a comprehensive evaluation of data collected through different sources that are intended to provide epidemiologic/scientific resources in support of evidence-based planning for HIV/AIDS prevention and care activities. The HIV/AIDS Surveillance and HIV/AIDS Investigation Sections of the Division of Infectious Disease Epidemiology (IDE), Bureau of Epidemiology (BOE) are the primary entities in the Commonwealth with the capacity and responsibility for: a) HIV/AIDS surveillance and epidemiologic investigations; b) providing data and ongoing epidemiology support to prevention and care service development, evaluation and community planning processes (including participating in planning and implementation meetings, prioritization of population-transmission groups and interventions, conducting analyses to monitor trends, assess need for health-care resources, and project the future impact of the disease); and c) disseminating surveillance data through publications and presentations throughout the Commonwealth. Important uses of the collected data involve supporting the Prevention and Care Planning (PCP) programs during their planning process. As outlined in greater detail in this profile, the data collected and presented here, clearly demonstrate that the current HIV/AIDS situation in PA is increasingly taking its toll in the heterosexual population (whose probable modes of transmission are unprotected male-female sexual contact and sharing of injection equipment by injecting drug users), affecting predominantly and disproportionately vulnerable minority communities (blacks/African-Americans and Hispanics/Latino/as especially) and younger age groups, while it continues to pose a disproportionate threat to men who have sex with men. In accordance with the Centers for Disease Control and Prevention (CDC), and the Health Resources and Service Administration (HRSA) Integrated Guidelines for HIV/AIDS Epidemiologic Profiles, this report represents a break from the previous approach of providing separate profiles for the two main HIV intervention program planning processes, namely CDC-mandated prevention planning and HRSA-mandated care services planning. But although this profile presents an integrated approach to prevention and care planning, for analytical reasons a number of analytical approaches used in previous epidemiologic profiles have been retained, consolidated and updated as they were very timely in foreseeing the need to describe the growth rate of persons recently diagnosed or living with HIV/AIDS, highlighting changes in the epidemic and the disproportionate impact. The tables, graphs and analysis presented in this report depict the public health emergency created by HIV/AIDS in Pennsylvania. The Commonwealth of Pennsylvania had 101.55 cases of HIV (non-AIDS) per 100,000 population, and 168.96 cases of AIDS per 100,000 population in 2007, which ranked in the upper 20 states for either HIV (non AIDS) or AIDS case rates in the US. HIV/AIDS is increasingly taking its toll among injecting drug users and their female sexual partners, in communities of color and it

continues to pose a significant threat to men who have sex with men. Almost 1/3 of all prevalent/living HIV cases in recent years (2003 onwards) were directly or indirectly due to injecting drug use (IDU), and another 1/3 occurred among men who have sex with men. More sobering is the realization that the epidemic is now predominantly affecting heterosexuals [>55% of prevalent/living cases are among those whose probable modes of transmission include both IDU (26%) and heterosexual contact (30%)], while continuing to pose a significant and disproportionate impact on MSM (with 36%, comprised of 32% among MSM, and 4% among MSM-IDU). We also highlight the ensuing cascade of intersecting sub-epidemics which involves IDU males and childbearing-age females who are IDU or (hetero-) sexual partners of IDU, and their children. Racial/ethnic minorities are disproportionately affected as they account for over 60% of persons living with HIV in PA in recent years from 2003 onwards; in particular blacks account for 51% of living cases although they account for 10.6% of the population (11 times the rate, per 100,000 population, compared to whites), followed by Hispanics with 13% of living HIV cases although they account for 4.4% of the population (9 times the rate, per 100,000 population, compared to whites). Our analysis of recent epidemic growth rates indicates that there were 5 counties that were identified as high outcome counties based on a) a general population of greater than 500,000, b) high average annual rates of increase in HIV/AIDS prevalence (>+6%, between 2004 & 2007), and c) high background HIV prevalence rates (> 90 cases per 100,000 population): i.e. Allegheny, Bucks, Delaware, Montgomery and Philadelphia Counties. Survival after diagnosis with AIDS is improving over time resulting in an increase in the pool of persons living with HIV who may be at risk of transmitting HIV. Prevention and care services must therefore be correspondingly increased and focused on this growing potential source population which may be the driving force of the epidemic.

2. Unmet Need Data and Description of the needs of individuals who are aware of their HIV-positive status but are not in care.
  - **Unmet Need data and Description of the needs of individuals who are aware of their HIV positive status but are not in care (with emphasis on outreach, referral, and linkage to care needs) AND EIIHA/Unaware Estimates and a Description of the needs of individuals who are unaware of their HIV status (with an emphasis on outreach, counseling and testing, referral, and linkage to care needs)**

For the updated unmet need data please see, Unmet Needs among PLWH/A in PA (2010/11 – interim update) included as Appendix B. Also included as Appendix A is the full abstract of a Special Project of National Significance (SPNS) called Linkage PA – A Critical Phase Interventions Project. This project has two primary focus areas; to enhance health service and information systems for 1.) testing and referral tracking, and 2.) linkage to prevention and care services. In addition, this SPNS project and the HIV service registry projects are intended to complement each other in assessing needs beyond what are known about the extent of unmet needs and the size of the population which is unaware of its HIV infection. The secondary objectives of these projects address needs assessment elements for those who have unmet needs and those infected with HIV who are unaware of their status include:

- a) SPNS: Assessing client-level service needs and barriers to prevention/care faced by the two subgroups, those who have unmet needs and those infected with HIV who are unaware of their status. This will be done through routinely administered intake unmet needs assessments (UNAs) for newly diagnosed persons at intake and those who have unmet needs and return to care. This will be part of the standard of care as each of these two groups are reached in the SPNS project (Please see the attached abstract document of the SPNS project



for information describing this project. Some information in the background section of the attachment should help articulate the preliminary knowledge of the needs of these populations);

- b) HIV Registry: Through service gap analyses, the State will assess the service supply and capacity (incl. competence) of HIV/AIDS service programs across the state, and their ability to meet the needs of the two subgroups, those who have unmet needs and those infected with HIV who are unaware of their status.

It is important to recognize that while the above activities are currently being conducted and will impact individuals with unmet need and individuals who are unaware of their HIV positive status, the State is in need of a mechanism for systematically assessing the needs of those two populations and the other subgroups shown in each of the columns in Table 1 of Appendix A. This mechanism must be created in a manner which generates representative/generalizable data which is also comparable across regions of the state. At this time, the RW program has no data on the needs of persons in these two subgroups which have been generated from a comprehensive, statewide, evidence-based and representative/generalizable assessment of needs of persons in these two subgroups (with comparability across regions). The above two projects are currently in progress and until data is available from those projects at specified data collection points there is no current data to include in this section. However, with these two project underway the State will be able to generate data at regular intervals and provide updates in future document submissions. (Please refer to Appendix A and B).

For the updated unmet need data please see the Unmet Needs among PDLWH/A in PA (2010/11-interim update) included as Appendix B.

- 3. EIIHA/Unaware Estimates and Description of the needs of individuals who are unaware of their HIV status (please see above description and also refer to appendix A and B).

- o **Back Calculation Estimate of the Number of Persons Living with HIV (PLWH) in Pennsylvania who are Unaware of their HIV Status as of December 31, 2008.**

**Objective:** To estimate the number of persons living with HIV (PLWH) in Pennsylvania who are Unaware of their HIV status as of December 31, 2009.

**Background & Rationale:** CDC estimates that 21% of persons living with HIV in the United States are unaware of their HIV status. Further, CDC estimates that over 2/3 of new infections are attributable to this population.

**Methods:** The estimated back calculation (EBC) methodology was used to estimate the number of persons living with HIV (PLWH) in Pennsylvania who are unaware of their HIV status as of December 31, 2009. An example of the formula for this estimation is given as follows: National Proportion Undiagnosed HIV (21%) =  $p$  Number of individuals diagnosed with HIV and living as of December 31, 2008 =  $N$  Local Undiagnosed =  $p \times N (1-p)$

**Results:** Assuming that  $p = 21\%$  and  $N = 33983$  (=PLWHaware), we used the above EBC methodology to estimate that the number of persons living with HIV (PLWH) in Pennsylvania who are unaware of their HIV status as of December 31, 2009, PLWHunaware = 9033.

## **B. Description of Current Continuum of Care**

- 1. **Ryan White funded and Non-Ryan White funded HIV care and service inventory.**

In 2011 the HIV/AIDS Service Provider registry (HASP) was created to streamline the process of compiling a service inventory. The HASP registry is an effort of the Department of Health and the Pennsylvania Prevention Project at the University of Pittsburgh, to create a central depository of Pennsylvania's HIV/AIDS service providers and HIV/AIDS related service providers. The goal of the Registry is to improve community knowledge of HIV services and resources available, to gather a comprehensive understanding of services available to community members and to facilitate improved coordination of service delivery through information sharing. The Registry will allow for better interaction among providers, improve access to information for consumers, and a greater ability to capture unmet needs information that can be used by the Department of Health in making planning, policy, and funding decisions. The vision of this Registry is to have a single location for this information so that it is more easily accessible to both the public and to professionals, easier to update, and more comprehensive. The inputting of data into this Registry was initiated in June of 2011, by the end of 2011 there were 116 providers participating in the Registry.

The following chart provides an inventory of the Ryan White funded providers across the State and which core and/or support services are available in each region. As a result of the payer of last resort policy and referral processes, there is a large volume of non-Ryan White funded providers with which each region interacts. It is the intention that all of these non-Ryan White funded providers also be captured in the Registry and be available to view online at [www.hasp.stophiv.org](http://www.hasp.stophiv.org).

<b>Region: Agency Names and Parts</b>	<b>Service Categories: Core Services Provided By Region</b>	<b>Service Categories: Support Services Provided By Region</b>
<b>Northeast Region:</b> Wyoming Valley AIDS Council (B) The Wright Center (B/C)	Outpatient/Ambulatory Health Srvs. Oral Health Care Medical Case Management Health Insurance Premium/Cost Shar. Medical Care- Vision Mental Health Services Medical Nutritional Therapy Local AIDS Pharmaceutical Assist.	Case Management Non- Medical Emergency Financial Assistance Psychosocial Support Housing Services Medical Transportation Linguistics Services Food Bank/Home Delivered Meals
<b>North Central Region:</b> Caring Communities for AIDS (B) HIV/AIDS Support Network — Packer Hospital (B) The AIDS Project, Inc. (B) The AIDS Resource Alliance (B)	Outpatient/Ambulatory Health Srvs. Oral Health Care Medical Case management Health Insurance Premium/Cost Shar. Medical Nutrition Therapy Mental Health Services	Emergency Financial Assistance Food Bank/Home Delivered Meals Health Education/Risk Reduction Housing Services Medical Transportation Psychosocial Support
<b>Northwest Region:</b> Clarion University (A/B /C)	Oral Health Care Early Intervention Services	Case Management Non- Medical

Family Planning Services of Mercer County (B)	(Parts A and B) Health Insurance Premium/Cost Shar. Mental Health Services Medical Case Management	Emergency Financial Assistance Medical Transportation
<b>AIDSNET Region:</b> AIDS Activity Office of Lehigh Valley Hospital (B/C) AIDS Services Center at St. Luke's Hospital (B) Berks AIDS Network (B) Easton Community HIV Org. (C) St. Luke's Hospital (C)	Outpatient/Ambulatory Health Srvs. Oral Health Care Medical Case Management Health Insurance Premium/Cost Shar. Mental Health Services	Case Management Non-Medical Emergency Financial Assistance Medical transportation Psychosocial Support services Legal Services Housing Services
<b>Southwest Region:</b> Jewish Healthcare Foundation (B) Allegheny Singer Research Inst. (B/C) Center for Community Resources (B) Conemaugh Memorial Medical Cnt(B) East Liberty Family Health Care Center (B) Mon Vough Community Services (B) PERSAD Center, Inc. (B) Pittsburgh AIDS Task Force (B) Senior Care Management Assistance Fund (B) Shepard Wellness Community (B) University of Pittsburgh Medical Center (B/C/D)	Oral Health Medical Case Management Health Insurance Premiums/Cost Shar. Mental Health Services	Case Management Non-Medical Emergency Financial Assistance Food Bank/Home Delivered Meals Congregate Meals Health Education Risk Reduction Housing Services Medical Transportation Psychosocial Services Treatment Adherence Counseling
<b>South Central Region:</b> Alder Health Services (B) Family First Health (B/C) Home Nursing Agency – AIDS Intervention Project (B) Keystone Rural Health	Outpatient/Ambulatory Health Srvs. Oral Health Medical Case Management Mental Health Services Medical Nutrition Therapy	Case Management Non-Medical Emergency Financial Assistance Health Education/Risk Reduction Housing Services Medical Transportation

Center (B/C) Lancaster General Hospital (B/C) REACCH Programs at Pinnacle Health (B/C)		Services Linguistics Services Food Bank/Home Delivered Meals
<b>AACO Region:</b> AIDS Activities Coordinating Office (A/B) Action AIDS, Inc.(A/B/D) AIDS Care Group (A/B/C/D) AIDS Law Project (A/B) AIDS Services in Asian Comm.(B) Albert Einstein Healthcare Net. (A) Ambulatory Health (A) Association de Puertoriquenos en Marcha (A) BEBASHI (D) Caremark, LLC (A) Catholic Social Services (A) Center for Comm. & Prof (B) Center for Family Services (A) Children's Hospital of Phila. (D) Circle of Care (D) Clinical Care Assoc. of Univ. of Pennsylvania (A) Congresso de Latinos Unidos, Inc. (A/B/D) Culcutta House (A) Drexel University (A/B) Family and Community Services of Delaware (A/B) Family Planning Council/Circle of Care (A/B/D) Family Service Association of Bucks County (A/B) Family Services of Chester County (A/B) Family Services of Montgomery County (A/B) GALAEI (A) Greater Phila. Urban Affairs (A/B)	Outpatient/Ambulatory Medical Care Medical Case Management Oral Health Care Mental Health Services Local AIDS Pharmaceutical Assistance Substance Abuse Services- Outpatient Home & Community-based Services Hospice Services Home Health Care Early Intervention	Respite Care Outreach Services Food Bank/Home Delivered Meals Medical Transportation Psychosocial Support Services Legal services Linguistic Services Emergency Financial Assistance Referrals to Health Care Housing Services

Haven Youth Center (A) Health Federation of Phila. (A) Kensington Hospital (A) Keystone Hospice (A/B) Mazzoni Center (A/B/D) Mercy Suburban Hospital Family Practice Center (A) Metropolitan AIDS Neighborhood Nutrition (A/B) One Day at a Time, Inc. (A) Orasure (A) Philadelphia Fight (A/B/C) Positive Effect Outreach Ministry (B) Presbyterian Medical Center (A) Prevention Point (A/B) Public Health Mngm. Corp. (A/B) St. Christopher's Hospital for Children(D) Temple University (A) Thomas Jefferson University (A) Trustees of Pennsylvania (A) University of PA, School of Dental Medicine (A/B/C) Urban Solutions (A) Women's Christian Alliance (A) Women's Institute for Family Hlth (B)		
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## 2. **How RW funded service providers interact with non-RW providers to ensure continuity of care.**

Ryan White funded organizations throughout the State interact regularly with numerous other organizations not funded via Ryan White in an effort to provide seamless services to HIV positive clients. Specifically, medical case management agencies often converse or meet in person with HIV medical providers at local hospitals, clinics and other medical settings to ensure that the medical needs of mutual clients are met. For example, some service providers physically attend medical appointments with their HIV positive clients' Infectious Disease (ID) specialist every few months so that they may all discuss issues relevant to the client's HIV status and how it may impact their overall health. Other providers also attend appointments or speak to their clients' primary medical doctors as well to determine if their medical needs not necessarily directly related to the management of their HIV infection are met. Regular communication between the Ryan White funded medical case managers and the medical community serving the client is essential as it allows the client and both providers to remain informed of all pertinent information as it relates to the HIV positive client's case.

In addition to primary and specialized medical care, many clients living with HIV/AIDS have to concentrate on corollary issues that can greatly impact their health and quality of life. In particular, clients have needs that pertain to housing, utility assistance, medical payments, medication co-pays and other similar issues. Those providers funded through the Ryan White are able to help by actively engaging in a regular relationship with other providers of these corollary services. For instance, some providers are able to work with state agencies or programs including Pennsylvania's ADAP, the Special Pharmaceutical Benefits Program (SPBP) to acquire services on behalf of their clients so that the life-saving medications may be paid for and given to them. Some providers have not only developed a rapport with professionals at this organization, but also sit on their advisory committee and can help to potentially shape policy and procedure for this entity which may ultimately help clients living with HIV in Pennsylvania.

Further, providers often take part in community task force meetings at the local level that enable them to become actively involved with other non-Ryan White funded community providers that can offer clients with HIV the ability to acquire housing or financial assistance with utilities, for example. Providers who take part in these meetings and gatherings gain valuable knowledge and develop relationships with professionals from other disciplines that ultimately benefit HIV positive clients who access HIV medical and support services.

**3. How the service system/continuum of care has been affected by state and local budget cuts, as well as how the RW program has adapted.**

There have been several impacts to the HIV continuum of care across Pennsylvania due to state and/or local budgets cuts. In addition to the already realized impacts there are also several concerns regarding anticipated budget cuts in federal, state, or local funding.

The most recent reductions took place as a result of a reduction in State funds for HIV prevention activities. The Centers for Disease Control and Prevention (CDC) funding in PA is primarily used for HIV counseling and testing, partner services, and surveillance, while State funds are used for health education/risk reduction efforts. Because the State funds were decreased the health education/risk reduction programs were reduced. Each regional planning Coalition receives a portion of these State funds for health education/risk reduction services. When the reduction was divided among regions, many regions were forced to decrease the number of health education/risk reduction services that the region provided. This resulted in fewer individuals being reached with these services. Because the Coalitions are the recipients of these funds, each region may choose to use these funds on RW patient care services or HIV health education/risk reduction services. Those regions using the funds only for health education/risk reduction services were impacted the most. The regions using the funds for RW patient care services were impacted less due to the ability to shift funding streams when receiving additional Ryan White funds. There have been no notable reductions in existing Part B and C funding.

There has been a reduction in funding for the State Medical Assistance prescription coverage which now places a limit of only six prescriptions per month. Although anti-retroviral medications are not "counted", many of the individuals receiving Ryan White care are on multiple drugs which will affect their success in HIV treatment. The universe of HIV drugs which will not be counted is not yet known; depending on how this is defined, some necessary drugs may not be counted (ex. Bactrim). The continuum of care has adapted to this by keeping close watch on what medications are subject to this requirement and by helping patients seek other prescription assistance to secure affected medications.

Several regions have identified transportation as a critical issue through their regional needs assessment process. Local reductions in the availability of public transportation have become an issue for both patients and staff. For example, in several areas throughout the State there has been a reduction in the number of bus routes, number of run times, and concomitant increases in fares. These reductions make it difficult for patients to attend medical appointments and support services. The case management organizations are then forced to find other means of funding to help these individuals pay for transportation to these appointments. The decrease in local funding forces Ryan White providers to utilize State and/or federal funds for these services in order to maintain the continuum of care.

Members of the Planning Council agreed that the true effects of several budgets cuts have not yet been felt because Ryan White providers and other agencies have responded to cuts by using discretionary funds. Once these discretionary funds are exhausted there are several anticipated consequences. These anticipated consequences are:

- A reduction in the State budget in mental health services will affect Part B and C participants.
- A reduction in the State budget in transportation funding for medical assistance transportation programs may lead to more missed medical appointments at Part C providers, community health centers, or other medical or dental providers.
- A reduction in Ryan White Parts A and D for ancillary services such as dental care, dietary services, and mental health services may have a large impact on Pennsylvania patients.
- A reduction in State prevention funding or placing limits on how prevention funding can be spent, such as required emphasis on prevention for positives, may be at the expense of other populations and may impact STD programs.
- A reduction in local funding at County Assistance Offices may affect benefits such as food stamps or energy assistance programs.

Although there have been no reductions to Ryan White Part B funding at this time, the Planning Council is concerned about potential reductions when the program is renewed. The Council anticipates less mental health funding, which will be problematic in portions of the state where there are no mental health providers that work with the uninsured or individuals on Medicare or medical assistance. There are also concerns about reductions in HOPWA funding which could lead to longer waiting lists for this service.

Ryan White programs have adapted in several ways listed in the above description but have also partnered with 340b programs to access additional funding, work to create a continuum between HIV prevention and treatment services, and partner with other agencies to apply for grants.

### **C. Description of Needs:**

#### **1. Care Needs to include a description of special populations including adolescents, injection drug users, homeless, and transgender.**

In order for Pennsylvania to identify care needs the Integrated Planning Council (IPC) uses information from the regional Ryan White Coalitions. The Needs Assessment subcommittee of IPC gathers available information in regards to regionally conducted needs assessments

for the purpose of statewide planning, however the group does not conduct statewide needs assessments on behalf of IPC. Therefore, care needs are addressed by the needs assessment subcommittee by looking at results from regional planning activities as well as reviewing any available statewide data which could garner perceived needs in care. Statewide data is utilized wherever possible; however with the rural and urban extremes present in PA, it is difficult to generalize for the entire state. We know it is a shortfall of Pennsylvania that no statewide needs assessment is conducted but that we will be making strides to change this in the future.

Among the care needs identified, unmet needs continue to be unchanged in the most recent estimates. In PA, up to 33% (detail in epidemiological profile) of individuals are aware of their status and are not in care. This remains to be a focus area in PA and efforts have been taken to impact this percentage. Efforts of the Expanded Testing program as well as the change in the PA HIV consent (Act 59) and efforts of the PA-DOH for partner testing may increase the number of individuals who are in need of care. While these activities aid in bringing individuals into care, this may challenge capacity statewide.

The needs assessment subcommittee recognized the statewide need to continue working toward a seamless prevention and care continuum. With the anticipated reductions in funding, services can no longer remain in silos based on funding streams; emphasis instead needs to be based on integration of services and working collaboratively.

The AIDS Education and Training Center is in the process of conducting a consumer survey that may describe perceived need on the part of participants who reply. The results of this survey will be included in the next submission of these documents.

<b>NEEDS ASSESSMENTS IN PENNSYLVANIA: STUDIES &amp;/OR SURVEILLANCE WITH NEEDS ASSESSMENT COMPONENTS</b>	
<b>PROJECT/TOPIC:</b>	Focus group studies among selected target populations for HIV prevention care:
<b>OBJECTIVES:</b>	To assess patient satisfaction with HIV care among persons enrolled in ADAP/SPBP;
<b>METHODS:</b>	
<b>STUDY DESIGN IF APPLICABLE:</b>	Focus group studies among self-selected participants drawn from selected target populations for HIV prevention and care;
<b>KEY DATA COLLECTION METHODS &amp; OVERALL TARGET POPULATION(S) FOR INTENDED INFERENCE:</b> i.e. target populations for prevention and care whose needs the project intends to assess, and major limitations of potential inference:	The key data collection methods entail in-depth discussions to elicit participant feedback on planned selected themes for each focus group. However, it is unlikely that findings of 1 focus groups of 15 persons in a given target population can generate findings which can be inferred to the target population whose needs the project intends to assess.
<b>SAMPLE SELECTION IF APPLICABLE:</b> i.e. describe sampling procedures/methods used	Each focus group's participants are a convenience sample of self-selected persons



<p>to establish population selected for needs assessment from the target population, incl. criteria for selection, and major limitations regarding representativeness in relation to the overall target population):</p>	<p>typically numbering 10 - 20 and drawn from the selected target populations for HIV prevention depending on the topic of the focus group. Although focus groups are conducted among selected target populations for HIV prevention and care determined by the CPG needs assessment subcommittee; the major limitations they face in terms of representativeness of the population studied cannot be compensated for by the depth of information elicited as long as the population studied is not representative of the target population to which inference is intended, e.g. in-depth information elicited from a self-selected more socially stable sub-population among a predominantly less socially stable target population is not likely to be applicable/represent the experiences of the predominant groups within the target population. It is therefore not clear whether/how data collected through this method can be reasonably applicable to the intended overall target population of investigation given these limitations.</p>
<p><b>LIMITATIONS:</b> incl. representativeness and generalizability of potential findings to the larger target population whose needs project intends to assess; description of samples selected and reached:</p>	<p>Additional information beyond limitations described above under methods is in preparation, and will be added when available.</p>
<p><b><u>PUBLIC HEALTH APPLICABILITY/APPLICATION OF FINDINGS OF PROJECT:</u></b> i.e. description of potential inference from findings in a public health context incl. a clear brief description of how/where the findings can be directly used/are actually used in program planning, implementation, and process and/or outcome evaluation:</p>	<p>Needs assessment findings which are applicable to the target populations for prevention/care are widely used in group-level public health activity such as data-driven/evidence-based prioritization of target populations, assessment of process and intermediate outcomes, behavioral and health service intervention protocol development, decision-making on whether further investigations/studies of emerging risk populations may be needed, etc. When needs assessments are conducted in the context of intake or follow-up care/prevention, findings are also used to direct individualized prevention/care services. Further information on project-specific applicability/application of findings from the project is in preparation, and will be added when available.</p>

The needs assessment subcommittee has identified several needs among special populations. Among adolescents, ages 13-19, transition planning from adolescent care to adult care is lacking. Among transgendered individuals it can be found that healthcare providers lack knowledge of the population for example, experience with hormone treatment, and therefore less than adequate care is offered. In addition, stigma continues to be experienced at all levels and types of care. For the injection drug user population, needle exchange programs have been very successful; however these programs are only available in Philadelphia and Pittsburgh. Other areas of the State would benefit from these programs. Care needs experienced within the homeless population include the availability of stable, affordable housing. In the care setting, these individuals are very difficult to manage due to their transient nature and no single location at which to contact them. Similarly, it is difficult to provide transitional/migrant populations with consistent care across providers. Healthcare reform and the implementation of electronic medical records may help with this need. There is a need among non-English speaking individuals for other services to be accessible via language lines. Medical care is available via language lines which is very beneficial for the clients however when medical services need to communicate with support services a barrier is created. Another special population to consider is those individuals who are undocumented. With the lack of the ability to provide identification these individuals are then closed off to many services and therefore do not access care services. The final special population identified is incarcerated individuals, specifically long-term. The transition from incarceration to community-based care is of high need and therefore priority. These individuals also have difficulty securing housing and gaining access to some benefits due to their criminal history.

2. **Capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities.**

The State of Pennsylvania has extremely diverse areas, with all of those areas having different capacity development needs. Despite the diversity there are some capacity development needs that are seen across Pennsylvania. Ryan White providers statewide have experienced interactions with healthcare professionals who lack training in HIV care and are unfamiliar with the needs of individuals living with HIV. In addition, there is limited access to infectious disease doctors statewide which often leads to individuals not receiving medical care in a timely manner due to these physicians carrying an unmanageable caseload. With the time of these physicians being strained often there is lack of communication between doctors and other medical disciplines. These communications are extremely important when trying to provide a continuity of care and seamless service delivery. On the same topic of communication, experienced within the urban and rural regions, is the issue of language barriers between clinician and patient. Adding to the issue of language barriers is high rates of illiteracy. According to the National Center for Education Statistics, Pennsylvania matches the national average of approximately 13% of adults lacking basic literacy skills. While certainly a statewide issue at 13%, when looking at counties individually, literacy is a larger problem in the more urban areas of the state. Philadelphia County for example has the state's highest illiteracy rate with 22% of adults lacking basic skills. These issues continue to present a challenge to healthcare providers in helping a client to navigate the healthcare system and effectively communicate about their care. Gaining the necessary healthcare coverage, understanding the complexity of insurance benefits, and accessing necessary system supports are challenges to any consumer of healthcare services and individuals with HIV/AIDS are no exception. The need to increase health literacy is an on-going capacity

need. The final capacity development needed statewide relates to the stigma of this disease that is still present within the healthcare community. Until further HIV/AIDS education is provided to healthcare professionals the existing stigma will continue to hinder patients in accessing services.

<b>NEEDS ASSESSMENTS IN PENNSYLVANIA: STUDIES &amp;/OR SURVEILLANCE WITH NEEDS ASSESSMENT COMPONENTS</b>	
<b>PROJECT/TOPIC:</b>	Focus group studies among selected target populations for HIV prevention care;
<b>OBJECTIVES:</b>	To assess patient satisfaction with HIV care among persons enrolled in ADAP/SPBP;
<b>METHODS:</b>	
<b>STUDY DESIGN IF APPLICABLE:</b>	Focus group studies among self-selected participants drawn from selected target populations for HIV prevention and care;
<b>KEY DATA COLLECTION METHODS &amp; OVERALL TARGET POPULATION(S) FOR INTENDED INFERENCE:</b> i.e. target populations for prevention and care whose needs the project intends to assess, and major limitations of potential inference:	The key data collection methods entail in-depth discussions to elicit participant feedback on planned selected themes for each focus group. However, it is unlikely that findings of 1 focus groups of 15 persons in a given target population can generate findings which can be inferred to the target population whose needs the project intends to assess.
<b>SAMPLE SELECTION IF APPLICABLE:</b> i.e. describe sampling procedures/methods used to establish population selected for needs assessment from the target population, incl. criteria for selection, and major limitations regarding representativeness in relation to the overall target population):	Each focus group's participants are a convenience sample of self-selected persons typically numbering 10 - 20 and drawn from the selected target populations for HIV prevention depending on the topic of the focus group. Although focus groups are conducted among selected target populations for HIV prevention and care determined by the CPG needs assessment subcommittee; the major limitations they face in terms of representativeness of the population studied cannot be compensated for by the depth of information elicited as long as the population studied is not representative of the target population to which inference is intended, e.g. in-depth information elicited from a self-selected more socially stable sub-population among a predominantly less socially stable target population is not likely to be applicable/represent the experiences of the predominant groups within the target population. It is therefore not clear whether/how data collected through this method can be reasonably applicable to the intended overall target population of

	investigation given these limitations.
<b>LIMITATIONS:</b> include representativeness and generalizability of potential findings to the larger target population whose needs project intends to assess; description of samples selected and reached:	Additional information beyond limitations described above under methods is in preparation, and will be added when available.
<b><u>PUBLIC HEALTH</u></b> <b><u>APPLICABILITY/APPLICATION OF FINDINGS OF PROJECT:</u></b> i.e. description of potential inference from findings in a public health context incl. a clear brief description of how/where the findings can be directly used/are actually used in program planning, implementation, and process and/or outcome evaluation:	Needs assessment findings which are applicable to the target populations for prevention/care are widely used in group-level public health activity such as data-driven/evidence-based prioritization of target populations, assessment of process and intermediate outcomes, behavioral and health service intervention protocol development, decision-making on whether further investigations/studies of emerging risk populations may be needed, etc. When needs assessments are conducted in the context of intake or follow-up care/prevention, findings are also used to direct individualized prevention/care services. Further information on project-specific applicability/application of findings from the project is in preparation, and will be added when available.

- D. Description of priorities for the allocation of funds based on:** The Pennsylvania Department of Health is the recipient for all Part B funding awarded by the Health Resources and Service Administration (HRSA). These funds are then distributed by the Department of Health to the seven regional Coalitions. Distribution to each region is based on the number of people living with HIV/AIDS in each region. Therefore, the percentage of people living with HIV/AIDS in a given region compared to the total number in the State would establish a percentage of funding awarded to that region. In addition to these percentages, there is a ‘floor’ and ‘ceiling’ established so that each region has enough funding to operate. When Part B funds are awarded, in addition to this formula, amounts may be adjusted in response to urgent needs and/or lapses in funding in the previous funding year.

After funds are awarded to each region, it then becomes the responsibility and requirement for the region to conduct priority setting followed by a competitive Request for Proposal process. Underserved populations are identified and prioritized within each region and funding is directed accordingly. Through the Request for Proposal process the organizations which will most effectively reach the prioritized populations are selected.

Ryan White Parts A, C, and D are all awarded funding directly from HRSA through a competitive application process.

- E. Description of Gaps in Care:** to include needs which obstruct access to care for HIV-positive individuals.

The Barriers and Gaps subcommittee began working to identify barriers and gaps in care while addressing HRSA's 4th goal of Eliminating Health Disparities. Discussion ensued around the method that would be most supportive in addressing the goal. The group agreed to begin by listing every categorical barrier that affected access to medical care. Once the list was developed, the group then identified key barriers and designated them as lead category's, then strategically placed the remaining barriers under each of the key barrier category's that made the most sense. The group then researched existing data that would support the newly developed list and all key barriers that were discussed in the previous submission of the State Coordinated Statement of Need.

I. Barriers and Gaps Identified

- Complexity of the Health Care System
- Dental Care
- Health Literacy
- Limited English Proficiency
- Insurance
- Cultural Competency
- Rural Issues/Access to Care
- Transportation
- Medicare
- Medicaid
- Education of Health Professionals
- Housing
- Daily Living Needs
- Poverty
- Stigma
- Social Security
- Growing lack of Urgency and Understanding of the Impact of HIV Disease
- Denial of Disease
- Racial/Ethnic and Health Disparities
- Cost
- Aging population
- Shortage of Primary Care Physicians and HIV specialists
- Case Management
- Mental Health and Substance Abuse
- Emergency Financial Assistance

II. Identify 4 Groups that are affected by the Barriers and Gaps

- Consumers
- Providers
- Community
- Society

III. Barriers and Gaps Listed in all 4 Groups

- Complexity of Health Care System
- Education
- Transportation
- Mental Health and Substance Abuse
- Stigma
  - Decrease fear associated with disease and treatment

- Denial of disease
- Intimidation of disease
- People feeling like they aren't like others
- Fear of perception and association of disease
- Fear of complexity of disease
- Fear of judgment by others
- People do not want certain programs in their areas (needle exchange programs, HIV clinics, etc.)

IV. Identify and describe barriers to accessing health care

- Complexity of the Healthcare System
  - Language barriers and illiteracy
  - Lack of awareness of the healthcare system and how to gain the necessary healthcare coverage and system supports
  - Complexity of the way insurance benefits work
  - Access to doctors
  - Lack of communication between doctors and continuity of care between medical disciplines.
  - Delay of treatment or not receiving medical care in a timely manner due to busy schedules.
- Education
  - Funding – limitations to what you can do with certain types of funds and the need for private funding to support certain educational initiatives.
  - Stigma related teaching issues (doctor/patient relationship), educating the medical community about HIV.
- Transportation
  - Lack of HIV clinicians/specialists in the state.
  - Complexity of transportation systems – limitations of county transportation systems to cross county/regional lines.
  - Lack of transportation funding
  - Rural versus urban
- Citizenship disclosure, undocumented status as a barrier to gaining healthcare coverage – lack of knowledge on the part of undocumented clients to access Ryan White care without being deported
- Mental health and substance abuse
  - Perception
  - Lack of programs
  - Homelessness
  - Personal issues/behavior
  - Delay of treatment
  - Confidentiality issues that are present between the medical system, drug and alcohol, and mental health systems
- Stigma
  - Decrease fear associated with disease and treatment
  - Denial of the disease
  - Intimidation of the disease

**F. Description of prevention and service needs:** The primary purpose of the prevention needs assessment activities is to provide data for the Department of Health and Community HIV Planning

Group (CPG) to support their HIV-prevention planning processes and application to the CDC. It is also hoped that local health departments and community agencies can be provided with needs assessment findings to assist their prevention activities and that the assessments can serve as a model for others working across the U.S. in addition to providing information about needs and barriers to HIV prevention to individuals nationally.

In 2010-2011, at the direction of the CPG, the Departments contractor, the University of Pittsburgh, Pennsylvania Prevention Project conducted a Substance use and mental health provider study.

The Needs Assessment committee of the CPG wanted to learn about HIV prevention provided by substance abuse and mental health care providers across Pennsylvania. An online survey was distributed to mental health and substance abuse clinics throughout the state. Providers returned 189 completed surveys. Descriptive statistics of the data were provided to the committee. Relevant findings included the following:

- Addictions counselors constituted 26% of the sample.
- 57% provide care in drug and alcohol treatment facilities.
- 66% conduct risk assessments, mainly around substance use behaviors and less around disclosure of HIV status.
- 53% claimed to have HIV+ clients.
- Face-to-face discussion and written materials were most often cited as educational formats used with HIV+ clients to help them in preventing transmission of the virus to their partners.
- Respondents sought to build their clients skills most around using condoms/barriers (50%) and negotiating harm reduction (49%), while providing clean needles (2%) or distributed drug/works cleaning kits (6%) at the least.
- Counseling issues principally concerned the HIV+ client's substance abuse, such as a need for referral and adhering to harm reduction practices. Disclosure of status to partners (42%) was the least cited counseling issue addressed.
- Respondents claim to spend between 1-25% of their time giving HIV+ clients information and resources to prevent transmission.
- Respondents received information about prevention activities from professional trainings the most, as well as professional publications and Internet resources.
- Respondents relied upon friends and colleagues as well as their professional networks to find out about community resources.
- Respondents use government websites as reliable sources of information for their clients. The Centers for Disease Control and Prevention as well as the SAMHSA website were cited as often used resources.

In addition, these were the top identified Needs and Barriers:

<b>Top 5 Needs</b>	<b>Top 5 Barriers</b>
Education pamphlets for clients	Substance use/Mental Health issues
Free condoms	Lack of accurate information regarding safer sex
Professional trainings	Silence around disclosure
Receive updated communications about prevention	Complacency about HIV
Funding	Policy barriers (i.e. paraphernalia laws)

The data provides a general understanding of how substance use and mental health providers in Pennsylvania do HIV prevention. Qualitative analyses are needed for a more nuanced understanding.

Recommendations from this study include, providing yearly HIV prevention trainings to substance abuse/mental health care providers, providing free condoms to mental health/substance abuse clinics, and providing educational literature for clients of mental health/substance abuse clinics.

The Pennsylvania Prevention Project also developed a Compendium of all Needs Assessments conducted on behalf of the CPG.

Since the inception of the CPG, community needs assessments have been a useful tool in identifying risk behaviors among specific populations, barriers in accessing HIV testing and other related services, and aiding in the prioritization of target populations. Needs assessments have been identified as an important companion to the epidemiologic and counseling and testing data collected by the Department. While the Department's data serves the committee by identifying overall trends in HIV prevalence and usage of testing services, needs assessment activities are important in identifying reasons why populations at risk for infections are not using condoms or being tested for HIV.

Over the years, needs assessments conducted by the Pennsylvania Prevention Project have focused on prevention with positives and populations of HIV-negative men who have sex with men, intravenous drug users, and heterosexual people at high risk of infection. Groups have focused on the experiences of race/ethnic groups, gender (including transgender), age, disability, and factors like HIV status and internet usage. Commonalities between needs assessment studies emerged. Many studies identified the need for greater education, skills training, and condoms. Material that is culturally appropriate for specific groups was also a common outcome. Stigma (HIV, homophobia, racism) have been identified as important factors in HIV prevention. The needs assessments have been helpful not only in developing the Commonwealth's HIV prevention plan but they have led toward the development of resources to aid support in HIV prevention. With the Department of Health, The Pennsylvania Prevention Project has created capacity building programs to aid agencies in working with diverse communities in a culturally appropriate manner (e.g. working with MSM communities). Programs and interventions utilizing internet based resources arose with the findings that more MSM are using the internet to find sexual partners.

The compendium provides coalitions and community based organizations information that they can use in their activities. Since many CBOs and coalitions do not have the ability to conduct needs assessments, the needs assessment committee can be an important resource for them by conducting needs assessments that they can use to help with their prevention activities. The compendium will be an easily accessed resource to help with their programs.

As we move forward, this compendium will serve as the basis of future needs assessments. This document will allow the Needs Assessment Committee to know who has been the focus of previous activities and what has been previously identified regarding HIV prevention within Pennsylvania. Future activities will include a focus of specific groups under the three main risk categories. The future needs assessments will focus upon those already infected along with an emphasis on testing and accessing care. The role of communities and social relationships will also be an important area of investigation as current literature state these are significant factors in people's behaviors, especially those of men of color who have sex with men.

The Department is implementing a program to increase partner services within private provider locations. The focus is on private providers because approximately 70% of all new HIV diagnoses are tested by private providers. Ryan White Part C organizations are also participating in this project



through the expanded testing program. Once these entities implement the project it will also be rolled out to Ryan White Part B providers and then to other private HIV medical providers.

In addition to the prevention needs described above, participant retention in interventions has been identified as an issue for HIV prevention providers. While CDC Effective Behavioral Interventions have been implemented across the State, these interventions are very difficult to maintain participants. Many of the interventions are several sessions and incentives are not provided until the completion of the intervention. With the risk populations these organizations are targeting, it is extremely difficult to maintain them for the entire intervention. In addition, the cost of these interventions is very high. When the pilot of each intervention was conducted, in many cases, the incentives for participation were very good and desired by the participants. Because of reductions in State funding for the provision of HIV prevention/education programs, it has become difficult to provide incentives for participation in some areas. This then makes it even more difficult to retain individuals for the length of the intervention.

**G. Description of barriers to care:**

1. Routine testing (include any state or local legislation barriers)
  - Time (when services are offered)
2. Program related barriers
  - Culture Competency
  - Not enough physicians that specialize in primary care and HIV/AIDS care.
3. Provider related barriers
  - Stereotype of patients who present with the disease.
  - Clients that don't keep appointments
4. Client related barriers
  - Literacy (educational and medical)
  - Gender Identity
  - Transportation
  - Time (when services are offered)
  - No Medical Insurance

**H. Evaluation of 2009 Comprehensive Plan:** The Broad Goals presented below are those which were listed in the Statewide Coordinated Statement of Need of 2009. The Integrated HIV Planning Council felt that it was important to further develop these goals and present a statewide picture of these goals over the past two years. These goals have served as a guide for regional planning in that planning entities could construct objectives to meet local needs. In addition, these goals have, in many situations, extended into statewide initiatives.

**1. Strengthen communication and/or explore new collaborations with federal, state, and local partners or agencies.**

In addition to the activities taking place at the State level to strengthen communication and/or explore new collaborations with federal and state partners there have also been extensive efforts conducted on the regional level. These regional collaboration efforts have been successful in providing clients with additional services, establishing cost sharing relationships, delivering HIV prevention more effectively, and increasing HIV testing.

Of high importance in all regions is strengthening communication with local individuals and organizations. Several regions have made it a priority to meet with physicians, both primary care and infectious disease, to create links and share information about available

programming. These links not only provide physicians with program information, which facilitates referrals, but it also creates contacts within organizations, such as hospitals, to open communication for cost sharing consideration. For example, regions have utilized these contacts and in turn worked with hospitals in the event a client has no insurance. The success of this relationship building has led to several hospitals willing to reduce bills by up to 40% which alleviates some of the cost burden on Part B funds. Regions have also met with dental providers with the same goal in mind. Some of these dental providers have been willing to work with regional Part B offices to discount any oral health services provided to our clients. Dental providers who are willing to accept Medical Assistance continues to be a problem statewide. Collaborations have been established with dental clinics within regions so that our clients have access to dental services. In addition to physicians and dentists, relationships have been built with organizations such as Value Behavioral Health which is a resource for locating credentialed mental health therapists. This connection has provided additional referral sources. Also, in the area of mental health, there are regions who currently participate in initiatives funded by the Substance Abuse and Mental Health Services Administration to impact regional needs in the area of substance abuse and mental health as related to HIV.

Other newly developed collaborations with the medical field include VA Hospitals and Federally Qualified Health Centers.

While exploring new collaborations may lead to more efficient ways in which to use funds, these collaborations have also led to in-kind donations such as space. Collaborating with numerous church groups across the state has provided free space in which to conduct programs for clients. Often times these locations are those which high risk populations frequent and/or are in rural areas. This lends itself to higher success of the programs due to engaging the program participants in locations in which they are comfortable and do not require extended travel. In addition to churches, success has also been experienced with programming offered in homeless shelters as well as locations in which LGBT groups meet.

In an effort to reduce unmet need, in 2009 the State organized conference calls between the regional Part B Coalitions and County Assistance Offices (under the Department of Public Welfare). The primary purpose of these calls was to inform the Offices of the regional Coalitions and the services available through them. Since these calls, several regions have gone a step beyond and strengthened that effort within their region by continuing communication with CAO on a one-on-one basis so that the referrals may be correctly initiated. Paralleled efforts were also extended to Probation Offices in some regions.

With the same intent of information sharing similar efforts have been conducted with pharmacies. Fostering relationships with pharmacies has made it possible to spread the word on a more direct level about programs such as the Special Pharmaceutical Benefits Program (PA's ADAP program) as well as regional Coalition services. The northern tier, being more rural, has had success with building these collaborations due to a smaller number of pharmacies in those regions.

While the correctional Transitional Planning Initiative (TPI) is on-going throughout the State, it is important for each region to maintain or further establish relationships with correctional facilities. The TPI is specific to the State Correctional Institutes; however several regions have also built relationships with Federal and County facilities located within their region and extended this program to them.

As part of need assessment activities, one region has coordinated with Hispanic Leaders in the South Central part of the State to facilitate a summit on Healthcare needs in the Hispanic community. This collaboration includes Hispanic centers, FQHC's, large hospital systems, health insurance agencies, schools and consumers. While only one region has conducted this effort, the results of the summit may be shared which may open some interest in other regions to emulate those efforts.

Local collaboration which extends into State discussion includes partnering with local legislators to inform them on HIV and alert them to the importance of HIV funding. Partnering with these legislators for community events, such as Black HIV Awareness Day, provides additional visibility and acknowledges that the disease is, indeed, still present in our communities.

Other connections are established through applying for and securing grants at the contractor and subcontractor level. Organizations throughout the State receive additional funding with which to serve our clients from funders such as the United Way, Broadway Cares, and the Blue Ribbon Foundation. A significant accomplishment for one region includes being awarded its second Special Project of National Significance (SPNS) grant, with a start date of September 1, 2010. SPNS grants are considered the most prestigious of the Ryan White grants, and are designed to, "advance knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection". The program funds innovative models of care and supports the development of effective delivery systems for HIV care. This award is designed to implement outreach, education, and testing services for individuals co-infected with Hepatitis C (HCV) and HIV. After patients are identified as HIV and/or HIV/HCV-positive, treatment is offered through the Part C Rural Health Care Clinic.

## **2. Establish a statewide model for medical case management.**

The State of Pennsylvania determined that the establishment of a statewide model for medical case management was a priority for a variety of reasons. In 2009, while there were several areas of the State which had long-term experience with medical case management there were still some areas in the initial phases of implementation. Due to the health outcomes reported as being associated with the implementation of medical case management programs the State wanted to make strides in positioning all agencies to effectively deliver medical case management services. Some of the reported health outcomes include the following:

- A higher quality of care for patients
- Higher patient-reported satisfaction with care
- Improved quality of life
- Decreased overall financial cost
- Decreased hospitalization and re-hospitalization rates
- Decreased use of emergency departments
- Decreased number of clinic visits
- Increased medication adherence
- Changes in health behaviors
- Increased patient self-management
- Decreased number of missed appointments

Because Part B funding includes the provision of case management (non-medical or medical), in 2009 the State formed the Statewide Part B Case Management Standards

committee. In January of 2010, this committee finalized Medical Case Management Standards. These standards were then released to all Part B funded Coalitions for distribution among medical case management subcontractors. To-date all subcontractors providing support services to HIV positive individuals have and are using the finalized medical case management standards.

To further familiarize the PA Integrated HIV Planning Council with an effective medical case management model the group invited an individual from the AIDS Activities Coordinating Office of Philadelphia to provide an overview of the model in Philadelphia. After this presentation and further review of these standards, the Implementation subcommittee of the PA Integrated HIV Planning Council discovered that there may be discrepancies between the standards created in Pennsylvania and those created and presented by HRSA (Julia Hidalgo).

Having taken initial steps to position agencies statewide to effectively implement medical case management, the PA Integrated HIV Planning Council recommends the following items to further this goal:

- Research HRSA expectations concerning medical case management.
- Make a recommendation to the Standards Committee to review the training information concerning medical case management conducted by Julia Hidalgo and compare with the current case management standards and make appropriate changes.
- Recommend that all regions have case management performance indicators in place and report on those indicators at appropriate time intervals.
- Recommend that the Standards Committee develops a monitoring tool to assure that agencies are following the medical case management standards, this tool may also be used as a checklist by agencies applying for funds to assure appropriate provision of service.
- To further the availability of these standards, recommend that the University of Pittsburgh attach a copy of the standards to the StopHIV.com website and notify everyone of availability through the HIV/AIDS Service Provider Registry.

### **3. Integrate the HRSA performance measures into service delivery systems and quality improvement programs.**

As of February 2010 the PA Quality Management Plan was released. This plan was distributed throughout the State and commitment to the Plan was garnered. Commitment statements were collected through July of 2010. Specifically relevant to this goal is information and requirements listed in the Plan under the Performance Measurement section which is copied below. Currently in the state of Pennsylvania HRSA performance measures, specifically group 1, 2, and 3, have been integrated into service delivery systems and quality improvement programs.

#### **Performance Measurement**

Each Ryan White grantee/subgrantee will:

- Have a documented process by which HRSA/HAB performance measure data is collected, analyzed and reviewed.
- Have a process in place to use the data to develop quality improvement activities to address identified gaps in service.
- Generate and submit a report of the HRSA/HAB performance measures on a bi-monthly basis to the Pennsylvania Ryan White Quality Management Project.

- Have a plan for identifying stakeholders and distributing HRSA/HAB performance measure data and quality improvement activities to stakeholders.

Each grantee/subgrantee now submits performance measure data bi-monthly to the Ryan White Quality Management Project (Project). The Project had been submitting aggregate grantee/subgrantee data to the National Quality Center and HRSA bi-monthly as an expectation of the HRSA Cross Part Quality Management Collaborative. Performance measurement (data) and quality improvement are two of the most important aspects in quality management. The ultimate goal is to use performance data results to improve HIV care, while balancing performance measurement and quality improvement. Frequent review of the performance measure data is necessary to assess whether the quality improvement activities are having an impact.

Upon receipt of the performance measure data, the Project aggregates the Pennsylvania data for each of the performance measures. The Project then releases the aggregate performance measure data via a newsletter prior to the submission of the subsequent performance measure data.

The Part A grantee (Philadelphia Department of Public Health) and Part B (Pennsylvania Department of Health) grantee collect the bi-monthly performance measure data from both their subgrantees as well as providers who are also Ryan White grantees (e.g. Part B subgrantee who is also a Part C grantee). The Part C grantees that do not receive funding from either Parts A or B submit the bi-monthly performance measure data to the Part A grantee.

Pennsylvania is still in the progress of achieving full implementation of all the performance measures. Most of the Pennsylvania grantees/subgrantees are regularly reviewing the HRSA/HAB group 1 performance measures. However, some of the Pennsylvania grantees/subgrantees have more experience than others in collecting and reviewing the HRSA/HAB group 2 and race/ethnicity performance measure data. Also, HRSA/ HAB released the case management performance measures early in 2010. The goal for the Commonwealth of Pennsylvania is to have all grantees/subgrantees:

1. Collecting, reviewing, and reporting performance measure data for the HRSA/HAB group 1, group 2 and race/ethnicity performance measures.
2. Collecting and reviewing HRSA/HAB case management performance measures. Case management performance measure data submission will be developed pending the possible involvement of CAREWare. These measures are currently being developed and tested within the CAREWare system in one region for implementation across regions as soon as issues are corrected.
4. **Improve case findings and facilitate linking individuals to care and treatment.**

The State of Pennsylvania continues to coordinate efforts which will improve case findings and facilitate linking individuals to care and treatment. Several Ryan White Part C medical clinics are members of the HIV Integrated Planning Council and have shared their strategies with the group. While Part C clinics play an integral role in case findings and linkages to care, they cannot do the job alone. Pennsylvania has well-functioning regional networks comprised of HIV prevention providers, regional and/or city departments of health, federally qualified health centers, and varieties of other health and human services agencies to support these efforts.

To improve case findings, several sites have found it useful to incorporate the expanded HIV testing initiative. This initiative is implemented in many locations and is funded by the Centers for Disease Control and Prevention. This program has been successful in improving case findings because HIV screening is offered to all primary care patients with the goal of testing everyone once per year. Most sites offering this program are larger primary care facilities with an existing HIV program on site, for example FQHC's, or Emergency Departments. In these sites the requirements for HIV counseling and testing are integrated into the clinical care setting in ways that do not interfere with patient flow. These efforts continue to expand into other locations with emphasis on the CDC testing guidelines. When a positive result is found in this setting, the individual is directly linked to the on-site HIV program and its social workers or case managers.

Many of the existing regional networks foster collaboration between care and prevention agencies. Prevention providers across the State incorporate testing into their prevention programs. These prevention programs are conducted in high behavioral-risk populations such as men who have sex with men, injection drug users, and high risk heterosexuals. These testing activities in high risk populations increase case findings and when a positive is found, the individual can be directly linked to HIV care within the regional network. Both prevention and care agencies throughout the State are exploring ways in which to increase partner testing and utilization of partner notification services.

While improving case findings generally refers to identifying individuals with the disease who do not know their status, facilitating linkages to care and treatment can also speak to individuals who know their status but have fallen out of care. In circumstances such as this there are a variety of activities which take place at providers throughout the State to locate those individuals and bring them back into care. There are numerous organizations in Pennsylvania which receive both Ryan White Part B and C funding. In those locations, the Part B case managers attempt on several occasions, if necessary, to contact the individuals by phone or by mail to schedule an appointment and bring them back into medical care. While having Part B services located within Part C structures is not the norm, the regional networks throughout the State have demonstrated collaboration between the two. In several locations this is demonstrated in the form of multi-disciplinary meetings. Part B providers, specifically case managers of shared clients, will attend meetings with Part C providers to discuss mutual clients and combine efforts to re-link them to care. Providers conducting these meetings generally have the meetings on a monthly basis. Success has been experienced with these meetings in part because staff may combine efforts in the best interest of the client.

The following were the goals and objectives are from the 2009 Comprehensive Plan. Followed by a brief narrative as to what the status is regarding of the implementation of each. The goals that follow are service delivery specific, focusing on the Core Service areas, and were submitted as part of the 2009 Part B Grant Application.

### **Goals, Objectives, and Activities**

**Goal 1:** Increase linkages with the Division of TB/STD

**Objective** – Invite participation of staff from the Division of TB/STD on the Integrated Planning Council by March 2009.

**Implementation Status -** Staff from the Division of TB/STD have been regular participants in the Integrated Planning Council meetings since March 2009.

**Objective –** By June 30th, 2009, the Division of HIV/AIDS will be granted access to PA- NEDSS (Pennsylvania National Electronic Disease Surveillance System) for the purpose of conducting partner notification on individuals co-infected with HIV and Syphilis. Partner notification of co-infected individuals will occur in conjunction with the Department's STD program.

**Implementation Status -** Staff from the Division of HIV/AIDS have been granted access to PA- NEDSS since November 2011 for the purpose of conducting partner notification on individuals co-infected with HIV and Syphilis. Partner notification of co-infected individuals will occur in conjunction with the Department's STD program.

**Objective-** By 2010, the Division of HIV/AIDS will fully integrate its stand-alone PS (Partners Services) database in PA-NEDSS.

**Implementation Status -** Staff from the Division of TB/STD and HIV/AIDS fully integrated the PS Services effective 9/28/2011 and also have integrated all PS activities within PA-NEDSS.

**Goal 2:** Revise and update the regional monitoring tool

**Objective –** Assign the Standards Committee to begin the revision process by June 2009.

**Implementation Status -** The release of the new HRSA Standards has required a complete revision of the monitoring documents and processes for all Ryan White Part B funded entities.

**Objective –** Advise the Committee to complete the revision by December 2009.

**Implementation Status -** Not Applicable.

**Goal 3:** Complete CAREWare conversion to Network

**Objective –** Finalize sole source with JPROG by April 2009.

**Implementation Status -** The Division completed this in March 2010.

**Objective –** Test program modification by October 2009.

**Implementation Status -** The Division completed this in October 2011.

**Objective –** Seek collaboration with Part A by January 2010.

**Implementation Status -** The Division did not complete this and still plans on completing this by April, 2013.

**Objective-** Issue network program to regional coalitions and providers by April 2010.

**Implementation Status-** The Division's intention is to have this completed by April 2013

**Goal 4:** Improving the efficiency of the working relationship between the Department of Public Welfare (DPW) and the Department of Health.

**Objective** – Continue monthly meetings with staff associated with the SPBP program.

**Implementation Status** - The Division holds regularly scheduled meetings and conference calls with the SPBP program staff. The SPBP and staff will be transferred to the Department of Health effective July 1, 2012.

**Objective** – The leadership of DPW and DOH will establish boundaries concerning work flow and communication by July 2009.

**Implementation Status** - Plans are being made to transfer the SPBP Staff from the DPW to the DOH to be new staff of the Division of HIV/AIDS effective July 1, 2012.

**Objective-** The leadership of DPW and DOH will confirm the roles and responsibilities of staff from each Department by September 2009.

**Implementation Status** - The Division of HIV/AIDS will ensure clarity of roles when all staff are part of the Division of HIV/AIDS.

**Goal 5:** Continue statewide and Part B efforts to develop effective quality management programs.

**Objective** – Continue participation in All Parts Collaborative.

**Implementation Status** - The State Wide - All Parts Collaborative Committee continues to meet on a regular basis.

**Objective** – Complete regional coalition and provider training for web portal in order to begin collecting data for quality management indicators by February 2009.

**Implementation Status** - In 2007, the Jewish Healthcare Foundation of Pittsburgh, in partnership with The University of Pennsylvania School of Medicine Office of Continuing Medical Education , CECity.com, Inc., the National Institute for Quality Improvement and Education and Creative Education Concepts were awarded a grant to develop a comprehensive quality management web portal to allow HIV service providers from across Pennsylvania to track and benchmark their progress related to an agreed upon set of HIV/AIDS care and supportive service quality indicators. This data collection system was initially utilized by the Part B providers; it was upgraded significantly over the past two years, and now has the capacity to: 1) track Part B and Part C data separately, 2) consolidate the data to provide Pennsylvania statewide data, and 3) allow participating service providers to view how they are performing against up to 53 quality indicators and immediately link to CME/CE-certified and non-certified activities in an effort to drive improved performance with respect to each of the quality indicators.

Presently, all of the Part B providers are submitting data to the web portal every two months. However, it has been a challenge to gain buy-in from those Part C providers who are not required to submit the information. The All-Parts Quality Management Team is currently working to overcome this challenge by having individuals on the team with existing relationships with those



organizations make contact with them and encourage participation. It is anticipated that it will take three to six months to get full participation from all the Part C providers.

**Goal 6:** Explore best practices for services that target racial and ethnic minorities, and women.

**Objective** – Assess existing targeted services to these populations no later than March 2010.

**Implementation Status** - No action has been taken on this Goal's Objective.

**Objective** – Finalize a report of findings no later than June 2010.

**Implementation Status** - No action has been taken on this Goal's Objective.

**Objective** – Share findings with all interested/appropriate constituents September 2010.

**Implementation Status** - No action has been taken on this Goal's Objective.

**Goal 7:** Insure that consortia planning for increasing service delivery capacity include efforts to address racial and ethnic minorities and women.

**Objective** – Review newly devised plans for required content no later than March 2011.

**Implementation Status** - The Department of Health submitted a draft plan in April 2012 to HRSA to implement activities for the Minorities AIDS Initiative (MAI).

**Objective** – Review plans to insure that all necessary corrections are completed by April 2011.

**Implementation Status** - Deadline not met – The newly planned MAI activities will begin to be implemented in July 2012.

**Goal 8:** Improve collaboration between Prevention and Care planning bodies.

**Implementation Status** – To enhance coloration and communications between these two planning bodies, in the fall of 2011, the Division of HIV/AIDS began to process of merging the Prevention and Care Planning Committees. The Steering Committee members of each planning body were joined to form an Integration Workgroup – which has been meeting bi-monthly since November of 2011. The committee has set January 2013 as a goal date for having a merged planning body that will work with the Division of HIV/AIDS for all planning in both HIV Prevention and Care services.

**Objective** – The steering committees from each of the States planning bodies will meet to assess current gaps in coordination between the two groups by September 2009.

**Implementation Status** - Completed and the results were to form an Integration Workgroup in November 2011.

**Objective** – The steering committees will offer recommendations to the full planning bodies by March 2010.

**Implementation Status -** The recommendations were to merge the two planning bodies to have a single planning group for HIV services throughout the entire continuum.

**Goal 9:** Improve case finding and facilitate linking individuals to care and treatment.

**Objective –** Collaborate with the AETC to identify methods for reaching out to physicians by June 2009.

**Implementation Status -** The new Division administrative staff have determined that the objective set for this Goal is not appropriate to meet the stated goal. The Division has implemented the SPNS project, which can be reviewed as an attachment at the end of this document.

### **III. Where Do We Need To Go?**

The purpose of this section is to provide an opportunity to discuss Pennsylvania's vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system.

#### **A. Plan to meet 2009 challenges** which were identified in the evaluation of the 2009 Comprehensive Plan

The PA Integrated HIV Planning Council identified four goals within the 2009 document submission and described in the previous section of this document.

The first of those goals was to strengthen communication and/or explore new collaborations with federal, state, and local partners or agencies. Over the past two years, each region of the State has experienced success with this goal. While this was listed as a goal in 2009, it is very much an on-going statewide effort to strengthen collaborations at all levels in order to provide the highest quality of care to clients as well as use the funding as efficiently as possible. While some relationships and collaboration are more difficult to establish than others, no significant challenges were identified as related to this goal.

The second goal identified was to establish a statewide model for medical case management. There were several challenges identified with this goal and the plan established for meeting those challenges includes a set of recommendations developed by the PA Integrated HIV Planning Council, Implementation Subcommittee. These recommendations are as follows:

- Research HRSA expectations concerning medical case management.
- Make a recommendation to the Standards Committee to review the training information concerning medical case management conducted by Julia Hidalgo and compare with the current case management standards and make appropriate changes.
- Recommend that all regions have case management performance indicators in place and report on those indicators at appropriate time intervals.
- Recommend that the Standards Committee develops a monitoring tool to assure that agencies are following the medical case management standards, this tool may also be used as a checklist by agencies applying for funds to assure appropriate provision of service.
- To further the availability of these standards, recommend that the University of Pittsburgh attach a copy of the standards to the Stop HIV website and notify everyone of availability through the HIV/AIDS Service Provider Registry.

The third goal identified was to integrate the HRSA performance measures into the service delivery systems and quality improvement programs. The Commonwealth of Pennsylvania has experienced significant success in the work towards this goal, but has encountered some barriers as well. The foremost challenge was that Part B providers and Part C providers were using two separate systems to collect performance measure data. From a positive standpoint, well over 95% of the HIV providers in the Commonwealth were submitting data to one or the other data collection systems. However, most of the Part C providers in Pennsylvania also receive Part B funding, so many organizations were being asked to submit data to both systems, and there was no mechanism developed to integrate the two sets of data. Many organizations were frustrated and resisted having to submit data twice.

Over the past year, the Part B Quality Management group and the All-Parts Quality Management Team have come to an agreement to consolidate the data collection. This will be done utilizing the PA HIV Initiative Web Portal. In 2007, the Jewish Healthcare Foundation of Pittsburgh, in partnership with The University of Pennsylvania School of Medicine Office of Continuing Medical Education, CECity.com, Inc., the National Institute for Quality Improvement and Education and Creative Education Concepts were awarded a grant to develop a comprehensive quality management web portal to allow HIV service providers from across Pennsylvania to track and benchmark their progress related to an agreed upon set of HIV/AIDS care and supportive service quality indicators. This data collection system was initially utilized by the Part B providers; it was upgraded significantly over the past two years, and now has the capacity to: 1) track Part B and Part C data separately, 2) consolidate the data to provide Pennsylvania statewide data, and 3) allow participating service providers to view how they are performing against up to 53 quality indicators and immediately link to CME/CE-certified and non-certified activities in an effort to drive improved performance with respect to each of the quality indicators.

Presently, all of the Part B providers are submitting data to the web portal every two months. However, it has been a challenge to gain buy-in from those Part C providers who are not required to submit the information. The All-Parts Quality Management Team is currently working to overcome this challenge by having individuals on the team with existing relationships with those organizations make contact with them and encourage participation. It is anticipated that it will take three to six months to get full participation from all the Part C providers.

Initially, submission of data on a bi-monthly basis was seen as a challenge, however all providers currently submitting data have met this challenge and it now is a seamless submission process.

The All-Parts Quality Management Team will take leadership for analyzing the statewide data and promoting quality improvement activities to address areas where the state is underperforming against HRSA standards. Once the majority of Pennsylvania's HIV service providers are routinely submitting data, the All Parts Quality Management Team will also be responsible for distributing the statewide data to providers and other stakeholders on a regular basis.

## **B. 2012 Proposed Care Goals:**

### **i. Unmet Need - SPNS Project**

- A. Rationale:** Please review the Appendix A titled, "SPNS /Linkage PA – A Critical Phase Inventions Project" for the full abstract of this project. This project has two primary focus areas; to enhance health service and information systems for 1.) testing and referral tracking, and 2.) linkage to prevention and care services.

- B. Progress: Implementation of this project has been initiated within seven Part C sites. The project is in progress and data is not yet available, however reporting will take place as required through the SPNS award at periodic intervals and of course at conclusion.

- ii. Integration of care and prevention planning

- A. Rationale: HIV care and prevention planning bodies currently operate independently of each other utilizing guidance and funding from two federal agencies, HRSA and CDC respectively. An emerging national trend sees the integration of these two planning groups as a means to create a more efficient and effective continuum of care for at-risk and HIV+ individuals. Integration of these groups will lead to eliminating duplication in the planning process and more efficiently utilizing limited resources. In the fall of 2011, the HIV Integrated Planning Council and the HIV Prevention Community Planning Group initiated dialogue for this integration. The steering subcommittees of each group and PA Department of Health staff began meeting to initiate this transition.
- B. Progress: As of June 2012, the Integration Workgroup had convened on four occasions. These meetings have been very productive and often the work of task groups has been established. These task groups have specific tasks to accomplish between meetings so that all work is on target for completion by January 2013. The current goal is to have implementation of a joint group, recently named the HIV Planning Group, begin meeting in January of 2013. A timeline has been established for the Integration Workgroup so that the deadline is able to be met.

- iii. Work with AIDS Education and Training Center to develop education programs on several HIV related topics.

- A. Rationale: The Council engaged in conversation surrounding concurrent diagnoses. Considering the frequency at which concurrent diagnosis takes place the group felt that this speaks to the need for education on these topics. Topics specific to concurrent diagnosis include Hepatitis C and Mental Health issues. Other areas were identified by the group as needing education programs available. These topics included HIV care in primary care settings, routine testing, and adherence education.
- B. Progress: Communication between the HIV Integrated Planning Council and the AETC has already been initiated. The AETC has requested additional information and provided a list of elements to consider while planning a training session or sessions. This information will be completed by IPC in the latter portion of 2012 with a target date for implementation of these trainings being mid-year 2013.

- C. **Goals regarding individuals Aware of their HIV status, but are not in care:** A thorough review of the Pennsylvania Epidemiological Profile indicates that an unmet need can be accurately quantified for the State. After analyzing this information subcommittees of the Integrated Planning Council identified the following goals to continue addressing unmet need in Pennsylvania.
  - 1) Continued expansion of HIV testing along with CDC guidelines and ACT 59. This would include encouraging medical providers to provide opt-out testing and expanding on the work of the PA Expanded Testing Project.
  - 2) Impact medical education (schools) via the AIDS Education and Training Center by promoting HIV testing curricula.

- 3) Utilize epidemiological data to better describe the cohort of HIV+ individuals who do have unmet need. If these individuals can be better identified and location better targeted, focus case-finding efforts could be conducted to connect these individuals to care.
- 4) Steer individuals who are inconsistent in care to Part C providers who have staff to assist with retention.

**D. Goals regarding individuals Unaware of their HIV status:** Pennsylvania plans to better integrate the Expanded Testing Program into each regions case-finding efforts. Currently, there is an assumption that each region has a case-finding component and this may be a starting point for discussion of case-finding initiatives regionally. Currently, there is a standardized case-management approach in development which will be in the form of a SPNS project. In addition, by better defining the unmet need population (demographic/location) case-finding efforts can be targeted. Integration of the partner notification process into case-management training and function would be extremely helpful for increased case findings. For example, case-managers should be trained in how to speak with newly diagnosed individuals about the importance of partner notification and how it is accomplished in their jurisdiction (local or regional health departments).

**E. Proposed solutions for closing gaps in care:**

- Combining care and prevention,
- Streamlining the process so clients can access care by utilizing one point of entry into the healthcare system instead of having to meet with multiple providers,
- Outreach to rural areas, and
- Educating clients and providers on how to navigate the healthcare system.

**F. Proposed solutions for addressing overlaps in care:**

- Streamlining the process so that providers are able to access a patient's medical record regardless of where they entered care, which then allows a provider to see what kinds of treatment and/or care has already been provided.

**G. Provide a description detailing the proposed coordinating efforts with providers:** the following programs (at a minimum) to ensure optimal access to care: Part A, B, C, D, F, private providers, prevention programs, substance abuse treatment programs, STD programs, Medicare, Medicaid, CHIP, Community Health Centers.

The Pennsylvania Regional Coalitions coordinates services with the following programs:

1. Part A Services

- Direct referrals from the Coalitions and Providers to Part A (Philadelphia) takes place when clients have a change in residency and move from the NW to SE region of the state.
- For regions that have federal and state prisons in their area, Counselors and medical providers from these facilities have contacted the Coalitions and requested assistance in locating referral sources for HIV positive inmates that are returning to Philadelphia.

2. Part C Services

- The Coalitions and Providers make direct referrals to Part C providers in and out of the region. All Part B clients are assessed at regular intervals for unmet medical needs.
- In the North West Region, Part B clients identified as having a need for HIV specialty medical care are provided the option of attending the Alliance Part C clinic. If a client is a

Part B client and a Part C clinic patient all care, treatment, and referrals are made between Ryan White providers to ensure no duplication of effort occurs. Alliance Part B and C staff members have direct access to CARE Ware (Part B) and Lab Tracker (Part C), and reside at the same office location. This allows access by providers to written documentation and eliminates duplication of effort.

- Community Health Network (CHN), located in Erie, is also a Part C provider. Part B clients needing medical care and residing in Erie are provided information on CHN's program as an option for specialty and primary care. CHN is a Federally Qualified Health Center (FQHC). In addition, quarterly team meetings occur between the Part C staff at CHN and the Part B medical case management staff at the Alliance in order to provide care coordination and to make certain clients are retained in care.
- Part B clients may receive specialty HIV care and attend a Part C clinic outside of their regions. Part C providers in the Pittsburgh area include Positive Health Clinic or Pittsburgh AIDS Center for Treatment (PACT). In these instances, the medical case manager communicates regularly and receives doctors notes and/or other correspondence from the specialty clinic in order to follow-up on the patient's plan of care, coordinate insurance, arrange for transportation and follow-up on adherence to treatments and services.
- The Part C in the North East region (The Wright Center for Primary Care) is also funded with Part B. Services are very integrated and the Part C also invites our stand-alone Part B to multidisciplinary meetings so that all parties are up-to-date with all aspects of the client's needs.
- Each of the two Part C's in the South West region also receives Part B funding. Thus, they participate in all subgrantee meetings.
- The Part C's and the other providers in the South West region have open communications and referrals for services.
- The Part B's and Part C's in all areas are continuing to improve the systems for sharing necessary client information for certification and medical case management.
- During the last 18 months, the South West region has worked collaboratively with one of the two part C's in their region to reduce 30-day hospital readmission rates to their affiliated hospital. Through this initiative, they have reduced the rate by more than 50% as compared to the 14-month baseline period.
- South Central region collaborates with Part C medical providers who are Part B funded as well as non-funded Part C providers through Coalition meetings, trainings and special events. South central B providers collaborate with the Part C providers to ensure continuum of care from supportive services to medical services through regular contact and monthly meetings with the medical care team. The case management agencies who are not also Part C agencies meet with the Part C care team to discuss special client needs and coordinate the care and supportive services of clients. Most Part B case managers in our region are part of the medical care team.
- Two of the South Central HIV providers are currently involved in a SPNS grant (The Linkages PA CARE Program: A Critical Phase Interventions (CPI) Project) to use a integrated health information and management system to better get and keep people in case management and medical care. It will also be used for partner notification, to track referrals in order to prevent people from falling out of care

### 3. Part D Services

- Part B clients that are pregnant or present with an advanced gynecological clinical issue may be referred to Magee Women's Hospital (in Pittsburgh) in order to receive the appropriate medical treatments.

- HIV positive children are referred to Children's Hospital in Pittsburgh for care and treatment services. Pediatricians in the South West region will not provide HIV specialty care to children.
  - There is only one part D in the South West region and it is administered by one of the Part C providers. Therefore everything from that section applies.
4. Part F Services
- The Part B providers, collaborates with the PA/MA AETC in Pittsburgh on meeting the training needs in the region. The Coalitions have coordinated trainings with the AETC on quality management, dental care, mental health, and the provision of medical specialty care.
  - The AETC has requested speakers from the Coalitions on the subjects of HIV specialty care and treatment adherence.
  - Part B staff members serve as Planning Committee members for the Pennsylvania All Parts Summit.
  - Part B providers attend AETC trainings when available.
  - The South West region partnered with the AETC to host a meeting regarding how to implement the National HIV/AIDS strategy in their region. They also participate in and promote many of their training sessions.
  - The South Central region collaborates with the AETC when opportunities for training are available in our region.
  - HIV providers in the South Central Region use AETC trainings for case managers, medical providers and outreach and HIV testing staff.
5. Private Providers (Non-Ryan White Funded)
- Part B providers are in frequent communication with the private physicians that some of our clients utilize. Private providers present various barriers but have more recently aided in fulfilling Part B requirements in the best interest of the clients.
  - Part B providers are active in care coordination for PLWH/A. Referrals to non-Ryan White funded providers include referrals to primary care physicians, dentists, eye doctors, mental health providers, obstetricians, gynecologists, cardiologists, nutritionists, nephrologists, hepatologists, etc.
  - Based on Act 59 recommendations, the Coalitions and Providers are taking an active role in linking newly diagnosed clients to care.
  - Emergency financial assistance is accessed for HIV related medical services for PLWH/A in the region through a 'grant' process established by the Coalitions.
  - The South Central Region collaborates with privately funded providers on a regular basis. We have service providers in our region who provide HIV services, not funded by Part B, which we invite to Coalition meetings, request participation in needs assessments and other activities such as priority setting and input for the state of the region report on services in south central PA.
  - HIV agencies in all regions also refer to Infectious disease doctors and specialists who may not be in the Ryan White system, if needed.
6. Prevention Programs including Partner Notification Initiatives and Prevention with Positives
- All of the HIV prevention programs have close relationships with the Part B providers in each of the Coalitions. Any positives identified are immediately linked to care. Many of the local and regional Departments of Health staff are Coalition planning board members and work well with both care and prevention providers. The North East and the North Central

area currently fund prevention programs that are required to have prevention for positives component in their services.

- Our Part B/C providers provide Prevention with Positive interventions within their clinics
- We have seven providers in our region conducting CDC approved interventions to MSM, heterosexual African American women, positive individuals, at-risk youth and IDUs.
- All of our agencies that conduct HIV testing have protocols in place to link positive people to partner services and care.
- The North West Alliance is developing a referral mechanism to link clients to the Prevention Specialist in order to decrease risk behaviors through intervention strategies. The Specialist, as a staff member of the Alliance, will have direct access to CARE Ware and Lab Tracker and is being trained to work as part of the healthcare team.
- The North West Alliance has a direct connection/linkage with the Northwest District Office of the PA DOH. The HIV Nurse Consultant makes direct referrals to the Alliance and its many programs when clients are identified as HIV positive. The referral point for access to Ryan White services in the region is through the medical case management department. The medical case manager is then responsible for linking the client to needed services in their county of residence. The DOH HIV Nurse Consultant is responsible for partner notification services. The Alliance discusses partner notification services with each client so that services are delivered to all clients regardless of their testing location.
- In the County of Erie, it is the responsibility of the Erie County Department of Health (ECDOH) to do testing and partner notification services. The ECDOH HIV staff member informs PLWH/A of Part B and Part C services available within the county.
- North West Alliance staff members are trained counselor testers and conduct HIV tests throughout the region. Positive test results and partner services are provided by the HIV Nurse Consultant.
- The North West Alliance subcontractors in Erie, the Multi-Cultural Health Education Delivery System (MHEDS) and Gaudenzia, provide counseling and testing services. Both subcontractors are located in Erie and refer positives to medical case management services for assessment and linkage to care.
- The North Central region has a direct link to the PA DOH offices in our region and they make referrals directly to our sub-contracted agencies.
- All of the sub-contracted agencies in the North Central region have trained counselors/testers on staff who conduct HIV tests throughout the region.
- Care agencies in the South Central region collaborate with prevention providers to do partner testing and refer clients to participate in programs like Healthy Relationships.
- A few care agencies in the South Central Region are funded to provide prevention services like Partnership for Health.

#### 7. Substance Abuse Treatment Programs / Facilities

- In the Coalitions, Memorandums of Understanding are developed with substance abuse facilities in their region. PLWH/A are referred to the Part B service provider by the substance abuse facility. Care agencies do substance abuse assessments and refer clients as necessary. Clients are also referred to substance abuse facilities based the medical case management assessment and unmet need. Need is established based on the results of the CAGE and DAST assessment that is completed by the client. All referrals to substance abuse treatment are tracked in CARE Ware.
- Most of the South West region prevention providers conduct interventions within treatment facilities.



- A part B provider in the South West region is specifically a MH/SA Facility focusing on LGBT and HIV+ clients.
- South Central providers work closely with substance abuse and treatment programs to coordinate referrals between agencies. Agencies, like Guadenzia, Inc., are present at Coalition and planning meetings in order to gain prospective of HIV from these types of programs. They have also participated in our allocation panel in the past.
- One Part C/B agency in the South Central region is currently working with a drug and alcohol treatment program (Gaudenzia) on a project to referral eligible clients back and forth between the agencies. This agency also does HIV/AIDS and STD education to the drug and alcohol clients on site at their program.
- Medical case managers across the state offer treatment options and facilitate enrollment in substance abuse treatment. The HIV program coordinates ancillary services, such as transportation to a facility for residential treatment.

#### 8. STD Programs

- The Coalitions have close working relationships with many of the Adagio Health and Family Planning clinics across the state. The State has trained STD staff on HIV testing and has a referral mechanism in place for direct linkage to care for those identified as PLWH/A. In addition, clients with a need for STD or family planning services are referred directly to the STD programs that are easily accessible to the patient. Care and treatment services are coordinated through the medical case manager and/or the HIV clinical provider.
- Most, if not all, of the South West region agencies have linkage to local STD treatment facilities.
- Many of the HIV providers in the South Central region offer STD testing, however, if they do not, referrals are made to agencies like Planned Parenthood.

#### 9. Medicare

- All clients receiving Part B services are screened for insurance coverage and eligibility. Clients are educated on insurance types and scope of coverage. Clients covered by Medicare insurance are educated on the benefits, scope of coverage and associated Part D plans.
- Clients needing additional coverage are educated on various Medicare Supplement programs and/or are referred to SPBP in order to limit the out-of-pocket costs associated with care and treatment.
- Recertification requires a review of insurance coverage every six months.
- Every eligible client is enrolled in Medicare and all billable services are billed appropriately.

#### 10. Medicaid

- All clients receiving Part B services are screened for insurance coverage and eligibility. Uninsured clients and clients with limited incomes are referred directly to the Department of Public Welfare for eligibility. Clients experiencing a change in income or insurance are referred back to DPW to be reassessed for coverage. Clients who are disabled, but working, are regularly referred to Medical Assistance for the Working Disabled (MAWD) program.
- The Coalitions have participated in conference calls between the District Managers overseeing the County Assistance Office so that Ryan White services are explained and referred to by welfare staff members.
- Recertification requires a review of insurance coverage takes place every six months.
- Although some of the case management agencies in the South Central region have attempted to get certified as a targeted case manager through the Medicaid program, this has not been an easy process.

- All eligible clients are enrolled in Medicaid and billable services are billed appropriately.

#### 11. Children's Health Insurance Program (CHIP)

- Families with children are referred to CHIP if an unmet need is identified. Children typically have insurance coverage when they enter Part B services.
- Most clients in the CHIP age range are eligible for Medicaid, but referrals are made to CHIP, if needed.

#### 12. Community Health Centers

- The Coalitions refer PLWH/A to Community Health Centers (CHC's) for primary care and dental services.
- Some of the Coalitions have established relationships with CHC's and have a Part C specialty clinic at local hospitals and CHC's.
- One Part B provider in the South West Region is a Community Health Center
- A MCM provider in the South West Region is currently in talks with a Community Health Center that focuses on medical care to the LGBT community to provide MCM services to their HIV+ population.
- Two of the Ryan White funded agencies in the South Central Region are community health centers. Case management agencies also work closely with community health centers that may not be Ryan White Part B funded in order to provide case management services to their clients.

The Implementation subcommittee of the Integrated Planning Council believes the following strategies could be adapted by Ryan White providers and other stakeholders to improve access to care:

- Integration of case management services, behavioral health consultants, and nutritional counseling into Part C provider programs.
- When a patient is stable, Part C providers could consider allowing the client's primary care physician to manage the HIV so that they can focus on the patients most in need of care.
- Part C providers can offer more flexible scheduling including same day appointments or walk in hours.
- Integration of HIV care into community health centers.
- Promotion of planning on local level by Coalitions.
- Improve IT structure including medical appointments with doctors by video in rural areas where there are no providers and increase the use of electronic medical records.
- Collaboration with sexually transmitted disease programs or hepatitis C programs on grants to receive additional funding.
- Integration of the Department of Health partner notification services into primary care settings.

The Department of Health has developed an HIV/AIDS Services Provider (HASP) Registry. This is a listing of individuals and agencies within Pennsylvania working to assist persons living with HIV/AIDS or to prevent the spread of HIV/AIDS. The HASP is a collaboration between the Pennsylvania Department of Health (PADOH) and the Pennsylvania Prevention Project at the University of Pittsburgh with the goal of establishing a statewide registry of HIV service providers. It is a long-term collaborative effort with the Integrated Planning Council and Ryan White funded Coalitions to conduct a study on the unmet needs of HIV positive men and women. This project has included an examination of national, regional, and local resources to draft the most comprehensive level of detail that meets the needs of both epidemiologists and consumers.

## **Benefits identified include:**

- Aligns with the National HIV/AIDS Strategy to assist both the Centers for Disease Control and Prevention (CDC) and the PADOH to understand what services are currently being offered, what services are needed, where funding is needed, and where resources can be better utilized within the state when planning and referring.
- Agencies enrolled in the Registry:
  - Are among the first in line for available funding.
  - Are already identified within their region as sources to meet unmet needs. This will prevent an overlap of services that would be created if new sources were funded.
  - Are better equipped to make quality referrals across the state.
- Allows consumers a single comprehensive place to locate services.

## **IV. How Will We Get There?**

The purpose of this section is to describe the specific Strategy, Plan, Activities, and Timeline associated with achieving specified goals and meeting identified challenges.

- A. Introduction to How Will We Get There:** The Implementation subcommittee was charged with identifying best practice models for addressing the barriers and gaps to HIV care in the state of Pennsylvania and in finding ways to promote these models. This committee chose to focus on the five areas identified by the Barriers subcommittee including: Complexity of the health care system; mental health and drug and alcohol issues; education of doctors, consumers, and the public; stigma; and transportation. Next the subcommittee reviewed approaches taken to address these barriers not only in Pennsylvania, but throughout the country and internationally including presentations at the 2010 Ryan White Grantee Meeting.

The subcommittee determined that of these five barriers, the most frequently and/or successfully addressed issues with measurable results were complexity of the health care system and drug and alcohol issues. While the subcommittee does not believe these two issues are more important than the others, and do believe that Ryan White Grantees are trying to address the other barriers; these results are not always reported and therefore not easily accessible. The subcommittee will address the other barriers indirectly and hopes that there will be additional literature addressing best practice models for resolving these barriers in the future.

The Implementation subcommittee believes the following strategies and models promote the US Department of Health and Human Service's Healthy People 2020 Goals for HIV along with the National HIV/AIDS Strategy (NHAS) for the United States and could be adapted by Ryan White Grantees throughout the state.

One of the primary strategies brought forth by the PA Integrated HIV Planning Council regarding the items in this section is to distribute this document widely and make recommendations to use the best practice models which have been researched here.

**Brought by the Implementation Committee of the PA Integrated Planning Council on HIV:**  
S. Lloyd, RN ; D. Woodman; S. Rubinstein, MPH; A. Ayorinde; M.L. Akers, MHA; M. Witmer, LSW; T. Danowski, MHA; D. Hakanan; W. King; M. Dolatoski, MA; J. Montgomery; S. Emel; A. Lapp.

**Members of the Implementation subcommittee bring a proposal to:** provide the following best practices found and determined by our committee in addressing barriers to people living with HIV (PLWH) in finding access to and remaining in care. The best practices presented here seek to address more specific issues directly contributing to the list of general barriers as determined by the Barriers Committee.

## **1. The Navigator Project (Fenway Community Health)**

### Description

The Navigator Project was funded under a SPNS grant as part of the “Targeted HIV Outreach and Intervention Model”. The overarching goal was to facilitate service system changes to enhance the probability that individuals from historically underserved populations are engaged and retained in quality medical care. A curriculum was developed that included five days of training for the health system navigators. Upon completion of the training, the navigators are paired with patients to identify and address barriers to care. Evidence shows that the use of a navigator for three months leads to long-term retention in care as well as reduced morbidity and mortality. The following should be focal points for any health system navigator program and should work as strategies to reduce readmissions:

- Improved patient education upon discharge
- Individualized care plan
- Follow-up call from pharmacist within two days
- Prompt follow-up with PCP
- Prompt response to exacerbations
- Improved discharge planning and coordination across transitions of care
- Productive provider-patient communication

This model directly or indirectly addresses Healthy People 2020 goals 1 through 15, 17, and 18 and NHAS goals 2 and 3.

### Links

[www.fenwayhealth.org/site/DocServer/Health\\_System\\_Navigation.ppt?docID=362](http://www.fenwayhealth.org/site/DocServer/Health_System_Navigation.ppt?docID=362)

## **2. The Use of EIS (Early Intervention Services) to Address Unmet Need**

### Description

Under early intervention services, access to the HIV care system is facilitated by HIV testing, referral services, health literacy/education and linkage to care. All of these activities help to create a bridge to medical care, medication access and treatment adherence. Early intervention services can be a strategy to address unmet need that collaborates with various points of entry. It can resemble a model of case finding or patient navigation. Some early intervention service sites use peer community health workers to link people to care. They are also being used to conduct HIV testing in some areas.

This model directly or indirectly addresses Healthy People 2020 goals 1 through 15 and NHAS goals 2 and 3.

### Links

[http://www.hektoen.org/programs\\_hiv\\_rw.html](http://www.hektoen.org/programs_hiv_rw.html)

## **3. Behavioral Health Consultation Model**

### Description

The Behavioral Health Consultation Model is a way to integrate behavioral health into a primary care setting and works well in settings where the patient population is not interested in counseling. Typically, the primary care practice employs LCSWs and/or psychologists who are embedded into the primary care team. The Behavioral Health Consultants (BHC) do not have their own offices or caseloads, but, rather, take from hand-offs from the primary care provider (PCP) when patients are depressed, anxious, have sleep problems, or exhibit other symptoms, such as signs of post-traumatic stress disorder (PTSD). In some clinics the BHC sees the patient before the PCP, but in other clinics the BHC sees the patient after their PCP visit. In clinics where the PCP sees patients before the BHC, the BHC may proactively go into the exam room to introduce him/herself to the patient and possibly use this time to do a quick assessment or short psycho-education about self-care, and then leave when the PCP comes in. The BHC explains to the patient that the practice is a comprehensive care clinic and they want to take care of all of them, including how they feel/function day-to-day. Thus, when the BHC comes into the exam room, s/he identifies what is impairing the patient's functioning. Then, using motivational interviewing, the BHC teaches the patient symptom management or self-care during a 15 to 30 minute intervention. In these sessions, the BHC addresses a specific problem, but they do not treat a diagnosis. Immediately after the session, the BHC gives feedback to the PCP and the rest of the care team. When the patient returns to the clinic either the PCP or BHC follows up with the patient.

- This model is particularly effective with populations that are not interested in participating in on-going counseling or therapy.
- The Health Federation of Philadelphia is helping the city's FQHCs implement this model. One clinic using it is Esperanza Health.
- Wayne State University in Detroit has been using the Behavioral Health Consultation Model for more than three years.

This model directly or indirectly addresses Healthy People 2020 goals 11, 12, and 17 and NHAS goals 2 and 3.

### Links

<http://web.me.com/nefserrano/PrimaryCarePsychology/Welcome.html>

<http://www.integratedprimarycare.com/consulting%20for%20integrated%20primary%20care.htm>

Collaborative Family Healthcare Association; 2011 Conference, October 27-29, Philadelphia, PA;  
<http://www.cfha.net/>.

## **4. Project ECHO (Extension for Community Healthcare Outcomes)**

### Description

Project ECHO, a project of the University of New Mexico, started as a way to provide Hepatitis C care to people from rural areas. In this model, specialists collaborate with rural providers using technology, so that providers in rural and underserved areas develop the capacity to treat chronic, common and complex diseases safely and effectively. The project also monitors the outcomes of this treatment. This model has grown to cover 19 specialty areas, including Hepatitis C, HIV/AIDS, and Integrated Addiction and Psychiatry.

This model directly or indirectly addresses Healthy People 2020 goals 10, 11, 12, and 15 and NHAS goal 3.

#### Links

<http://echo.unm.edu/index.shtml>

### **5. Horizons Program**

#### Description

Horizon program (a USAID funded collaboration project) was started in 1997 to research and understand the underlying issues perpetuating stigma in the arena of HIV. The program identified effective interventions and approaches used by collaborating organizations to address the issue of stigma. Collaborating partners varied from CBO's to hospital based programs.

One approach the study highlights is raising awareness and acknowledgment of stigma in health care settings. Noting the experiences of a hospital based in India, the Horizon project explains how this hospital conducted interviews and surveys to assess the levels of stigma of their employees. Based on the results, action plans addressing the issues of universal pre-cautions, provider education, sensitivity and support were developed. As noted in the study, these interventions facilitated social and environmental changes in the work environment of the hospital. Also, the interventions changed the healthcare worker's attitudes about HIV infected persons.

A second approach the Horizon program has employed is the integration of HIV related services with general health services. This integration process reduces the levels of stigma associated with receiving HIV services. Their study examined this model of providing HIV integrated healthcare services to Brazilian truck drivers. The study concludes this population was more receptive of HIV related services using this approach.

This model directly or indirectly addresses Healthy People 2020 goals 9, 10, and 16 and NHAS goals 1, 2, and 3.

#### Links

[www.popcouncil.org/pdfs/2010HIV\\_HorizonsStigmaBackground.pdf](http://www.popcouncil.org/pdfs/2010HIV_HorizonsStigmaBackground.pdf)  
[aidsalliance.3cdn.net/d8810bc5c431db5354\\_cum6vtkva.pdf](http://aidsalliance.3cdn.net/d8810bc5c431db5354_cum6vtkva.pdf)

### **6. Reducing HIV and AIDS-related Stigma and Discrimination Program**

#### Description

Reducing HIV and AIDS-related Stigma and Discrimination Program was a program based in Vietnam that aimed to reduce stigma and discrimination through policy changes, the use of mass media and the engagement of communities. Through this multi-level approach, the project engaged policy makers from national and local levels to participate in toolkit exercises such as "Understanding and Challenging HIV Stigma". These activities initiated policy changes and thinking of politicians regarding stigma surrounding the issue of HIV. These activities also encouraged community level anti-stigma and discrimination action plans.

The researchers found that the Reducing HIV and AIDS-related Stigma and Discrimination Program to engage politicians and community level works on the issue of HIV related stigma. Policy makers participating in these activities also became more engaged and invested in creating guidelines addressing stigma in the areas of AIDS reporting and communication.

This model directly or indirectly addresses Healthy People 2020 goals 9, 10, and 13 and NHAS goals 1 and 2.

#### Links

## **7. HRSA's Unified Health Communications (UHC) Training Demonstration**

### ***Description***

Unified health communications (UHC) is an online educational module to be used by clinicians, providers, and lay persons. It provides training for cultural competency, limited English proficiency, and health literacy (all three issues that commonly impact Ryan White Funded programs). The training increases awareness of these three factors and provides concrete examples of improved patient-centered communication practices.

This model directly addresses Healthy People 2020 goal 10 and NHAS goal 2.

### ***Links***

<http://www.hrsa.gov/publichealth/healthliteracy/>

[http://careacttarget.org/2010\\_rw\\_grantee\\_meeting/papers/F-14.pdf](http://careacttarget.org/2010_rw_grantee_meeting/papers/F-14.pdf)

## **8. Helping Patients Help Themselves in 20 Minutes or Less**

### ***Description***

The Chronic Care Model, developed by Dr. Ed Wagner, MD, MPH, is an approach to providing medical care for individuals with chronic conditions. A highlight of the CCM is patient self-management support. Self-Management Support is defined as empowering and preparing the patient to manage their health and healthcare. The Collaborative Care Model is an approach for integrating Self-Management Support into patient care, before, during and after a visit. This session used role-playing and real world examples to explore both models as related to Self-Management Support.

This model directly or indirectly addresses Healthy People 2020 goals 11 and 12 and NHAs goal 3.

### ***Links***

The Chronic Care Model: <http://www.ihl.org/IHI/Topics/ChronicConditions/>

The Collaborative Care Model: <http://www.newhealthpartnerships.org/>

[http://careacttarget.org/2010\\_rw\\_grantee\\_meeting/papers/H-18.pdf](http://careacttarget.org/2010_rw_grantee_meeting/papers/H-18.pdf)

## **9. Use of Client Diagnostic Questionnaire**

### ***Description***

People living with AIDS may not reveal the signs of mental health or drug and alcohol issues to their medical professionals. Part B providers such as case managers often are the ones that clients may choose to disclose this information to, but knowledge and experience in these areas varies with the case manager. In order to screen for these issues, case managers need the correct tools. One such tool is the Client Diagnostic Questionnaire, which screens for both mental health and drug and alcohol concerns and can be administered by a non-mental health professional (Aidala, Haven, Peake, & Keane, 2011). The results of this scale are 88 percent consistent with the Zung self-scoring scale for depression and anxiety, and in one study in New York, sixty two percent of the respondents who had scores indicating a mental health or drug and alcohol diagnosis were not in treatment. This model directly or indirectly addresses Healthy People 2020 goals 7, 10, and 18 NAHS goal 2.

### ***Links***

[http://careacttarget.org/library/Client\\_Diagnostic\\_Questionnaire.pdf](http://careacttarget.org/library/Client_Diagnostic_Questionnaire.pdf)

## **10. Evaluation of SBRIT Implementation in Colorado HIV Clinics and Community Organizations**

### ***Description***

One way to address substance abuse at the Part C level is through the Screening, Brief Intervention, Referral, and Treatment Model. While five percent of the general population is dependent on substances, another twenty percent misuses substances on occasion. By screening all patients for drug and alcohol use, medical providers not only reduce stigma by treating it as part of routine medical care, but also uncover patients who they have not realized are at risk. In Colorado, 46 percent of HIV positive individuals who were screened were found to be at risk for alcohol abuse, but 68 percent reported a decrease in consumption six months following the initial assessment. Two thirds of those screened also reported that the process made them think differently about their consumption of alcohol and other substances. Due to the SBIRT's effectiveness, SAMSHA is looking for ways to apply this model to screening for mental health also.

This model directly or indirectly addresses Healthy People 2020 goals 7, 10, and 18 and NHAS goals 1 and 2.

*Links*

[www.improvinghealthcolorado.org/files/documents/SBRIT\\_CO%20evaluation\\_of\\_implement\\_HI\\_Vclinics.pdf](http://www.improvinghealthcolorado.org/files/documents/SBRIT_CO%20evaluation_of_implement_HI_Vclinics.pdf)

## **11. Substance Abuse Suboxone Treatment Program**

*Description*

Although Suboxone is an effective means of treating substance abuse, it works best when provided in the context of additional support under a multi-disciplinary approach. The Waterbury Infectious Disease Clinic integrated Buprenorphine into their program and combined it with a 90 minute weekly educational support group which utilized the cognitive behavioral model. These groups focused on harm reduction and when individuals relapsed based on urine tests, they remained in the program, but were referred to a higher level of care. Of the sixteen participants in this pilot program, 15 remained for the duration including remaining in HIV care, 13 remained adherent to HAART, 13 remained using drugs either at rate at intake or reduced usage, and none of the 12 in jail previously returned. The authors credit using harm reduction and peer support as the primary reasons for the program's success.

This model directly or indirectly addresses Healthy People 2020 goals 7, 16, and 18 and NHAS goals 1, 2, and 3.

*Links*

[www.careacttarget.org/2010\\_rw\\_grantee\\_meeting/papers/F-15.pdf](http://www.careacttarget.org/2010_rw_grantee_meeting/papers/F-15.pdf)

## **12. Implementation of a Centralized Medical Case Management System**

*Description*

In order to better meet the standards for Medical Case Management (MCM) and increase collaboration between the Ryan White parts, the Hartford Transitional Grant Area (TGA) placed at least one medical case manager in all medical settings. These case managers worked under the supervision of a clinical nurse and received trainings not only on medical issues such as adherence and side effects, but also on more traditional case management topics such as entitlements and quality of life issues. In order to assist case managers in addressing these issues, they were provided an assessment tool that addressed medical, mental health, social issues, and adherence. The TGA hired enough case managers so none had a caseload higher than 35. In the two years since implementing this model, the TGA's care compliance scores increased 20 percent.



This model directly or indirectly addresses Healthy People 2020 goals 10, 11, and 12 and NHAS goals 2 and 3.

Links

[www.careacttarget.org/2010\\_rw\\_grantee\\_meeting/papers/F-01.pdf](http://www.careacttarget.org/2010_rw_grantee_meeting/papers/F-01.pdf)

- B. **Strategy, plan, activities (including responsible parties) and timeline to close gaps in care:**
- a. Work with AIDS Education and Training Center to develop education programs on several HIV related topics that will help close gaps in care.
- C. **Strategy, plan, activities, (including responsible parties) and timeline to address the needs of individuals Aware of their HIV status** but are not in care (with emphasis on retention in care).

The Department will initiate the diffusion of Anti-Retroviral Treatment and Access to Services (ARTAS). Training will be scheduled and obtained in FFY 2012 and HIV Provider staff across the state will be strongly encouraged to attend to get staff trained to implement this intervention.

ARTAS is an individual-level, multisession, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-Based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (especially the concept of Self-Efficacy) and Humanistic Psychology. SBCM is a case management model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). The SBCM model views the community as a resource for the client; client sessions take place outside the office.

ARTAS consists of up to five individual client sessions conducted over a 90 day period or until the client links to medical care – whichever comes first. Eligible clients should be within 6– 12 months of receiving an HIV-positive diagnosis. During the client sessions, the Linkage Coordinator builds a relationship with the client. The client, focusing on his/her self-identified strengths, creates an action plan (known as the ARTAS Session Plan) with specific goals, including linking to medical care. Not every client will move sequentially through the five sessions nor will every client complete all five sessions.

For those who complete all five, the sessions will be structured as follows:

The 1st session will consist of building a trusting, effective relationship between the client and the LC, and identifying the client's strengths, needs, and barriers to accessing medical care. The 2nd and 3rd sessions will focus primarily on goal-setting and creating the ARTAS Session Plan, which identifies and emphasizes the client's strengths. The 4th session will consist of reviewing progress made in the previous sessions, while continuing to emphasize the client's strengths. The 5th session may involve accompanying the client to his/her medical appointment or transition activities if the client linked to medical care. Following the final session with the LC, the client may be linked to a long-term/Ryan White case manager and/or another service delivery system to address his/her longer term barriers to remaining in care, i.e., those beyond linkage to medical care such as substance use treatment, or mental health services.

At any point, if the client successfully links to medical care, the LC does not need to continue with the remaining sessions. However, implementing agencies may find it useful to hold the last session (transition) and introduce the client to his/her new case manager, if that has not already been done in a previous session.

The target population for ARTAS is *any* individual who is recently diagnosed with HIV (typically defined as within 6–12 months) and willing to participate in the intervention.

During the research stage, the criteria to participate were that the client must:

- Have been 18 years of age or older
- Have received an HIV-positive diagnosis within 6 or 12 months
- Not have been on antiretroviral treatment
- Not received case management or social work services for HIV-related needs
- Have been interested in participating in the intervention
- Not have visited an HIV care provider more than once

The above criteria should serve as guidance for implementing agencies. To best address the needs of the community, implementing agencies should adjust the criteria as appropriate and/or as allowable by the funding agency.

While the benefits of early entry into medical care are well-documented, over one-third of people living with HIV/AIDS (PLWHA), who know their serostatus, are not linked to medical care. Nearly 39 percent delay entry into care by 12 months, and 32 percent delay entry for more than two years. People do not link to medical care following an HIV-positive diagnosis for a variety of reasons. These may include, but are not limited to: personal barriers such as unemployment, lack of health insurance, fear, stigma, substance use, mental health issues, lack of transportation, homelessness, and/or not having the required forms of identification to receive services. People do not seek medical care due to system-level barriers as well, such as a lack of personnel and health care providers, culturally appropriate interventions, and multilingual personnel. Other system-level barriers include wait lists for services and/or medications, and complex, confusing administrative processes. Rarely do people face only one barrier to accessing medical care.

The ARTAS intervention has proven to be successful in helping clients make changes because it emphasizes one's *abilities* to address barriers rather than one's *inabilities* to do so. The goal-setting is client-driven and determined by the person who must implement the changes as opposed to being dictated to the client by a third party, e.g., a case manager or health care provider. Finally, because the relationship between the client and LC is based on mutual respect and cooperation, the client feels supported in his/her efforts to implement changes and overcome barriers.

Interventions, such as ARTAS, that link people to medical care soon after receiving a positive test result are important because delays in seeking care can result in a negative treatment prognosis and contribute to the spread of the disease. Early treatment has many benefits for HIV-positive individuals, such as improved health outcomes, additional opportunities for risk-reduction interventions, and costs savings. ARTAS is a theory-based intervention. The three defining features of the intervention are: (1) building effective, working relationships between the client and LC, and between the LC and community partners; (2) focusing on the client's strengths rather than weaknesses; and (3) maintaining a client-driven approach. As noted earlier, ARTAS is based on the Strengths-Based Case Management model with some modifications. As such, ARTAS borrows from Social Cognitive Theory.

Strengths-based practice has four basic assumptions:

- People have an inner capacity to effectively cope and fix their own personal challenges
- People must be active participants in their own change

- People have personal and environmental assets
- Most people have untapped strengths and are unaware of their personal or environmental strengths

Strengths-based Case Management is a specific implementation of the strengths perspective, through the process of facilitating desired change in individuals. It adds the technique of focusing on client strengths to the primary principles of case management, which are:

- Encourage clients to identify and use their strengths, abilities, and assets to accomplish goals
- Recognize and support client control over goal-setting and the search for needed resources
- Establish an effective working relationship with the client
- View the community as a resource and identify information sources of support
- Conduct case management as an active, community-based activity<sup>1</sup>

In ARTAS, the Linkage Coordinator helps the client learn new information, such as the benefits of accessing medical care, and discuss strategies to achieve the client's goals. During sessions, the LC may discuss strategies to overcome barriers to visiting an HIV care provider. The LC and client may practice or role-play interactions between the doctor and patient, if that is helpful to the client. These activities help a client's self efficacy and increase his/her belief in the positive outcomes of visiting an HIV care provider or linking to medical care.

**D. Strategy, plan, activities, (including responsible parties) and timeline to address the needs of individuals Unaware of their HIV status:** (with emphasis on identifying, informing, referrals, and linkages to care needs)

Over the last several years, in an effort to increase the number of HIV-infected people who know they are infected, the Department has reconfigured its HIV Prevention Program to focus on the core components of testing and partner services. The Department is continuing its efforts to evaluate and enhance its extensive network of HIV testing sites in non-healthcare and healthcare settings. This comprehensive network consists of both targeted outreach testing and routine opt-out screening through the use of various testing technologies, including venipuncture (serum), OraSure, and OraQuick rapid testing. A recent amendment to PA law that took effect in September 2011 allows for opt-out HIV-testing protocols with documentation of verbal consent in the medical record, which presents an opportunity to increase HIV testing in clinical settings. In addition to routine screening in healthcare settings, we continue to focus resources (CDC/State funds) to targeted testing in non-healthcare settings in order to effectively reach priority populations (disproportionately impacted racial/ethnic populations and high-risk groups) in prioritized counties. In 2012, the Department is continuing HIV testing through existing providers and also conducting gap analysis to identify unmet testing needs in prioritized counties to focus our recruitment and capacity building efforts.

The Department supports HIV testing providers through a variety of contractual agreements, all of which require the provider to include Partner Services (PS) staff in the post-test results counseling of all HIV positive individuals. This inclusion, allows the PS staff to immediately enter into a discussion with the infected person not only regarding the voluntary notification of his/her partners, but to also serve as a link to other prevention, care and treatment services. Beginning in September 2011, the Department began to leverage the STD functionality in the Pennsylvania National Electronic Disease Surveillance System (PA- NEDSS) for conducting and

documenting HIV and Co-infection (HIV and other STDs) PS activities. This arrangement also allows PS staff to identify individuals who have been newly diagnosed at a non-publicly funded HIV testing sites (through reports in PA-NEDSS) and provides an opportunity to offer them PS and linkage to prevention, care and treatment services.

In regards to the tracking of linkage to HIV care and treatment services for those persons testing HIV positive or currently living with HIV/AIDS, the Prevention Section has conducted a review and assessment of various options for tracking HIV positive individuals to determine access to care. Currently the Department is implementing two tracking strategies: 1) cross checking individuals with positive Western Blot test results with surveillance data on CD4 and Viral load testing (as an indicator of successful referral for medical care) and, 2) utilizing the HIV Test Data Collection form (Part 2), which is completed by PS staff. Both of these strategies have limitations since only detectable HIV Viral Loads and CD4 tests < 200 cells/ $\mu$ L are reported in the HIV/AIDS surveillance system and because the matching of Part 2 form data with newly identified clients in PA-NEDSS is a manual process. The Department has drafted changes to the HIV reporting regulations, which call for all CD4 and Viral Load tests to be reported to the Department. These new changes to the regulations, which are currently under review, would enable the Department to more accurately link newly identified positives with all subsequent CD4 and Viral Load tests to verify linkage and ongoing engagement in care.

To address the limitations of the currently available tracking tools, the Department has been developing a coordinated protocol for cross-program collaboration between prevention and care to enhance linkage and maintenance of HIV-positive clients in care and prevention services, including the Referral Tracking and Unmet Needs projects. Please see additional information about The Critical Phase Interventions (CPI) Testing & Referral Tracking (TRT) module, which is described in greater detail in Appendix A to this document.

**E. Strategy, plan, activities, (including responsible parties) and timeline for addressing the needs of special populations:** including but not limited to: adolescents, injection drug users, homeless, and transgender.

The following strategies are suggested to address the needs of various special populations due to current available data:

- Unmet housing needs of the homeless: According to Housing and Urban Development 2010 data, 8,000 families have unmet housing needs in Philadelphia, 189 families have unmet housing needs in Pittsburgh, and 145 families have unmet housing needs in the balance of the State. Using Part B data sources on participating clients, the demographic data should include the percentage, by zip code, of Part B clients experiencing unstable housing. Case managers may then work more intensively with those clients to stabilize their housing status.
- Pennsylvania plans to continue targeting adolescents and young adults through expansion work of the Community Planning Groups' Young Adult Roundtables. Efforts to link their work to care planning are currently taking place through the Integration Workgroup which is responsible for the merge of the care and prevention planning processes.
- With regard to transgendered individuals, there are specialists who are competent working with transgendered individuals, both from a medical and supporting/mental health perspective. For example, the PERSAD Center in Pittsburgh has both a mental health and medical component to its transgendered programming. Organizations around the State that have a transgender population to serve are strongly urged to discuss with expert providers, like PERSAD, who can knowledgeably address this population.

- There are no specific recommendations surrounding the injection drug population. The subcommittees would encourage the Department of Health to look at the HIV/AIDS, mental health, and injection drug cohort of clients, who challenge both the mental health and medical care systems. The subcommittees speculate that this cohort of individuals may make up the majority of the individuals who know their status but are not in care. Many Part C programs, utilizing the harm-reduction approach to engaging clients, are successfully engaging this population in programs across the country; they often present at the All-Grantee meeting. Perhaps the Department of Health HRSA project officer could suggest colleagues who could be contacted for programming suggestions.

**F. Provide a description detailing the activities to implement the proposed coordinating efforts of providers:** with the following programs (at a minimum) to ensure optimal access to care: Parts A, B, C, D, F, non-RW funded, prevention programs, SA, STD, Medicare, Medicaid, CHIP, Community Health Centers.

The Implementation subcommittee of the Integrated Planning Council believes the best way to promote the above mentioned coordinating efforts is through education to all stakeholders and more integration of services by the Department of Health. The following activities will promote this process:

- State Health Improvement Plan can provide forums on grant writing or collaboration with other agencies.
- Ryan White Part F can provide trainings to Part C providers to promote use of navigators (peers, nurses, or case managers) or on utilizing IT to improve coordination of care and access to medical record or trainings to Part B providers on mental health, drug and alcohol issues and co-morbid conditions such as diabetes, hepatitis C, etc.
- The Department of Health could provide trainings to primary care providers on how to collaborate for partner notification.
- Complete the integration of the care (Integrated Planning Council) and prevention (Community Planning Group) planning bodies.
- Ensuring all HIV Providers are registered with the HASP Registry.

**G. How the plan addresses Healthy People 2020 objectives:** As part of this, How Do We Get There? Section, the Implementation subcommittee of the PA Integrated HIV Planning Council has researched best practices which are being recommended for use across the State. This subcommittee recognizes that all best practice models may not be feasible in all areas; however adaptations of these models could occur for implementation in areas experiencing difficulty. Under each one of the recommended best practice models the subcommittee has listed which objectives of Healthy People 2020 are being addressed either directly or indirectly. Please refer to pages # 52-58 for that information. In addition, many regions around the State have provided presentations to their stakeholders on Healthy People 2020 and established which objectives their providers could address and possibly impact.

**H. How this plan reflects the Statewide Coordinated Statement of Need:**

All required elements of the Statewide Coordinated Statement of Need are included within Section II, Where Are We Now. The subcommittees then used the needs identified and described in that section to formulate goals and strategies to address those needs in the subsequent sections.

**I. How this plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act:**

Several elements of the Affordable Care Act may be beneficial to Pennsylvania Ryan White programs participants including the following:

- Rights and Protections: Consumers now have the right to ask health plans to reconsider denial of payment for services.
- Insurance companies cannot deny coverage to individuals with pre-existing conditions.
- Insurance companies can no longer cancel coverage due to a mistake on an application.
- If an individual has been denied health coverage due to a disability or pre-existing condition and uninsured for 6 months they could qualify for Pre-Existing Condition Insurance Plan (PA Fair Care).
- With the expansion of Medicaid more Ryan White clients may be eligible therefore alleviating some of the assistance needed from Ryan White providers.
- In the effort included in the Law to strengthen community health centers
- With the encouragement of integrated health systems Ryan White physicians may have more opportunity to interact with other providers to provide quality care to patients and receive the benefits for doing so.

Under this new law, States may apply for funding to establish consumer assistance programs to help clients navigate the insurance system. Health literacy was discussed in the capacity development section of this document and applying to set-up or expand such a service for all Pennsylvanians but specifically those with HIV/AIDS would be a very helpful first step. The availability of this service may take some burden off medical case managers in helping clients to navigate the insurance system and the completing of necessary paperwork.

The Affordable Care Act states that 68 percent of medically underserved communities across the nation are rural and that these communities have trouble attracting and retaining medical professionals. In an earlier section of this document it was stated that it is difficult to find, specifically infection disease doctors, but also primary care physicians in many parts of rural Pennsylvania. With this incentive for payment for rural health care providers offered by the Affordable Care Act there is potential for this issue to be resolved or at least improved. Of the same benefit are the incentives included in the law for rebuilding the primary care workforce. In addition to incentive applied to rural areas and rebuild the primary care workforce, part of the new law also plans to construct or expand Community Health Centers. With the expansion of these Centers additional clients will be able to be seen and more services provided. Most of the Ryan White programs throughout Pennsylvania interact with Community Health Centers and some of the burden may be removed from infectious disease physicians in dealing with primary care issues.

**J. Describe how the comprehensive plan addresses the goals of the National HIV/AIDS Strategy, as well as which specific NHAS goals are addressed:** As part of this, How Will We Get There? Section, the Implementation subcommittee of the PA Integrated HIV Planning Council has researched best practices which are being recommended for use across the State. This subcommittee recognizes that all best practice models may not be feasible in all areas; however adaptations of these models could occur for implementation in areas experiencing difficulty. Under each one of the recommended best practice models the subcommittee has listed which goals of the National Strategy are being addressed either directly or indirectly. Please refer to pages # 51-57 for that information. In addition, many regions around the State have provided presentations to their stakeholders on the National Strategy and have prioritized those goals within their region.

## **V. How Will We Monitor Progress?**

The Division of HIV/AIDS currently relies on the web portal process previously discussed to support some statewide assessment of clinical quality assurance activities. It is important to note that with the exception of Philadelphia, there is no major scope of clinical service activities funded out of Part B (mainly clinical case management and medical service agencies that may already be receiving Part C funding). This is determined by the supports and resources existing within a region and the prioritization of funding to fill gaps where services are most needed.

### **Quality Management Web Portal**

The University of Pennsylvania School of Medicine Office of Continuing Medical Education (U of Penn SOM OCME), collaborated with the Jewish Healthcare Foundation of Pittsburgh (the Foundation), CECity.com, Inc. (CECity), the National Institute for Quality Improvement and Education (NIQIE), the Pennsylvania Department of Health and Creative Educational Concepts (CEC) to develop a comprehensive quality management web portal to allow AIDS Service Organizations (ASOs) from across Pennsylvania to track and benchmark their progress related to an agreed upon set of HIV/AIDS care and supportive service indicators. The Division of HIV/AIDS is assessing the efficacy of using this tool long term.

The Web Portal will be monitored / reviewed by the Department of Health, Division of HIV/AIDS, HIV Care Section. Individual Regional and overall State reports will be created, reviewed and analyzed in meeting the performance measurements on a quarterly basis. From quarter to quarter the percentages in meeting the Performance measurements should increase and thus indicate an improved use of the RW client data along with an increase in service utilization.

### **Current Quality Management Activities:**

#### **Division of HIV/AIDS Quality Management Plan**

The Division of HIV/AIDS is committed to providing quality HIV/AIDS health services consistent with current Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and in developing strategies for improvement in the access and quality of HIV/AIDS health services.

The Division of HIV/AIDS developed a quality assurance/quality management plan. The Program Manager, Public Health Project Administrator, Quality Management Administrator and two Project Officers (one Project Officer position is vacant) support the entire Ryan White Part B service structure and have a hand in the development and implementation of Quality Management efforts. The plan is intended to be a statewide Part B shared vision for planning, designing, measuring, assessing and improving performance for HIV/AIDS health services. The plan consists of the following components:

- A. Continued development of processes to incorporate baseline data from internal and external sources including: client files, CAREWare database, monitoring site visits, epidemiology profiles, RDR/RSR reports and client satisfaction surveys as well as input from department leaders, staff, coalitions, providers and consumers.
- B. Maintain work flows and support systems associated with new and existing services and patient care delivery through continued monthly staff and fiscal agent meetings and integrated planning council meetings, ADAP presentations, HOPWA refresher training, CAREWare technical assistance, coalition's operation manual updates and feedback on annual CRSSP. These

processes allow for increased communication and satisfaction with staff, consumers and their families and physicians.

- C. Refine our measurement systems to identify trends in patient care and monitoring events by regularly collecting and recording data. Utilizing reports to collect and record data as well as observations from annual site visits.
- D. Utilize assessment techniques such as: regional needs assessments, self-monitoring tools, satisfaction surveys and site visits to determine efficiency, appropriateness of services and evaluate overall how well services are delivered and what opportunities for improvement exist.
- E. Concentrate on improving overall quality by implementing and/or coordinating with multidisciplinary, data driven, project teams such as: The State Health Improvement Plan (SHIP) committee, Statewide Coordinated Statement of Need (SCSN) Committee, Community Health Improvement Partnerships, Local Advisory Councils, Integrated HIV Planning Council (IPC), Community Planning Groups (CPG) and related sub-committees and encouraging participatory problem solving.
- F. Continue promoting and encouraging communication, dialogue and exchange of information between grantees/coalitions, providers, consumers and bureau staff (Administrative support, Project Officers, CAREWare Administrator, QM Administrator, Program Managers, Program Director and Bureau Director) with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement.
- G. Continue to develop collaborative relationships with diverse community agencies such as: Community Health Improvement Partnerships, Local Advisory Councils and SHIP Steering Committee for the purpose of collectively promoting the general health and welfare of the community served.



<b>Department of Health Program Performance Measures</b>	
Outcome Measure 1	Increase number of clients whose record indicates participation in care within the measurement year.
Outcome Measure 2	Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.
Customer Service	-----
Efficiency	Percentage of HRSA service funding supporting Core Services
Activity/Output	Number of funded providers able to submit data in support of assessing Met/Unmet Need
<b>Coalition Performance Measures</b> (required by DOH)	
Performance Measure 1	Staff Development - Percentage of Coalition and Fiscal Agent staff members who complete eight hours or more of training per year.
Performance Measure 2	Clients in Case Management with a Risk Reduction Plan - Percentages of active case management clients that do a risk reduction plan at least one time annually.
Performance Measure 3	Customer Satisfaction regarding Service Delivery - Percent of consumers who agree or strongly agree for each of the seven questions asked.
Performance Measure 4	Addressing Priority Populations and Services through Funding - Percentage of priority populations or services identified in the needs assessment that were addressed in the funding plan.
Performance Measure 5	Inclusion of a Minimum Set of Elements in a Needs Assessment - Percentage of HRSA-defined elements of Needs Assessment contained in the document.
<b>*Coalition Core Clinical Performance Measures</b>	
Group 1 Measures	<ol style="list-style-type: none"> <li>1. ARV Therapy For Pregnant Women</li> <li>2. CD4 T-Cell Count</li> <li>3. HAART</li> <li>4. Medical Visits</li> <li>5. PCP Prophylaxis</li> </ol>
Group 2 Measures	<ol style="list-style-type: none"> <li>6. Adherence Assessment and Counseling</li> <li>7. Cervical Cancer Screening</li> <li>8. Hepatitis B Vaccination</li> <li>9. Hepatitis C Screening</li> <li>10. HIV Risk Counseling</li> <li>11. Lipid Screening</li> <li>12. Oral Exam</li> <li>13. Syphilis Screening</li> <li>14. TB Screening</li> </ol>
Group 3 Measures	<ol style="list-style-type: none"> <li>15. Chlamydia Screening</li> <li>16. Gonorrhea Screening</li> <li>17. Hepatitis B Screening</li> <li>18. Hepatitis/HIV Alcohol Counseling</li> <li>19. Influenza Vaccination</li> <li>20. MAC Prophylaxis</li> <li>21. Mental Health Screening</li> <li>22. Pneumococcal Vaccination</li> <li>23. Substance Use Screening</li> </ol>

### **Department of Health Part B Committee**

The Part B committee, made up of representatives from the Northwest, North Central, Northeast, Southwest, South Central, AIDSNET, AACO and SPBP utilize a workplan for annual quality assurance/quality management planning activities from July 1<sup>st</sup> to June 30<sup>th</sup> of each year. The goals define the workplan purpose, the objectives are more specific, and the key action steps describe precise methods on how it will be achieved, including target dates and responsible parties. The committee utilized the SM.A.R.T (Specific, Measurable, Achievable, Realistic and Time-Bound) process as it developed its objectives.

The work plan allows for greater transparency as it allows the committee to share with stakeholders what they are doing and why, during that time period.

Each of the seven regions developed individual quality management plans following guidance from the HRSA Quality Management Technical Assistance Manual. The plans are submitted to the Division's QM Administrator annually for review and discussed during the annual monitoring site visit.

To strengthen quality assurance/quality management capacity the Part B committee members utilize various resources to include but, not limited to: Quality Management 101 Trainings, NQC Quality Academy Tutorials, NQC Quality podcasts, NQC National Technical Assistance Calls, NQC Training-of-Trainers (TOT) Program, NQC Training of Quality Leaders (TQL) Program, HRSA/HAB Webcasts/Calls, HAB Information Emails, HIVQUAL Web-based trainings, and the Pennsylvania RW All-Parts Summit.

On an annual basis the seven regions share best practices and offer recommendations.

### **Planned Quality Management Activities:**

Ensuring our providers understand and are actively tracking the performance measures we have in place is our key focus moving forward. The information received from these measures allows us to view the coalitions individually and statewide and begin to identify strengths they possess as well as weaknesses due to geographic location, size and/or number of providers. In addition communication is essential in sustaining the processes we have in place, we continue to report out to internal and external stakeholders.

### **Quality Findings:**

#### **Department of Health Program Performance Measures**

The Division of HIV/AIDS – HIV Care Section annually submits to the DOH policy office four of the five program performance measures listed below. The policy office uses this information to assist in updating the Governor's Budget Office Agency Performance Plan. The division began tracking these five measures with the July 1, 2007 - June 30, 2008 time period. The chart below indicates our performance since that time.

Program performance measures 2 and 4 show a 4.05% and 10.16% increase over last year's reported percentages. As we continue to assess these measures over time we will address improving our percentages for program measures 2 and 4, maintain or increase the number of funded providers, develop a process within CAREWare to count client files only once so the file count is not inflated and begin to measure customer service.

	<b>Program Performance Measures</b>	<b>7/1/07- 6/30/08</b>	<b>7/1/08- 6/30/09</b>	<b>7/1/09- 6/30/10</b>	<b>7/1/10- 6/30/11</b>
1.	Increase number of clients whose record indicates participation in care within the measurement year.	Not available	Not available Unable to un-duplicate in CAREWare		
2.	Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.	Not available	81.4%	82%	86.05%
3.	Customer Service				
4.	Percentage of HRSA service funding supporting Core Services (4/1/10 - 3/31/11)	Not available	77.5%	65.44%	75.6%
5.	Number of funded providers able to submit data in support of assessing Met/Unmet Need	13	61	56*	50

*\*Note: Included services provided by regional coalitions.*

### **Coalition Performance Measures**

All seven coalitions are required to report on an annual basis on the performance measures listed below. The commitment to tracking these specific measures identified by DOH is evident in the strong statewide average percentages shown as well as in the overall regional percentage for performance measure adherence which is 90%. This is the first annual report on the five performance measures. Moving forward we expect to utilize this report to first conduct an annual side by side analysis specifically looking at each region to determine strengths and weaknesses, identifying opportunities for assistance and encouraging regions that are excelling to mentor those who need help, ultimately improving our statewide average percentage. Secondly this report will be used to annually review our overall regional percentage for performance measure adherence and improve on the previous year's percentages.

	<b>Performance Measures</b>	<b>Statewide Average</b>
1.	Staff Development - Percentage of Coalition and Fiscal Agent staff members who complete eight hours or more of training per year.	80%
2.	Clients in Case Management with a Risk Reduction Plan - Percentages of active case management clients that do a risk reduction plan at least one time annually.	91%
3.	Customer Satisfaction regarding Service Delivery - Percent of consumers who agree or strongly agree for each of the seven questions asked.	----
4.	Addressing Priority Populations and Services through Funding - Percentage of priority populations or services identified in the needs assessment that were addressed in the funding plan.	100%
5.	Inclusion of a Minimum Set of Elements in a Needs Assessment - Percentage of HRSA- defined elements of Needs Assessment contained in the document.	88%
	Overall Regional % for Performance Measure Adherence	90%

**Coalition Core Clinical Performance Measures**

Three of the seven coalitions are currently reporting on the HRSA group 1, group 2 and group 3 performance measures listed above\*. There is no policy currently in place requiring all coalitions to report on these measures. The performance measures are submitted every two months with the most recent reporting date of July 1, 2010 - June 30, 2011. Reviewing HAB group 1 measures, the average of the reporting regions shows: HAB 1 - 98%, HAB 2 - 72%, HAB 3 - 87.5%, HAB 4 - 79.04%, HAB 5 - 86.52%. The overall percentages on group 2 and 3 measures are also above average and indicate that the reporting regions understand the importance of collecting and reporting on these measures. As we move forward we are determined to improve on the percentages of the reporting regions as well as to eventually have all coalitions report on the HAB group 1, 2 and 3 measures. We are initially focusing our efforts on coalitions reporting on group 1 measures and will then add groups 2 and 3.

**PENNSYLVANIA DEPARTMENT OF HEALTH (PA DOH)**

**Bureau of Communicable Diseases, Division of HIV/AIDS**

**SPNS/Linkages PA - A Critical Phase Interventions (CPI) Project**

**Implementation of CPI Tools and Protocol in a Ryan White Care Act (RWCA) Part C HRSA-funded HIV Clinic to Expand Routine HIV Testing, Coupled with Proactive Referral, Tracking, Retention in Care and Ongoing Comprehensive Prevention for Positives' (CPFP)**

Key Project Collaboration Group Participants & Roles		
<b>Co-PIs: PA Department of Health</b>		
<b>Program Area:</b> State HIV Care & Prevention Interventions	<b>Program Area:</b> State HIV Epidemiology Support for Disease Control & Prevention	
<b>Contribution/Responsibility:</b> Conceptualization, facilitation of cross-program coordination with care support services, and prevention programs	<b>Contribution/Responsibility:</b> Conceptualization, overall study design, monitoring & evaluation analyses	
Joseph Pease, MPH, MS Division Director Division of HIV/AIDS (Intervention Programs) Division of HIV/AIDS Bureau of Communicable Diseases PA Dept. of Health 1010 Health and Welfare Bldg 7 <sup>th</sup> and Forster Streets, Harrisburg, PA 17120 <a href="mailto:JPease@pa.gov">JPease@pa.gov</a>	Benjamin Muthambi, DrPH, MPH HIV Epidemiologist/Co-PI HIV Epidemiology Investigation Section Division of Infectious Disease Epidemiology Bureau of Epidemiology PA Dept. of Health 933 Health and Welfare Bldg 7 <sup>th</sup> and Forster Streets, Harrisburg, PA 17120 <a href="mailto:BMuthambi@pa.gov">BMuthambi@pa.gov</a>	
<b>Lead Co-Is: Penn State College of Medicine, Department of Public Health Sciences</b>		
<b>Implementation Coordination Center</b>		
<b>Program Area:</b> System Linkages Development	<b>Program Area:</b> Project Coordination	
<b>Contribution/Responsibility:</b> Cross-Program System Linkages Development, Overall Data Center Management & Program Evaluation	<b>Contribution/Responsibility:</b> Project Coordination, Data Management, Monitoring & Evaluation	
Vladimir Krepets, PhD Lead Site Co-I/Project Associate, System Linkages Development Department of Public Health Sciences Project E-Mail: <a href="mailto:PEHTI@hmc.psu.edu">PEHTI@hmc.psu.edu</a>	Khaled Iskandarani, MPH Site Co-I/Project Coordinator, Department of Public Health Sciences	
	Tonya Crook, MD, MS, DTM&H Lead Site Co-I/Cross-program collaboration with PEHTI Dept. of Medicine, Div. Infectious Diseases & Epidemiology	
<b>Performance Site Co-Investigators</b>		
<b>Contribution/Responsibility:</b> Project facilitation and integration within clinic system flow, and coordination of performance site implementation of clinical interventions.		
<b>Affiliated Performance Sites</b>	<b>Performance Site Co-Investigator</b>	<b>Role in Project</b>
<b>Part C Clinical Sites</b>		
University of Pittsburgh, HIV Program	Deborah McMahon, MD, Clinical Director	Lead Site Co-I
Penn State College of Medicine	Tonya Crook, MD, MS, DTMH, HIV Specialist	Lead Site Co-I
	John Zurlo, MD, Medical Director	
<b>AIDS Care Group</b>	Howell Strauss, DMD, Executive Director	Lead Site Co-I
Kensington Hospital	Eileen Hause, MBA, COO	Site Co-I
Philadelphia FIGHT	Jane Shull, MA, Executive Director	Site Co-I
Pinnacle Health	Laura Brubaker, MSN, Part C Director	Site Co-I
<b>Part B Integration with Part C</b>		
Alder Health Care	Philip Goropoulos, President	Site Co-I
<b>Part F - Provider Training</b>		
Pennsylvania AETC, based at University of Pittsburgh	Linda Frank, PhD, RN, Director, PAMAETC	Site Co-I



**OBJECTIVES:** The Pennsylvania Department of Health (PA DOH) is collaborating with the US Centers for Disease Control and Prevention to routinize screenings for conditions of public health importance (including HIV) in healthcare settings and also to ensure linkage of individuals offered screenings with relevant care/prevention and with primary care providers through the CDC's Pennsylvania Expanded HIV Testing Initiative (PEHTI). The PADOH is also collaborating with the Health Resources and Services Administration (HRSA) to test, and evaluate the Critical Point Interventions (CPI) protocol and software module aimed at proactive referral, tracking and linkage of persons diagnosed and living with HIV/AIDS (PDLWH/A) to appropriate HIV care, retention in care, and ongoing comprehensive 'prevention for positives' (CPfP) activities such as partner services (PS) or social network strategy (SNS) through HRSA's Special Projects of National Significance (SPNS). These activities are in line with the requirements for SPNS (reducing new HIV infections, increasing access to care and improving health outcomes of PDLWH/A, and reducing HIV-related health disparities) and for targeting critical phase interventions at points of vulnerability in the CPI continuum of engagement in HIV Prevention/Care (see Table 1, adapted from the HRSA model by Eldred & Malitz, 2007). The project objectives include: a) collaboration with healthcare settings which serve a substantial proportion of the disproportionately impacted target population of PEHTI (i.e. racial/ethnic minorities, specifically blacks/African-Americans and Hispanics) and implement the approved routine HIV testing protocol which will be part of the Enhanced Health Promotion Screening Program (EHPS), a comprehensive healthcare program facilitated by the Pennsylvania Department of Health, whose objective is to promote HIV and other disease screenings & linkage to primary healthcare; b) partnering with RWCA Part C HRSA-funded clinics which serve these populations to launch, routinely implement, and monitor deployment of CPI tools and protocols aimed at improving linkage/retention in care, and health outcomes among PDLWH/A; and c) development and dissemination of procedural toolkits which include all the materials necessary to replicate the project's enhanced service protocols in similar healthcare settings.

**BACKGROUND, RATIONALE AND SIGNIFICANCE:** HIV prevention and care programs still face major challenges. On the prevention side, an estimated 20% of people living with HIV remain undiagnosed, unknowingly fueling 50% of the estimated 56000 new infections every year. Previous studies show that persons living with HIV who know their status are more likely to adopt prevention measures such as safer sexual practices. In response to these findings, HIV testing will be offered in an opt-out format through the EHPS program which will be offered to all persons who do not readily have access to a primary care physician. EHPS is a comprehensive program which facilitates access to annual physical examinations, health screenings, public health services and partner and case management services to those afflicted by chronic diseases requiring regular care and who do not have access to a regular provider. Such healthcare services are provided by either a hospital, if applicable, or through one of the community health centers participating with the program. Selected health care providers will be chosen to demonstrate routine implementation of such a program as the standard of care and evaluate its impact on routine HIV screening. On the care side, previous studies have reported that: 20% of newly diagnosed patients may not enter care within the first 12 months after diagnosis, and 33% of those newly diagnosed are in late stages of disease and progress from HIV to AIDS within 1 year. In addition, several studies showed that more than 20% of persons in ongoing care for HIV may have uncontrolled viremia which is often associated with inconsistent retention in care or non-adherence to treatment. These indicators suggest that there may be substantial missed opportunities in the system of prevention and care and a great need for enhancement of services. There is a need to increase the proportion of persons who: are diagnosed early; get linked to care/treatment and do so in a timely manner; consistently remain in care and adhere to antiretroviral therapy; receive ongoing prevention services integrated with ongoing care (such as partner services and social network strategy testing); and receive support services to mitigate individual barriers by facilitating enabling factors such as entitlements, drug treatment, case management, housing, transportation, nutrition, and child care. The CPI module's tools and protocol coupled with the EHPS program will allow for a comprehensive HIV prevention and care program which addresses the shortcomings of the current system. The development of project toolkits to facilitate the replication of the project in other clinical sites will be an ongoing process. The toolkit will provide a clear road map for effective replication of the protocol and the necessary tools for its implementation. Such a toolkit may include: the EHPS informational and promotional materials, HIV testing protocols, CPI software module, user manuals, CPI protocol, staff training materials, and data collection and management forms.

**IMPLEMENTATION METHODS:**

**EHPS Implementation:** The routine implementation of the EHPS program (including clinic-wide adoption of a protocol for routine screening of patients for HIV) will be conducted as described below: All patients, ages 18 -64 years, visiting Pennsylvania healthcare settings (e.g. outpatient clinic, emergency department, or labor and delivery) which adopt the EHPS program (including routine HIV testing) as the standard of care, are considered eligible for the laboratory-based analyzer testing pathway if routine/clinically indicated blood draws are to be done for diagnostic purposes. Also, all other patients who do not need blood draws will be eligible for alternative testing pathways/approaches to be established with each clinic. At registration, each patient will sign the general consent for care that is currently in use and will also receive a brochure describing the EHPS program [including an offer to initiate linkage to a primary health care provider, HIV screening, along with any other screenings which the clinic may elect to initiate during the medical visit, in addition to additional screenings which may be offered after linkage to a primary care provider (PCP) as described in the EHPS brochure]. Each patient will have an opportunity to opt-out of any of the screenings, including the HIV test, as outlined in the brochure. Before initiating



any EHPS services, staff will ascertain with the patient (using an EHPS script as a guide) and consistent with Pennsylvania Act 59(2011) requirements document the following [as required by Act 59, following guidance provided on the back page of the EHPS brochure]: a) that the patient received the EHPS brochure (which includes information on various screenings including statutorily required information on HIV); b) that verbal consent for EHPS services is granted by way of asking if the patient understands and does not wish to opt-out of EHPS services that the clinic routinely offers to initiate for all patients (including referral and linkage to a PCP for age and gender-appropriate screenings for various indicated conditions including diabetes, cholesterol, HIV (which will be initiated that day at the clinic), and c) specific aspects of EHPS services the patient may have declined to receive, *if that is the case*. For patients who do not opt-out of HIV screening aspects of the initiation of EHPS as documented in the patient record, an HIV test will be included in the normal immunohematological assays as ordered by the clinicians (for those who have blood draws) and those not getting blood draws will be tested through alternative testing pathways/approaches to be established with each clinic.

**CPI Implementation:** The routine implementation of the CPI tools and protocols will be conducted as described below:

***CPI Testing and Referral Tracking (TRT) module:*** Patients who test positive and consent to referral to the HIV point-of-care of the EHPS referrals program will be referred to treatment through the CPI's TRT module. Upon receiving the confirmatory test result, the point-of-test (PoT)/testing site will refer the patient to its partnered/collaborating point-of-care/treatment (PoC/T) site by sending an encrypted unique ID (eUID) of the referred person. When the patient links to care, the eUID of the linked patient will be sent back from the PoC/T to the PoT to confirm/update the patient's referral/linkage status.

***CPI linkage and retention in prevention/care (LRP/C) module:*** Upon successful linkage to care, the CPI LRP/C module will be used to ensure the patient's retention in prevention and care (including CPfP). Upon, or prior to entry/re-entry to care, a case manager will administer the patient a baseline/intake unmet needs assessment (UNA) which is aimed at determining the patient's psychosocial barriers to retention in care and whether the patient requires CPfP. The case manager will then work with the patient to remove/address any barriers to LRP/C which may be flagged by the CPI LRP/C module by completing a case management plan which offers concrete solutions to the patient's problems/barriers to care (please see Fig 1 for example of CPI system messages showing automatic flags generated by the CPI LRP/C module to identify flagged PDLWH/A at the clinic and prompt case manager follow-up to address UNA-identified problems). A 6-monthly follow-up UNA will be administered to patients who have completed an intake UNA. If there is an indication that an enrolled patient requires case management support between 6-monthly update intervals, then they will be administered an interim follow-up UNA in order to address their current/urgent needs. The CPI linkage and retention in prevention/care module will also automatically indicate/flag certain patients for PS based on certain data points, e.g. two detectable viral loads in 1 year. If the system indicates that the patient requires PS, then a case manager will work with the patient in order to refer them to the PADOH district office staff to complete the CPfP activities according to the PS provider option which they have chosen. To facilitate clinician-case manager collaboration, Figure 2 shows a CPI patient facesheet showing a longitudinal graph and tabulation which integrates/correlates clinical outcome information from CareWare with information on UNA-identified problems/barriers to prevention/care.

**Monitoring and Evaluation of Program Implementation:** Performance sites participating in the CPI/EHPS/PEHTI program will be expected to report HIV morbidity and services monitoring data to the PA DOH by generating data from electronic medical record systems (including CPI application) used consistent with HIPAA, applicable state/local disease control statutes, reporting regulations, and preferred provider agreements, PPA, which will be established by PA DOH with participating performance sites. To measure the success of the EHPS/HIV testing and CPI protocols, primary analyses will be performed to monitor various outcome indicators such as rates/trends of testing acceptance, HIV seropositivity, linkage and retention in prevention/care, time from diagnosis to linkage to prevention/care, community viral load, stage of disease at diagnoses, progression to AIDS or death, etc. Further supplemental secondary analyses of disease investigation and service monitoring data to address the likelihood of various outcomes in relation to various predictors will be conducted within the framework outlined below if generation of knowledge that is generalizable beyond the population investigated is anticipated.

***Human Subjects Protections:*** CPI/EHPS/PEHTI interventions will be offered as part of the routine/standard of care at all performance/intervention sites; surveillance/program implementation monitoring and outcome assessment data submission to PA DOH is permitted by HIPAA (PA DOH is an exempt public health authority), and is covered by PPAs/contracts, and existing surveillance and public health regulations, hence the proposed PEHTI/EHPS activities are determined to be non-research public health intervention activities by CDC (a non-research determination letter will be provided to performance sites upon request). All supplemental secondary activities and analyses under PEHTI/EHPS and/or SPNS/CPI which may generate generalizable knowledge/findings applicable beyond the population in which the project is to be conducted (i.e. meeting the relevant federal regulations' definition of 'research') must be submitted to the PA DOH IRB for review before implementation of such supplemental project activities.

**ANTICIPATED USE OF FINDINGS:** Findings of analyses from the project will be used to support continuous quality improvement, determine appropriate protocols, and address program planning and resource allocation needs. Reports detailing project outcomes are expected to be presented to the PA Department of Health, site medical directors, project staff, scientific conferences and journals for quality assurance and continuing education through peer review, and to facilitate dissemination of findings.




**Table 1. HIV Service Organization/Provider Types (highlighted in gray) & Opportunities for Cross-Program Cooperation and Collaboration in Support of Critical Phase Intervention (CPI) Strategies for Engagement in Prevention and Care (prevention/care) along the CPI Continuum of Engagement in HIV Prevention/Care**

(Adapted from the HRSA Continuum of Engagement in HIV Care, Eldred & Malitz, 2007). Strategies to: a) Address Critical Phases of Vulnerabilities in CPI Continuum of Engagement in HIV Prevention/Care, and b) Assure Increased Early Screening, Timely Initiation of Treatment as Prevention, Retention in Care, Quality of Care, and Ongoing Comprehensive Prevention for Positives.

<b>Continuum of Engagement in HIV Prevention/Care</b>					
<b>Not in HIV Care ←=====→ Engaged in HIV Care</b>					
<b>Unaware of HIV infection (~20%)</b>	<b>Aware of HIV infection (~80%)</b>				
	<b>HIV-aware: not linked to prevention/care</b>		<b>HIV-aware: various levels of linkage to prevention/care</b>		
<b>Column A vulnerability</b>	<b>Column B vulnerability</b>	<b>Column C vulnerability</b>	<b>Column D vulnerability</b>	<b>Column E vulnerability</b>	<b>Column F vulnerability</b>
At-risk persons to be offered HIV testing/in pre-test phase	Post-test phase - Not in HIV or any other prevention/care	Some medical care, but not HIV prevention/care	Entered HIV prevention/care -lost to follow-up	Cyclical or intermittent HIV prevention/care	Fully engaged in HIV prevention/care
<b>Critical Phase Intervention (CPI) strategies to address vulnerabilities/deficiencies in engagement in prevention/care</b>					
<b>Column A Strategies</b>	<b>Column B Strategies</b>	<b>Column C Strategies</b>	<b>Column D Strategies</b>	<b>Column E Strategies</b>	<b>Column F Strategies</b>
<p><b>1. CPI through early testing:</b></p> <p>a) CDC-funded local Health Depts: collaborate with care providers on partner services (PS) &amp; hybridized social network strategy (h-SNS) to test the undiagnosed who are partners/ associates of persons diagnosed and living with HIV/AIDS (PDLWHIA);</p> <p>b) routine HIV testing by healthcare providers</p> <p>c) targeted testing by CDC-funded non-healthcare settings;</p> <p><b>2. Opt-out testing</b> with pre-test general consent including HRSA-funded Part B enhanced case management (ECM) for post-test engagement in early prevention/care if positive(at the time of test results, instead of waiting to initiate ECM after linkage to care); and linkage to primary care practitioners;</p>	<p><b>1. Timely CPI tracking of:</b></p> <p>a) persons testing positive who do not return for test results;</p> <p>b) persons who return for test results to ascertain and assure referral tracking (RT) &amp; timely linkage to prevention/care</p> <p>c) persons who are completely lost to follow-up;</p> <p>(Testing sites collaborate with ECM &amp; treatment clinics)</p> <p><b>2. Timely follow-up to assure initial/ongoing linkage to prevention/care through:</b></p> <p>a) Early/preventive intake/follow-up unmet needs assessments (UNAs) by ECM to assess needs for linkage/retention-enablers at time of return of test results/ link-up for prevention/care (to assure linkage to care; instead of waiting until linkage to care occurs/fails) &amp;/or</p> <p>b) timely ECM follow-up to return positive test results; &amp;/or link-up with persons not in prevention/care; &amp;/or address UNA-assessed needs for medical care (medication adherence and quality of care), retention-enabling support factors such as transportation, housing, health insurance, etc, &amp; comprehensive prevention for positives, CPfP (such as intake/ongoing PS &amp; h-SNS);</p>	<p><b>1. Strategies in column A</b> (routine testing in healthcare clinics may recapture this sub-cohort);</p> <p><b>2. Strategies in column B#1;</b></p> <p><b>3. Strategies in column B#2;</b></p> <p><b>4. CPI follow-up through:</b></p> <p>a) PA DOH Record-linkage of HIV care clinic patient roster vs. reportable disease registries, emergency dept/hospital admission ICD-9 codes for HIV/AIDS and AIDS defining illnesses, Medicaid claims, &amp; other admin databases;</p>	<p><b>1. Timely CPI tracking of:</b> persons in early stages of loss to care (PESLTC) by ECM</p> <p><b>2. Strategies in Column C#1, C#4;</b></p> <p><b>3. Strategies in Column B#1c; &amp; B#2;</b></p>	<p><b>1. Timely follow-up to assure consistent retention in prevention/care through:</b></p> <p>a) ECM conducts early/Follow-up 3-monthly/as needed unmet needs assessments (UNAs) to assess needs for retention-enabling factors (before loss-to-prevention/care);</p> <p>b) timely ongoing ECM follow-up to address UNA-assessed needs for retention-enabling support factors such as transportation, housing, health insurance, etc (before loss-to-prevention/care); &amp; ongoing CPfP;</p>	<p><b>1. Timely follow-up to assure consistent retention in prevention/care through:</b></p> <p>a) ECM conducts early/Follow-up 6-monthly/as needed unmet needs assessments (UNAs) to assess needs for retention-enabling factors (before loss-to-prevention/care);</p> <p>b) timely ongoing ECM follow-up to address UNA-assessed needs for retention-enabling support factors such as transportation, housing, health insurance, etc (before loss-to-prevention/care); &amp; ongoing CPfP;</p>
<p><b>Opportunities for Improvement</b></p> <p>a) Strategy A#1 is not systematically implemented by PA DOH/local HDs/providers to test partners/social network of persons in ongoing HIV care;</p> <p>b) Strategy A#2 is new &amp; recently authorized by change in state statute;</p>	<p><b>Opportunities for Improvement</b></p> <p>a) Strategy B#2 addresses lack of systematic tracking to facilitate linkage steps; &amp; ECM to link newly diagnosed;</p> <p>b) UNAs at post-test return of results =&gt; early assessment and ECM and CPfP to address UNA-assessed needs to ensure linkage (not wait till linkage as is the 'usual' practice).</p>	<p><b>Opportunities for Improvement</b></p> <p>a) Rationale for Columns A &amp; B strategies are in respective columns;</p> <p>b) Strategy C#4 address lack of systematic database searches facilitate by PA DOH;</p>	<p><b>Opportunities for Improvement</b></p> <p>a) Strategy D#1 addresses lack of systematic use of ECM for tracking of PESLTC;</p> <p>B) Rationale for Columns B &amp; C strategies are in respective columns;</p>	<p><b>Opportunities for Improvement</b></p> <p>a) Strategies in E#1 addresses deficient yearly ECM plan updates &amp; foster systematic early detection by more frequent/ 3-monthly UNAs &amp; ECM if needed to address UNA-assessed needs;</p>	<p><b>Opportunities for Improvement</b></p> <p>a) Strategies in F#1 will address deficient yearly ECM plan updates &amp; foster systematic early detection through more frequent/ 6-monthly UNAs &amp; ECM if needed to address UNA-assessed needs;</p>



**Figure 1. CPI Software Application Administrator Control Panel/Workflow Management Functionality**



## CPI Application | Unmet Needs Database

Unmet Needs Database Application - System Messages

- Add Client
- Find Client
- HAB Measures
- Adm. Options
- My Settings
- Sys. Messages
- Log out
- Exit

Logged in as an Administrator  
Default Administrator  
Log out in 00:03:00

New Questionnaires: [There are 4 new records in the database awaiting for approval.](#)

Imported Patients: [There is no new patient records awaiting for approval.](#)

New Patients: [There are 7 new patient records awaiting for export to CAREWare.](#)

Possible Matches: [There are 2 possible matches in the database.](#)

Patients not refilled meds: [There are 2 patients who had not refilled their medications.](#)

Flagged Domains: [There are 15 patients with flagged domain\(s\) in the database.](#)

10 days Reminder: [There are 19 CM Plan Reminders.](#)    30 days Reminder: [There are 19 CM Plan Reminders.](#)

70 days Appointment Reminder: [There are 59 Patients.](#)    80 days Appointment Reminder: [There are 58 Patients.](#)

	3 - 6 months:	6 - 9 months:	9 - 12 months:	<b>12 - 24 months:</b>	More than 24 months:
CD4 Counts:	<a href="#">10 Patients</a>	<a href="#">3 Patients</a>	<a href="#">3 Patients</a>	<b><a href="#">2 Patients</a></b>	<a href="#">31 Patients</a>
Viral Load:	<a href="#">10 Patients</a>	<a href="#">3 Patients</a>	<a href="#">4 Patients</a>	<b><a href="#">1 Patient</a></b>	<a href="#">27 Patients</a>
Last Medical Visit:	<a href="#">13 Patients</a>	<a href="#">4 Patients</a>	<a href="#">2 Patients</a>	<b><a href="#">5 Patients</a></b>	<a href="#">33 Patients</a>
<b>Unmet Needs:</b>				<b><a href="#">255 Patients</a></b>	

HAB ARV Therapy for Pregnant Women: [0 Patients](#)

HAB CD4 T-Cell Count: [30 Patients](#)

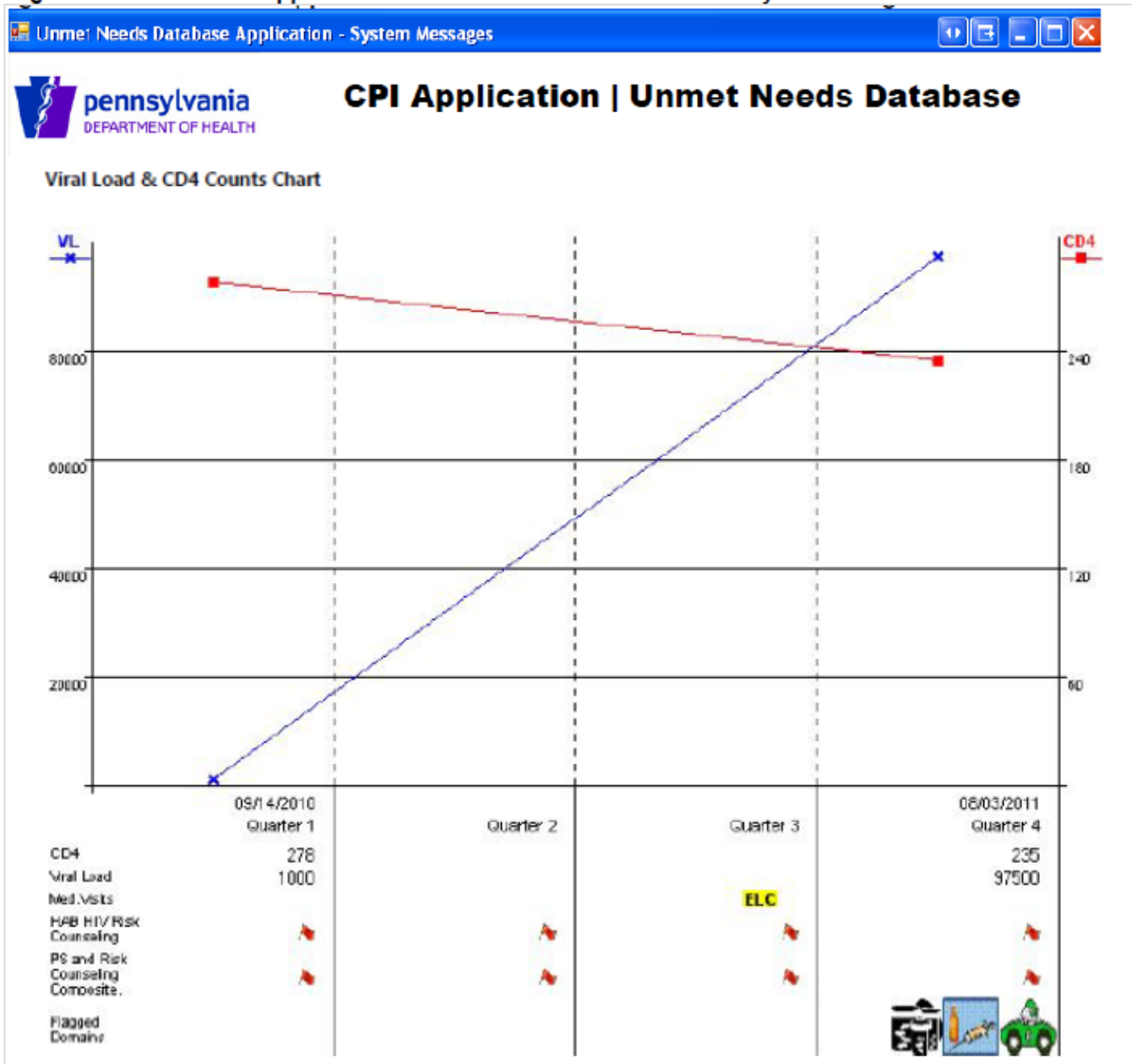
HAB HAART: [5 Patients](#)

HAB Medical Visits: [4 Patients](#)

Viral Load Blips: [3 Patients](#)

Close

Figure 2. CPI Software Application - Patient "Facesheet" Functionality



**Caption:** The CPI software application patient "Facesheet" above displays 12 months (4 quarters) of patient history showing rising HIV-RNA viral load (VL) and declining CD4 T-lymphocyte (CD4) during a period of loss to follow-up. On the table below the chart, the patient is 'flagged' for loss to follow-up after 6 months since the last medical visit as indicated by the ELC icon (indicating early stage of loss to care). The patient had been 'flagged' for HAB HIV and Partner Services (PS) risk counseling since the last medical visit. Upon field investigation to find and link the patient back to prevention/care, a follow-up unmet needs assessment (fUNA) conducted on the 9<sup>th</sup> month after the last medical visit detected patient unmet needs/difficulties with transportation, injection drug use, and medication adherence as the reasons for the lapse in care as indicated by the icon 'flags' for these domains. When the CPI software application is co-installed with CareWare, the HRSA software application used by most RWCA Part C HIV clinics (which only captures clinical information accessed by physicians), the CPI software application automatically imports CareWare clinical data including VL and CD4 and integrates these data with UNA psychosocial status data from the patient re-intake UNA interview (typically collected by case managers on a separate paper/electronic forms), thus allowing a visual display of the correlation of patient clinical and psychosocial status. The Facesheet is an enhanced case management (ECM) tool which facilitates clinician-case manager collaboration by enabling co-management of the patient through a common interface. The CPI application can also be used to document and track ECM actions taken on the flagged domains.

**ATTACHMENT 6: Table 9.2.1.(I) Modified Option 2 Framework and Estimated Numbers of Persons with Unmet Needs for Primary Medical Care among Persons Living with HIV(non-AIDS PLWH) and AIDS (PLWA) based on Estimates among Publicly vs. Privately Insured HIV+/aware populations.**

Publicly & Privately Insured HIV+/aware Population: Using population and care pattern data to calculate unmet need for HIV primary medical care OPTION 2: Care Data as Percents							
Input	Value	Data Source <sup>^^^</sup>	Value	Data Source <sup>^^^</sup>	Value	Data Source	
Population Sizes	Total Publicly & Privately Insured		Publicly-Insured (75% of Total) <sup>^^</sup>		Privately-Insured(25% of Total) <sup>^^</sup>		
A. Number of persons living with AIDS (PLWA), recent time period	20544	[2010 eHARS Data on PLWH/A]	15408	[2010 eHARS data on PLWH/A; derived proportions of public vs. private patients]	5136	[2010 eHARS data on PLWH/A; derived proportions of public vs. private patients]	
B. Number of persons living with HIV (PLWH non-AIDS/aware), recent time period	14675	[2010 eHARS Data on PLWH/A]	11006	[2010 eHARS data on PLWH/A; derived proportions of public vs. private patients]	3669	[2010 eHARS data on PLWH/A; derived proportions of public vs. private patients]	
A+B: Total^ number of persons living with HIV [PLWA+PLWH(non-AIDS/aware)]	35219		26414		8805		
Care Patterns							
C. Percent^ of PLWA who received the specified HIV primary medical care services	70%	[PA Medicaid-ADAP & Part C Sentinel Site Data]	63%	[PA Medicaid & ADAP Data]	90%	[PA Part C sentinel site data]	
D. Percent^ of PLWH (aware, non-AIDS) who received the specified HIV primary	74%	[PA Medicaid-ADAP & Part C Sentinel Site Data]	68%	[PA Medicaid & ADAP Data]	90%	[PA Part C sentinel site data]	
Calculated Results	Value	Calculation	Value	Calculation	Value	Calculation	
E. Number of PLWA who did not receive primary medical services	6163	$20544 - (20544 * 0.7)$	5701	$15408 - (15408 * 0.63)$	514	$5136 - (5136 * 0.9)$	
F. Number of PLWH (non-AIDS, aware) who did not receive primary medical services	3816	$14675 - (14675 * 0.74)$	3522	$11006.25 - (11006.25 * 0.68)$	367	$3669 - (3669 * 0.9)$	
G. Total^ HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	9979	9979 out of 35219 (or 28% with unmet need)	9223	9223 out of 26414.25 (or 35% with unmet need)	881	880.9 out of 8805 (or 10% with unmet need)	
SUMMARY: Of the 35219 people estimated to be living with HIV/AIDS in the jurisdiction, we estimate that 25240 (or 72%) received HIV primary medical care during the specified time period, while 9979 (or 28%) demonstrated unmet need for HIV primary medical care. Among the 20544 people with AIDS, 6163 (or 30%)^ had unmet need, and among the 14675 people with HIV (non-AIDS), 3816 (or 26%)^ had unmet need.			FOOTNOTES: ^Totals and percentages may not add to expected exact sums due to rounding; ^^The proportions of privately vs. publicly insured is estimated as 25% and 75%, respectively based on HARS data; ^^^Data sources and methods are described in the narra				

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**Table 9.2.1.(II) Modified Option 2 Framework and Estimated Numbers of Persons with Unmet Needs for Primary Medical Care among Persons Living with HIV(non-AIDS PLWH) and AIDS (PLWA) in Statewide & HIV/AIDS Service Coalition Areas.**

Using population and care pattern data to calculate unmet need for HIV primary medical care OPTION 2: Care Data as Percents									
Calculation of Indicators of Unmet Need	Statewide	Coalition Area=>	TPAC	South central	South west	North west	North central	North east	AIDSNET
Input	Value	Data Source	Value	Value	Value	Value	Value	Value	Value
Population Sizes									
A. Number of persons living with AIDS (PLWA), recent time period	20,544	[2010 eHARS Data on PLWH/A]	9,862	1,430	1,322	286	354	251	1,092
B. Number of persons living with HIV (PLWH non-AIDS/aware), recent time period	14,675	[2010 eHARS Data on PLWH/A]	12,006	1,741	1,609	348	431	306	1,329
A+B: Total number of persons living with HIV	35,219		21,868	3,171	2,931	634	785	557	2,421
Care Patterns									
C. Percent of PLWA who received the specified HIV primary medical care services in 12-month period	70%	[PA Medicaid+ADAP & Part C Sentinel Site Data]	60%	73%	70%	87%	90%	89%	64%
D. Percent of PLWH (aware, non-AIDS) who received the specified HIV primary medical care services in 12-month period	74%	[PA Medicaid+ADAP & Part C Sentinel Site Data]	66%	67%	69%	73%	78%	79%	74%
Calculated Results	Value	Calculation	Value	Value	Value	Value	Value	Value	Value
E. Number of PLWA who did not receive primary medical services	6163	20544 - (20544 * 0.7)	3945	386	397	37	35	28	393
F. Number of PLWH (non-AIDS, aware) who did not receive primary medical services	3816	14675 - (14675 * 0.74)	4082	575	499	94	95	64	346
G. Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	9979	9979 out of 35219 (or 28% with unmet need)	8027	961	896	131	130	92	739

#### Summary of Statewide Findings

Of the 35219 people estimated to be living with HIV/AIDS in the jurisdiction, we estimate that 25240 (or 72%) received HIV primary medical care during the specified time period while 9979 (or 28%) are estimated to have unmet need for HIV primary medical care. Among the 20544 people with AIDS, 6163 (or 30%) had unmet need, and among the 14675 people with HIV (non-AIDS), 3816 (or 26%) had unmet need.

#### Footnotes:

1. The coalition/regional data does not collectively reflect 100% of the statewide total due to a small number of cases with unspecified residence (not shown) that are not assigned to a particular coalition/region.
2. Each coalition/regional sample's estimates of PLWH/A (rows C & D) are based on independent distributions for the particular region, hence the sum of estimates of PLWH/A (rows E & F) in each coalition/region may differ slightly from the statewide total

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**Table 9.2.1.(III) Option 3 Cross-Validation of Modified Option 2 Framework and Estimated Numbers of Persons with Unmet Needs for Primary Medical Care among Persons Living with HIV(non-AIDS PLWH) and AIDS (PLWA) based on Estimates among Publicly vs. Privately Insured HIV+/aware populations.**

Using population and care pattern data to calculate unmet need for HIV primary medical care OPTION 3: Separate Public and Private Data			Use this table if you have separate information on receipt of HIV primary medical care through private and public sources. "Important note" If you are using lab reporting in HARS to help estimate unmet need and you wish to use this table, you must be able to separate those who received care through private sources from those who received care through public sources in your lab reporting database. If you are not able to make this separation, please use Option 1 (Number) or Option 2 (Percent).  Only peach-colored cells require inputs.  - Rows A & B: In the "Value" column, enter the number of PLWA and PLWH (non-AIDS/aware) living in your jurisdiction during the specified time period. In the "Data Source" column, indicate the source for these data. (See pages 4-5 of the Practical Guide for discussion.)  - Row C1: In the "Value" column, enter the percent of PLWA who are receiving care through private sources (see pages 17-18 of the Practical Guide). In the "Data Source" column, indicate the source for these data. Note that HCUP is a federal study of hospital discharges.  - Row C2: In the "Value" column, enter the percent of those in Row C1 (PLWA with private care) who received the specified HIV primary medical care services. If this percent is unknown, make an estimate. In the "Data Source" column, indicate the source for these data.  - Row C3: The estimated number of PLWA who received HIV primary medical care services during the specified time period through private sources will be automatically calculated.  - Row C4: In the "Value" column, enter the number of PLWA who are receiving care through public care sources. In the "Data Source" column, indicate the source for these data. (see pages 5-8 of the Practical Guide).  - Row C5: The number of PLWA with met need (the number receiving the specified primary medical care services) will be automatically calculated.  - Rows D1-D5: These rows exactly parallel Rows C1-C5. Follow those instructions.  - Once rows A-D5 are done, the calculated results will automatically appear in rows E-G, and a narrative description of the results will appear below the table.  - Row G indicates the total number of HIV+/aware individuals with unmet need.  - The table and narrative description of the results will be useful in your FY05 Title I/Title II application.
Input	Value	Data Source & Calculations	
<b>Population Sizes</b>			
A. Number of persons living with AIDS (PLWA), recent time period	20544	(2010 eHARS Data)	
B. Number of persons living with HIV (PLWH non-AIDS/aware), recent time period	14675	(2010 eHARS Data)	
<b>Care Patterns Among PLWA</b>			
C1. Percent of PLWA who relied on private care in a 12-month period	25%	(Part C, sentinel site data & eHARS data)	
C2. Percent of those in row C1 who received the specified HIV primary medical care services in a 12-month period	90%	(Part C, sentinel site data & eHARS data)	
C3. Number of PLWA who received the specified HIV primary medical care services through private sources in a 12-month period	4,622	$A \times C1 \times C2$ (or $20544 \times 0.25 \times 0.9$ )	
C4. Number of PLWA who received the specified HIV primary medical care services through public sources in a 12-month period	6,898	(PA Medicaid data)	
C5. Number of PLWA with met need for HIV primary medical care in a 12-month period	11,520	$C3 + C4$ (or $4622.4 + 6898$ )	
<b>Care Patterns Among PLWH (aware, non-AIDS)</b>			
D1. Percent of PLWH (aware, non-AIDS) who relied on private care in a 12-month period	25%	(Part C, sentinel site data & eHARS data)	
D2. Percent of those in row D1 who received the specified HIV primary medical care services in a 12-month period	90%	(Part C, sentinel site data & eHARS data)	
D3. Estimated number of PLWH (aware, non-AIDS) who received the specified HIV primary medical care services through private care in a 12-month period	3,302	$B \times D1 \times D2$ (or $14675 \times 0.25 \times 0.9$ )	
D4. Number of PLWH (aware, non-AIDS) who received the specified HIV primary medical care services from public sources in 12-month period	9,063	(PA Medicaid data)	
D5. Number of PLWH (aware, non-AIDS) with met need for HIV primary medical care in a 12-month period	12,365	$D3 + D4$ (or $9063 + 3301.875$ )	
<b>Calculated Results</b>			
E. Number of PLWA who did not receive specified HIV primary medical care services	9,024	$A - C5$ (or $20544 - 11520.4$ )	
F. Number of PLWH (aware, non-AIDS) who did not receive specified HIV primary medical care services	2,310	$B - D5$ (or $14675 - 12364.875$ )	
G. Total HIV+/aware not receiving specified HIV primary medical care services (quantified estimate of unmet need)	11,334	$E + F$ (or $9023.6 + 2310.125$ )	

Of the 35219 people estimated to be living with HIV/AIDS in the jurisdiction, we estimate that 23885.275 (or 68%) received HIV primary medical care during the specified time period, while 11333.725 (or 32%) demonstrated unmet need for HIV primary medical care. Among the 20544 people with AIDS, 9023.6 (or 44%) had unmet need, and among the 14675 people with HIV (non-AIDS), 2310.125 (or 16%) had unmet need.

## 9.1. AIDS Incidence, AIDS Prevalence and HIV Prevalence: Abstract/Summary of Findings:

### Objectives:

To provide a summary of AIDS incidence, AIDS prevalence and HIV (non-AIDS) prevalence within the Commonwealth of Pennsylvania.

### Methods:

The design of HIV case surveillance is conceptually a prospective dynamic cohort study with individuals included at the time of HIV diagnosis, and followed longitudinally through death. HIV/AIDS patients diagnosed and reported by clinicians across PA since 1981 constitute the population-based surveillance cohort used for these analyses. Pennsylvania's HIV (including AIDS) surveillance data from January 1, 1981 through December 31, 2009, and December 31, 2010 (reported through June 30, 2011) were used to determine prevalent (living) and newly diagnosed cases of HIV/AIDS at the conclusion of 2009 and 2010 and stratified by race/ethnicity, age group at diagnosis, mode of transmission. These tabulations were used to calculate the rates per 100,000 population and percent of total cases attributed to each demographic characteristic or risk behavior.

### Highlights of key findings in 2009:

#### ➤ AIDS Incidence:

- The greatest incidence of AIDS cases was among blacks comprising 50% of all newly diagnosed AIDS cases, which was 12 times the rate per 100,000 population than whites; Hispanics were 17% of the new AIDS cases diagnosed in 2009, yet they were 9 times the rate per 100,000 population than whites;
- Males were twice as likely as females to have been diagnosed with AIDS in 2009;
- 20-44 years old group contributed 53% of all AIDS cases;

#### ➤ AIDS Prevalence:

- Combined, blacks and Hispanics comprised 67% of all prevalent AIDS cases even though these minority groups only total 15% of the general population in PA. These populations were disproportionately affected with blacks having 12 times the rate per 100,000 and Hispanics having 10 times the rate when compared to whites.
- Males were nearly 3 times more likely than females to be living with AIDS in 2009;
- More than 70% of all persons living with AIDS were among the 20-44 years old age group for 2009;

#### ➤ HIV (non-AIDS) Prevalence:

- Combined, blacks and Hispanics comprised 62% of all prevalent HIV cases even though these minority groups only total 16% of the general population in PA. These race/ethnic minorities were disproportionately affected with blacks having 12 times the rate per 100,000 and Hispanics having 6 times the rate when compared to whites.
- Males constitute nearly 70% of all living HIV cases;
- HIV prevalence was greatest among the 20-44 years group (52%) followed by the greater than 44 years group (45%), 13-19 years (2%) and less than 13 years (1%);
- When behavioral risk groups of infected persons living with HIV are combined into reservoirs of potential sources of HIV infection, the greatest proportions of prevalent HIV cases was found among a) heterosexuals (who may have acquired HIV through IDU or hetero contact) with a collective total of 56%, b) MSM (who may have acquired HIV through MSM or MSM-IDU risk behaviors) with a collective total of 36%, and d) IDU (who may have acquired HIV through IDU or MSM-IDU) with a collective total of 23%;

#### ➤ Comparison of 2009 to 2010:

- The number of new/incident AIDS cases diagnosed in Pennsylvania in 2009 was 1,174 and this number decreased by almost 18% to 963 in 2010 (based on case reporting to PA Dept of Health through June 30, 2011);

## Persons Diagnosed and Living with HIV/AIDS (PDLWH/A) who are Capable of Transmitting HIV through Heterosexual Contact Pennsylvania (not including Philadelphia County and Corrections), 2009.

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Vladimir Kreps, PhD, and Tonya Crook, MD, MS, DTM&H<sup>E</sup>

<sup>A</sup>Commonwealth of Pennsylvania, Department of Health; Penn State College of Medicine, Departments of Public Health Sciences<sup>\*</sup> and Medicine<sup>E</sup>

### Background/Objectives:

Since the introduction of HIV reporting in 2002, there has been improved understanding of the overall number of persons diagnosed and reported with HIV infection that are presumed to be alive in Pennsylvania. However, few studies have described the distribution of PDLWH/A who are capable of transmitting of HIV through heterosexual contact and how the likelihood of this risk population amongst PDLWH/A varies according to several characteristics.

### Methods:

**Design and Study Population:** The HIV case surveillance dynamic cohort studied included 13,055 adults/adolescents ( $\geq 13$  years of age at the time of HIV diagnosis) with a definitive HIV diagnosis from January 1, 1980 who were longitudinally followed-up and ascertained to be alive through death registry linkage as of January 1, 2009, and whose current age on that date was 13 years of age and older (i.e. excluding those who likely acquired HIV through mother-to-child transmission). This cohort also excluded Philadelphia and correctional facilities.

**Primary Outcome Measure and Statistical Analyses:** The primary outcome measure is the *likelihood* of persons capable of transmitting HIV through heterosexual contact vs. those who are not in this risk population, among the selected cohort of PDLWH/A. Chi-square analyses were performed to compare the distributions of these two sub-cohorts according to each covariate assessed. Univariate and multivariate/adjusted logistic regression analyses were performed to estimate likelihoods of PLWH/A who are capable of transmitting HIV through heterosexual contact (among the cross-section of PDLWH/A) by several risk factors/covariates such as race/ethnicity, sex, current age group, and HIV service region of residence at diagnosis. Race/ethnicity-, age- and sex-stratified multiple logistic regression analyses were also performed.

### Results:

The proportion of PDLWH/A who are capable of transmitting HIV through heterosexual contact in Pennsylvania was ~45%. The likelihood of persons capable of transmitting HIV through heterosexual contact was greater for: a) those who were 30-39 years of age (OR=1.74;95%CI:1.45-2.08) compared to the age group 13-29 years, and increased with each successive age group; b) those among racial/ethnic minorities' groups [black (OR=2.78; 95%CI:2.52-3.02), Hispanic (OR=3.72;95%CI:3.29-4.21) as compared to white; c) females (OR=8.45;95%CI:7.67-9.30); Persons capable of transmitting HIV through heterosexual contact was less likely for all those among the HIV service area/regions at the time of diagnosis in Northwest (OR=0.77;95%CI:0.62-0.96), Southcentral (OR=0.84;95%CI:0.75-0.95), and Southwest (OR=0.57;95%CI:0.51-0.65)] when compared to AACO region (Philadelphia's surrounding four counties). Further research is in progress on sub-analyses stratified by sex, age group, race/ethnicity, and epidemic growth tiers.

### Conclusions/Implications:

The substantial proportion of the combined Hetero contact/IDU sub-population of PDLWH/A who are capable of transmitting HIV through Hetero contact suggests continuing urgent need among the risk groups identified for expansion of highly targeted prevention for Heterosexual 'positives' (linkage to HIV prevention and care, incl. early HIV testing). Program planning and resource allocation to expand and intensify outreach to this population (incl. both early risk-based and targeted HIV testing in non-clinical settings, and routine prevention and care in clinical settings) should consider these findings to assure timely access and linkage to HIV treatment and prevention services (to prevent transmission from this Heterosexual reservoir of potential sources of HIV infection).



## Persons Diagnosed and Living with HIV/AIDS (PDLWH/A) who are Capable of Transmitting HIV through Injection Drug Use (IDU) Pennsylvania (not including Philadelphia County and Corrections), 2009.

Benjamin Muthambi, DrPH, MPH<sup>§</sup>, Nathaniel Geyer, MS<sup>§</sup>, Khaled Iskandarani, MPH<sup>\*</sup>,  
Vladimir Kreps, PhD, and Tonya Crook, MD, MS, DTM&H<sup>§</sup>

<sup>\*</sup>Commonwealth of Pennsylvania, Department of Health; <sup>§</sup>Penn State College of Medicine, Department of Public Health Sciences

### Background/Objectives:

Since the introduction of HIV reporting in 2002, there has been improved understanding of the overall number of persons diagnosed and reported with HIV infection that are presumed to be alive in Pennsylvania. However, few studies have described the distribution of PDLWH/A who are capable of transmitting HIV through IDU, and how the likelihood of this risk population amongst PDLWH/A varies according to several characteristics.

### Methods:

**Design and Study Population:** The HIV case surveillance dynamic cohort studied included 13,055 adults/adolescents (>13 years of age at the time of HIV diagnosis) with a definitive HIV diagnosis from January 1, 1980 who were longitudinally followed-up and ascertained to be alive through death registry linkage as of December 31, 2009, and whose current age on that date was 13 years of age and older (i.e. excluding those who likely acquired HIV through mother-to-child transmission).

**Primary Outcome Measure and Statistical Analyses:** The primary outcome measure is the *likelihood* of persons capable of transmitting HIV through IDU vs. those who are not in this risk population, among the selected cohort of PDLWH/A. Chi-square analyses were performed to compare the distributions of these two sub-cohorts according to each covariate assessed. Univariate and multivariate/adjusted logistic regression analyses were performed to estimate likelihoods of PLWH/A who are capable of transmitting HIV through IDU (among the cross-section of PDLWH/A) by several risk factors/covariates such as race/ethnicity, sex, current age group, HIV service region of residence at diagnosis. Race/ethnicity-(racial ethnic minorities combined vs. all others, blacks vs. all others, Hispanic vs. all others), age- (current age 50 or older vs. 49 or younger) and sex-stratified multiple logistic regression analyses were also performed.

**Results:** The proportion of PDLWH/A who are capable of transmitting HIV through IDU in Pennsylvania (excluding Philadelphia) was ~22%. The likelihood of persons capable of transmitting HIV through IDU was greater for: a) those who were 30-39 years of age at HIV diagnosis (OR=2.22;95%CI:1.71-2.87) compared to the age group 13-29 and increased with each successive age group; b) those who were identified as racial/ethnic minorities [black (OR=2.24;95%CI:2.03-2.48), Hispanic (OR=2.90;95%CI:2.56-3.28)]; c) those who were residents of the AIDSNET (OR=1.26;95%CI:1.10-1.44) and Northcentral (OR=1.65;95%CI:1.34-2.03) HIV service areas/regions at the time of diagnosis compared to the AACO region (surrounding four counties outside of Philadelphia). Persons capable of transmitting HIV through IDU was less likely to be females (OR=0.90;95%CI:0.81-0.99) and those who were residents of the Southwest HIV service area/region (OR=0.55;95%CI:0.48-0.63) compared to AACO (contiguous four counties surrounding Philadelphia). Further research is in progress on sub-analyses stratified by sex, age group, race/ethnicity, and epidemic growth tiers.

### Conclusions/Implications:

The substantial proportion of the combined IDU/MSM-IDU sub-population of PDLWH/A who are capable of transmitting HIV through IDU suggests continuing urgent need among the risk groups identified for expansion of highly targeted prevention for IDU 'positives' (linkage to HIV prevention and care, incl. early HIV testing). Program planning and resource allocation to expand and intensify outreach to this population (incl. both early risk-based and targeted HIV testing in non-clinical settings, and routine prevention and care in clinical settings) should consider these findings to assure timely access and linkage to HIV treatment and prevention services (to prevent transmission from this IDU reservoir of potential sources of HIV infection).



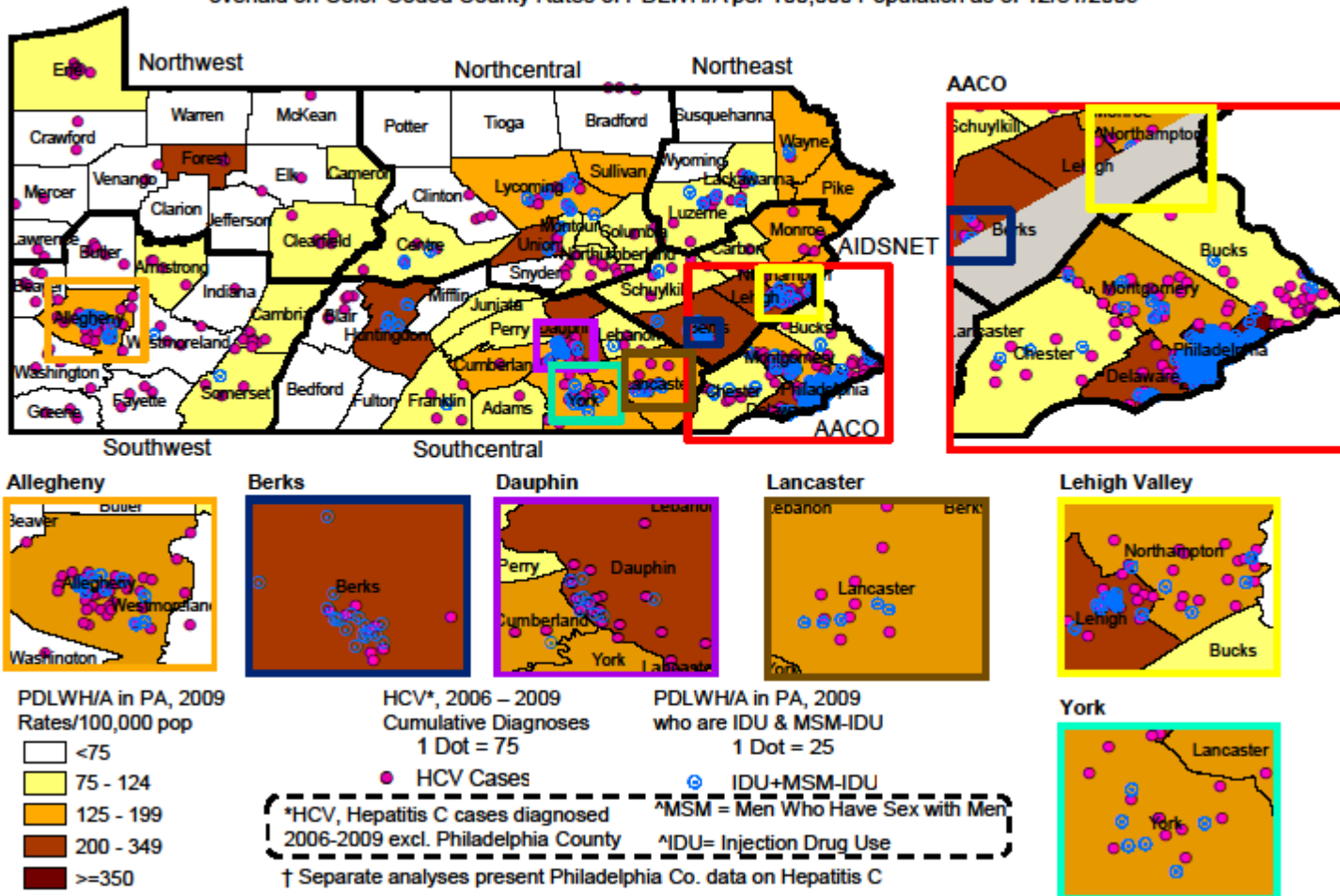
<sup>\*</sup>Literature references, tables and figures of results are available on request.

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HIV Epidemiology Investigations Section, Bureau of Epidemiology



# Geospatial Distribution of IDU<sup>^</sup> Persons Diagnosed & Living with HIV/AIDS(PDLWH/A) vs. HCV<sup>\*</sup> Diagnoses

Zip Code Dot Density of a) PDLWH/A Attributed to IDU<sup>^</sup> (incl. MSM-IDU) as of 12/31/2009 or  
b) 4-year Cumulative # of HCV<sup>†</sup> Diagnoses (2006-2009)  
overlaid on Color-Coded County Rates of PDLWH/A per 100,000 Population as of 12/31/2009



## Persons Diagnosed and Living with HIV/AIDS (PDLWH/A) who are Capable of Transmitting HIV through Males Having Sex with Males (MSM) Pennsylvania (not including Philadelphia County and Corrections), 2009.

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Vladimir Kreps, PhD, and Tonya Crook, MD, MS, DTM&H<sup>§</sup>

<sup>§</sup>Commonwealth of Pennsylvania, Department of Health; <sup>§</sup>Penn State College of Medicine, Department of Public Health Sciences

### Background/Objectives:

Since the introduction of HIV reporting in 2002, there has been improved understanding of the overall number of persons diagnosed and reported with HIV infection that are presumed to be alive in Pennsylvania. However, few studies have described the distribution of PDLWH/A who are capable of transmitting of HIV through MSM, and how the likelihood of this risk population amongst PDLWH/A varies according to several characteristics.

### Methods:

**Design and Study Population:** The HIV case surveillance dynamic cohort studied included 13,055 adults/adolescents ( $\geq 13$  years of age at the time of HIV diagnosis) with a definitive HIV diagnosis from January 1, 1980 who were longitudinally followed-up and ascertained to be alive through death registry linkage as of January 1, 2009, and whose current age on that date was 13 years of age and older (i.e. excluding those who likely acquired HIV through mother-to-child transmission).

**Primary Outcome Measure and Statistical Analyses:** The primary outcome measure is the *likelihood* of persons capable of transmitting HIV through MSM vs. those who are not in this risk population, among the selected cohort of PDLWH/A. Chi-square analyses were performed to compare the distributions of these two sub-cohorts according to each covariate assessed. Univariate and multivariate/adjusted logistic regression analyses were performed to estimate likelihoods of PLWH/A who are capable of transmitting HIV through MSM (among the cross-section of PDLWH/A) by several risk factors/covariates such as race/ethnicity, current age group, HIV service region of residence at diagnosis. Race/ethnicity- and age group-stratified multiple logistic regression analyses were also performed.

### Results:

The proportion of PDLWH/A who are capable of transmitting HIV through MSM (including MSM-IDU) was ~41%. The likelihood of those capable of transmitting HIV through the MSM risk behavior was greater for those who were residents of the Southwest Coalition/HIV service area at the time of diagnosis (OR=2.10;95%CI:1.88-2.34) compared to the AACO region (Philadelphia's surrounding four counties); and was less likely for: a) those currently in the age group 30-39 years (OR=0.49;95%CI:0.42-0.58) and among each of the successive age groups compared to the referent group (13-29 years), b) those whose residence at HIV diagnosis was the AIDSNET coalition/HIV service area (OR=0.53; 95%CI:0.46-0.60), and c) those who belonged to racial/ethnic minority groups [black (OR=0.29;95%CI:0.26-0.31), Hispanic (OR=0.25;95%CI:0.23-0.27)]. In the sub-analyses stratified by race/ethnicity, racial/ethnic minorities who were capable of transmitting HIV through the MSM risk behavior were more likely to be residents of the Southwest Coalition area (OR=1.94; 95%CI:1.86-2.28) at the time of diagnosis compared to the AACO region (though less likely to be in other regions except Northwest, which was comparable to AACO); and were less likely to be in the age group 30-39 years (OR=0.44;95%CI:0.35-0.54), and decreased with each successively older age group (i.e. conversely, they were more likely to be among progressively younger age groups). In age-stratified sub-analyses, those 50 years or older who were capable of transmitting HIV through the MSM risk behavior were more likely to be residents of the Southwest (OR=1.88;95%CI:1.55-2.22) and Northwest (OR=1.50;95%CI:1.05-2.15) coalition regions, compared to AACO; and were less likely to be a) residents of the AIDSNET service area, and b) racial/ethnic minorities (OR=0.45; 95%CI:0.36-0.56). Further research is in progress on sub-analyses stratified by epidemic growth tiers.

### Conclusions/Implications:

The substantial proportion of the combined MSM/MSM-IDU sub-population of PDLWH/A who are capable of transmitting HIV through MSM suggests continuing urgent need among the risk groups identified for expansion of highly targeted prevention for MSM 'positives' (linkage to HIV prevention and care, incl. early HIV testing). Program planning and resource allocation to expand and intensify outreach to this population (incl. both early risk-based and targeted HIV testing in non-clinical settings, and routine prevention and care in clinical settings) should consider these findings to assure timely access and linkage to HIV treatment and prevention services (to prevent transmission from this MSM reservoir of potential sources of HIV infection).



<sup>§</sup>Literature references, tables and figures of results are available on request.  
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## D2. HIV Service Region Mini-Profile | Abstract/Summary of Findings: Trends in Clinical Characteristics of Prevalent HIV (including AIDS) Cases in Pennsylvania.

### Objectives:

The objectives of these analyses are to facilitate more evidence-based planning, targeting and distribution of prevention and care resources in Pennsylvania. Findings of these analyses are used to elucidate the clinical impact of HIV/AIDS mainly manifested through the distribution of HIV (non AIDS) and AIDS cases and the subsequent burden of AIDS defining illnesses across the Commonwealth and its respective coalition/service areas.

### Methods: Study Design, Population and Analyses

The design of population-based case surveillance is conceptually a dynamic cohort with longitudinal follow-up of the study population (which consists of HIV/AIDS patients diagnosed and reported by clinicians across PA). AIDS cases diagnosed since 1980 and HIV cases diagnosed since 2000 entered follow-up at the time of diagnosis and case report; were retrospectively investigated to ascertain probable mode of transmission; and prospectively followed up to ascertain viremia, immunodeficiency and AIDS defining illnesses through death. Pennsylvania's HIV (including AIDS) surveillance data from January 1, 1981 through December 31, 2008 were analyzed by prevalent (living) cases at the end of each year and stratified by stage of disease and the presentation of AIDS defining illnesses at AIDS diagnosis.

### Highlights of key findings (please see Table 1, attached):

- Distribution of persons living with HIV/AIDS (PLWHA) in the state of Pennsylvania revealed that the majority of cases were diagnosed with AIDS (59%, a decrease of 15% since 2003); conversely, HIV (non AIDS) cases demonstrated a substantial increase (26% in 2003 to 41% in 2008), however this trend may simply be a reflection of the instability in reporting due to the recent changes in HIV reporting in PA;
- Among all prevalent AIDS cases in 2008, 61% (an increase of 8% since 2003) of these cases met the immunological criteria at the time of AIDS diagnoses. Of these cases 10% (a decrease of 1% since 2003) presented with *Pneumocystis carinii*, pneumonia, at that time which was the most commonly reported opportunistic infection across the Commonwealth (2003-2008), followed by wasting syndrome (7%, a decrease of 1% since 2003), esophageal candidiasis and chronic mucocutaneous herpes (tied at 5%), recurrent pneumonia (2%), Kaposi's sarcoma, cytomegalovirus, and pulmonary tuberculosis (all remained at 1%);
- In 2008 the distribution of prevalent cases of HIV (non AIDS) and AIDS was approximately 40% and 60% respectively across the entire state;
- Across all jurisdictions 59-66% of PLWH met the immunological criteria at AIDS diagnosis; *P. carinii*, pneumonia, which was the most commonly, presented opportunistic illness at AIDS diagnosis ranging from 6% to 13%. The frequency of the remaining AIDS defining opportunistic infections varied in rank by jurisdiction;

### Conclusions/Public Health Recommendations:

The results of these analyses suggest that the predominant impact of the HIV/AIDS epidemic in the state of Pennsylvania poses a significant and disproportionate threat to persons diagnosed with AIDS (stage 3). The increasing rate of infection of HIV (non AIDS) stages 1-2 reflects an overall increase in HIV (non AIDS) prevalence. This increase provides the potential risk of new transmissions from the increasing reservoir of infection, the source population of HIV infected persons, especially among disproportionately impacted communities. In turn, an increase in the number of people living longer with HIV/AIDS requires increased resources for care and prevention services. The steady number of opportunistic illnesses presented at AIDS diagnosis call for the need of earlier detection, treatment, and prophylaxis. Services targeting the AIDS (stage 3) of the disease need to be developed, since a larger proportion of individuals with HIV are currently living with AIDS.

**TABLE 1**  
**HIV<sup>a</sup> IN PENNSYLVANIA**

TRENDS OF NO. PERSONS LIVING WITH HIV (INCLUDING AIDS) AT THE END OF EACH YEAR: 2003-2008

CLINICAL CHARACTERISTICS			2003		2004		2005		2006		2007		2008	
	TOTAL <sup>b</sup>		number	percent	number	percent	number	percent	number	percent	number	percent	number	percent
STAGE OF DISEASE			18050	100	20085	100	22363	100	25969	100	28271	100	30479	100
	HIV, NON AIDS (STAGES 1-2)		4695	26	5890	29	7210	32	9485	37	10991	39	12501	41
	AIDS (STAGE 3) <sup>c,d</sup>		13355	74	14195	71	15153	68	16484	63	17280	61	17978	59
	AIDS DEFINING ILLNESSES	IMMUNOLOGICAL	7126	53	7829	55	8566	57	9689	59	10052	60	10931	61
	PRESENTING AT AIDS DX (OUT OF TOTAL NO. LIVING AIDS CASES AT END OF EACH YEAR) <sup>e,f,g</sup>	PNEUMOCYSTIS CARINI PNEUMONIA	1454	11	1506	11	1561	10	1628	10	1673	10	1710	10
		WASTING SYNDROME	1088	8	1113	8	1147	8	1183	7	1201	7	1205	7
		CANDIDIASIS, ESOPHAGEAL	775	6	785	6	818	5	856	5	880	5	899	5
		CHRONIC MUCOCUTANEOUS HERPES	715	5	740	5	792	5	808	5	832	5	842	5
		PNEUMONIA, RECURRENT	360	3	361	3	365	2	375	2	382	2	384	2
		KAPOSI'S SARCOMA	214	2	217	2	222	1	231	1	233	1	237	1
		CYTOMEGALOVIRUS DISEASE	167	1	176	1	196	1	202	1	208	1	219	1
		M.TUBERCULOSIS, PULMONARY	163	1	165	1	172	1	177	1	183	1	183	1
		CRYPTOCOCCOSIS <sup>h</sup>	156	1	165	1	170	1	174	1	176	1	182	1

NO. OF PERSONS LIVING WITH HIV (INCLUDING AIDS) AT THE END OF 2008 BY COALITION REGIONS/SERVICE AREAS

CLINICAL CHARACTERISTICS			AAO		AIDSNET		NORTHCENTRAL		NORTHEAST		NORTHWEST		SOUTHCENTRAL		SOUTHWEST	
	TOTAL <sup>b</sup>		number	percent	number	percent	number	percent	number	percent	number	percent	number	percent	number	percent
STAGE OF DISEASE			19525	100	2477	100	751	100	713	100	645	100	3290	100	3078	100
	HIV, NON AIDS (STAGES 1-2)		8023	41	980	40	300	40	302	42	257	40	1334	41	1305	42
	AIDS (STAGE 3) <sup>c,d</sup>		11502	59	1497	60	451	60	411	58	388	60	1956	59	1773	58
	AIDS DEFINING ILLNESSES	IMMUNOLOGICAL	6817	39	978	60	297	66	272	66	237	61	1255	64	1075	61
	PRESENTING AT AIDS DX (OUT OF TOTAL NO. LIVING AIDS CASES AT END OF 2008) <sup>e,f,g</sup>	PNEUMOCYSTIS CARINI PNEUMONIA	1051	9	130	9	47	10	26	6	45	12	181	9	230	13
		WASTING SYNDROME	914	8	71	5	10	2	22	5	18	5	82	4	88	5
		CHRONIC MUCOCUTANEOUS HERPES	677	6	43	3	8	2	12	3	10	3	58	3	34	2
		CANDIDIASIS, ESOPHAGEAL	510	4	71	5	27	6	21	5	20	5	119	6	131	7
		PNEUMONIA, RECURRENT	288	3	29	2	4	1	7	2	4	1	28	1	24	1
		KAPOSI'S SARCOMA	160	1	16	1	4	1	4	1	6	2	19	1	28	2
		M.TUBERCULOSIS, PULMONARY	138	1	13	1	4	1	5	1	2	1	13	1	8	0
		CYTOMEGALOVIRUS DISEASE	131	1	19	1	2	0	7	2	3	1	22	1	35	2
		HIV ENCEPHALOPATHY <sup>h</sup>	99	1	18	1	2	0	6	1	6	2	19	1	22	1
		CRYPTOCOCCOSIS <sup>h</sup>	96	1	19	1	2	0	5	1	12	3	25	1	23	1
		TOXOPLASMOSIS OF BRAIN <sup>h</sup>	84	1	23	2	4	1	4	1	6	2	21	1	19	1
		CANDIDIASIS, LUNG <sup>h</sup>	74	1	14	1	6	1	3	1	5	1	21	1	22	1
		IMMUNOBLASTIC LYMPHOMA <sup>h</sup>	38	0	9	1	2	0	2	0	2	1	7	0	9	1
		CERVICAL CANCER <sup>h</sup>	28	0	3	0	4	1	2	0	0	0	6	0	3	0

<sup>b</sup>Percentages for stage of disease may not add to 100% due to rounding.

<sup>c</sup>Excludes presumptive diagnoses of AIDS.

<sup>d</sup>Excludes presumptive diagnoses of HIV.

<sup>e</sup>Only AIDS defining illnesses diagnosed at time of AIDS diagnosis are included.

<sup>f</sup>Percentage of AIDS defining illnesses may total more than 100% due to potential multiple conditions being diagnosed for each case.

<sup>g</sup>The predominant AIDS defining illnesses ranked in accordance with their presentation in 2008.

<sup>h</sup>Conditions occurring more frequently prior to 2008.

<sup>i</sup>The predominant AIDS defining illnesses ranked in accordance with their presentation in regions/counties.

<sup>j</sup>Conditions occurring more frequently outside predominate region/county rank based on AAO.

Cases reported as of 06/30/2009

HIV Prevalence Supplement to the Integrated Epidemiologic Profile of  
HIV/AIDS in Pennsylvania (in support of prevention and care)

HIV/AIDS Investigations Bureau of Epidemiology  
Pennsylvania Department of Health