

**Pennsylvania
Community
HIV Prevention Plan
Year Three Update**

September 18, 2000

Tom Ridge, Governor
Robert S. Zimmerman, Jr., Secretary of Health



The Calendar year 2001 is the third year of a three-year Pennsylvania Community HIV Prevention Plan. As such the Pennsylvania HIV Prevention Community Planning Committee is providing this update for the Plan they submitted to the Centers for Disease Control and Prevention with the Pennsylvania Department of Health grant application in the Fall of 1998 covering the calendar years of 1999 through 2001. The year 2001 Plan Update will be available online at <http://www.stophiv.com> as well as the original multi-year Plan and last year's Plan Update are also located there.

The Pennsylvania Department of Health, Division of HIV/AIDS convenes the Pennsylvania HIV Prevention Community Planning Committee following guidelines for community HIV prevention planning provided by the Centers for Disease Control and Prevention. The Committee is currently composed of a diverse group of 40 members from across the Commonwealth excluding Philadelphia. Philadelphia is a Ryan White Title I City receiving HIV prevention funds directly from the Centers for Disease Control and Prevention.

New members of the Pennsylvania HIV Prevention Community Planning Committee are appointed in February for three-year commitments. They attend a one-day orientation session in March and are assigned a mentor from the more experienced Committee members. The Committee meets in Harrisburg for two-day meetings in May, July, and August and one-day meetings in January, March, September, and November.

The over-arching five-year programmatic goals of the Pennsylvania HIV Prevention Community Planning Committee are used as beacons to guide the overall process of community HIV prevention planning:

- I. Reduce the incidence of HIV transmission in the state of Pennsylvania
- II. Reduce HIV disease progression and prolong life in persons living with HIV in the state of Pennsylvania
- III. Reduce HIV-related stigmatization in the state of Pennsylvania
- IV. Increase the Involvement of priority populations in the development and implementation of effective HIV education and prevention in the state of Pennsylvania

Executive Summary

Section I of The Plan Update for 2001 commences by addressing the current status of the five **National Core Objectives** (page 1) established by the Centers for Disease Control and Prevention: (1) Fostering the openness and participatory nature of the community planning process, (2) Ensure that the CPG reflects the diversity of the epidemic in your jurisdiction, and that expertise in epidemiology, behavioral science, health planning and evaluation are included in the process, (3) Ensure that priority HIV prevention needs are determined based on an epidemiological profile and needs assessment, (4) Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values, and (5) Foster strong, logical linkages (i.e. connections) between the community planning process, the comprehensive planning HIV prevention plan, the application for funding, and allocation of HIV prevention resources.

Section II reviews the **Cross-Program Activities** (page 11) within the Pennsylvania Department of Health Bureau of Communicable Diseases, HIV antibody counseling and testing within county prisons and jails, and efforts at a uniform data collection system for all state/federally funded HIV prevention efforts.

Section III addresses the critical **Linkages Between Primary and Secondary Prevention Activities** (page 13) with an extensive review of the <http://www.stophiv.com> Website services. In addition, related counseling and testing objectives are presented.

Section IV outlines the development of the fifteen **Target Populations and** subsequent HIV prevention **Interventions** (page 19). In particular this section includes tables linking recommendations of the Plan Update for HIV prevention by target populations to the funded interventions of the department of health's Centers for Disease Control and Prevention grant application.

Section V summarizes the **Goals, Objectives, and Activities for Target Populations** (page 30) of the funded HIV prevention intervention demonstration projects of the Pennsylvania Prevention Project.

Section VI focuses upon **Additional 2001 Programmatic Goals and Objectives** (page 37) related to modifications of counseling and testing, health education and risk reduction, and capacity building. In particular, new recommendations for women and incarcerated populations are included within this section.

Section VII, Coordination of HIV Prevention Services and Programs (page 41), addresses liaison responsibility between the Pennsylvania Prevention Project and the independent county and municipal health departments, the local partnership members of the State Health Improvement Plan, and the Ryan White HIV/AIDS Regional Planning Coalitions.

Section VIII, Technical Assistance (page 42) reviews, in part, the efforts of the Planning Committee to improve its own understanding and functioning as a planning body. That is, improving their understanding of communication within the group, conflict resolution, and group consensus concerns. In addition, prevention and medical management of HIV/AIDS technical assistance from the Centers for Health Services Research and Policy of the George Washington University and the Special Needs Division of the Bureau of Managed Care Operations, Office of Medical Assistance of the Pennsylvania Department of Public Welfare was provided. This effort has resulted in technical assistance to be provided to the Ryan White HIV/AIDS Regional Planning Coalitions community-based service providers around HIV prevention and managed care in Pennsylvania.

Section IX, State Funded HIV Prevention Activities (page 44) provides the opportunity to understand the array of HIV prevention services provided by the Pennsylvania Department of Health using non-Centers for Disease Control and Prevention funds.

Section X provides an overview and timelines of **Program Evaluation** (page 46) for the Five Year Strategic Evaluation Plan (1999-2003).

Attached to the Year Three Plan Update is the current **Epidemiological Profile** (page 66). In the absence of data on newly diagnosed recently infected HIV cases, additional data to describe more fully and infer the likelihood of new HIV infection in various geographic areas and their affected population-transmission groups and at the same time describe the likelihood of growth in the population that is living with HIV/AIDS in Pennsylvania is utilized.

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Section I: HIV Prevention National Core Objectives

There are 65 HIV prevention community planning jurisdictions funded by the Centers for Disease Control and Prevention. A set of five national core objectives have been developed to provide a framework in which those jurisdictions can be compared as well as concerns specific to the HIV prevention community planning process can be readily identified and addressed. Following is the status from July 1999 through June 2000 of the Pennsylvania HIV Prevention Community Planning Committee in meeting those core objectives:

(1) Fostering the openness and participatory nature of the community planning process.

The current HIV prevention community planning committee is comprised of 39 individuals from across the Commonwealth of Pennsylvania excluding Philadelphia. The following is the step-by-step process by which Committee members are selected to participate: **(1)** the annual process evaluation by the Committee is conducted at the November meeting. This evaluation is comprised of an anonymous instrument (CDC model) taken home by members. This year the Co-Chair survey was utilized for the first time and is part of the Committee process evaluation report. In addition to the anonymous surveys, ninety-minute small group sessions facilitated by external individuals are conducted; **(2)** the Membership Subcommittee meets via a telephone conference call in November. At this meeting the subcommittee reviews the membership attendance for the year and makes recommendations for removal of non-participatory members. In addition, based on the current epidemiological profile as well as other more subjective criteria, gaps in representation are reviewed. Attention to criteria such as age, gender, race/ethnicity, HIV/AIDS status, and geography are provided; **(3)** the preceding resources are utilized to create a profile of new members needed for the following year; **(4)** the department of health widely distributes applications for membership on the Committee; **(5)** the membership subcommittee reviews the applications and meets via a telephone conference call to make decision on the selection of new Committee members by the end of January; and **(6)** potential Committee members are notified by the health department (alternates are also selected in case selected members decline) and invited to an Orientation meeting in March. A one-day orientation is conducted for new members and that evening a reception is held to introduce new members to the rest of the Committee, members of the Pennsylvania Prevention Project, and the department of health. Their initial Committee meeting is the following day in which new members sit with their assigned experienced Committee member mentor. In addition, each of the subcommittees has their initial meeting on a portion of this day. Therefore, each new Committee member can select a subcommittee in which to become actively involved.

A member of the Ryan White HIV/AIDS Regional Planning Coalitions is appointed by their Integrated Planning Council as a voting member of the HIV Prevention Community Planning Committee. In addition, two members of the HIV Prevention Committee serve as voting members of the Integrated Council. The Division of HIV/AIDS of the

Pennsylvania Health Department oversees both statewide planning bodies as well as department of health employees serving those groups are present at meetings. Many HIV prevention committee members also serve on various committees of their local Ryan White HIV/AIDS Regional Planning Coalitions.

Additional methods used to obtain input from outside group membership include the creation of the nationally recognized Young Adult Roundtables in eight communities (Erie, Harrisburg, Norristown, Pittsburgh, Reading, Scranton, Williamsport and York). According to process data obtained from CPG members over the past four years, Roundtables provide very valuable HIV prevention planning information relative to, about and from youth and young adults directly to the Committee. Elected by their peers, three members of the Young Adult Roundtable Executive Committee are voting members of the HIV prevention Committee. Through the Roundtables Pennsylvania has provided parity, inclusion and representation to youth in our state's community planning process since 1996. The liaison work between the Pennsylvania Prevention Project, the independent county and municipal health departments, and the local partnership members of the State Health Improvement Plan provides an additional feedback loop from the local level to the HIV prevention committee. The Pennsylvania Prevention Project provides community leadership development and community-wide planning in Erie, Williamsport, and York in which valuable local HIV prevention information is also garnered.

(2) Ensure that the CPG reflects the diversity of the epidemic in your jurisdiction, and that expertise in epidemiology, behavioral science, health planning and evaluation are included in the process.

The Committee conducts an annual process evaluation as previously outlined under national core objective 1 page 1 of this document. The Membership Subcommittee utilizes the information provided by the process evaluation in their selection of new members.

Geographic representation of the Committee is determined by representation from the seven Ryan White HIV/AIDS Regional Planning Coalition jurisdictions. The North Central Region remains under-represented and the South Central is inflated due to the state capital of Harrisburg being located in that jurisdiction. Several members of the Committee represent state government such as the Department of Education, Corrections, and so forth. Currently the Committee geographic representation is: Southwest 20% (8), AIDSNET 20% (8), South Central 20% (8), Northwest 12.5% (5), Northeast 12.5% (5), TPAC 12.5% (5), and north Central 2.5% (1). These percentages closely reflect the number of persons diagnosed with AIDS within those Coalition regions.

The Committee is represented by 50% (20) women of which 50% (10) are Caucasian, 35% (7) are African American, and 15% (3) are Hispanic/Latina. In addition, 50% (20) of the Committee is male of which 45% (9) are Caucasian, 20% (4) Hispanic/Latino, and 35% (7) African American. Total number of diagnosed cases of AIDS for the

Commonwealth as of 30 June 2000 by race/ethnicity is: 49% Black (non-Hispanic), 40% White (non-Hispanic), and 11% Hispanic. In Comparison 35% (14) of the Committee is Black (non-Hispanic), 47.5% (19) are White (non-Hispanic), and 17.5% (7) are Hispanic/Latino(a).

Twenty-percent of the Committee represent the community of persons living with HIV Disease. Committee members also represent communities of Men who have Sex with Men (MSM), Hispanic/Latino and African American MSMs, Injection Drug Use (IDU), bisexual, transgender, and incarcerated persons. In the next selection of Committee members for 2001 members of the hemophilia community who are not currently represented as well as representation from the Departments of Public Welfare is needed. The Membership Subcommittee will meet in November to examine the current Committee profile to determine the needs of maintaining the overall representativeness of the Committee.

The following steps have been taken to ensure expertise in Epidemiology, behavioral science, health planning, and evaluation:

- **Epidemiology:** The Planning Committee continues to benefit from expert consultation from the PA Department of Health's Bureau of Epidemiology in compiling and updating the Epidemiological Profile and provide data pertinent to prioritizing target populations or risk-behavior groups. This past year, the Bureau's HIV/AIDS epidemiologist assigned to work with the Planning Committee has also incorporated expert advice from a panel of nationally known communicable disease epidemiologists in devising a weighting-and-ranking system pertaining to epidemiological data used in the target- population prioritization process. This panel will continue to provide recommendations as this system is perfected in the 2001 planning cycle.
- **Behavioral Science:** The Planning Committee continues to benefit from behavioral and social scientists at the University of Pittsburgh through the PA Department of Health's contracting relationship with the University's Pennsylvania Prevention Project. Additionally, two nationally known behavioral/social scientists—one at the University of Texas at Austin and the other at the University of Wisconsin—provided preliminary consultation to the Planning Committee regarding the use of social indicators in the target population prioritization process. These research-practitioners will be joined by two to four other experts in behavioral/social sciences to complete the consultation process in the year 2001. In addition, the Facilitator for the Committee is a faculty member at the Graduate School of Public Health with a doctorate in social work. He also serves as a consultant with the American Psychological Association Behavioral and Social Science Volunteer Program.
- **Health Planning:** Statewide health planners will continue to contribute to updating needs assessment data. The needs assessment update has incorporated health planners and providers in both planning the assessment of needs of high-risk populations, as well as in conducting needs assessment data collection. For example, health planners of services directed toward injection drug users (IDUs), including rehabilitated IDUs, participated in the design of methods and questions being used to assess HIV-prevention needs of IDUs. Additionally, a smaller group of these

health planners are being trained by University researchers to conduct focus groups and interviews with IDUs as part of the data collection process. This process will be replicated in late 2000 and 2001 for assessment of needs of men who have sex with men (MSM) and heterosexuals at risk from sexual contact.

- Evaluation: The Planning Committee benefits from evaluation expertise through the PA Department of Health's contract relationship with the Pennsylvania Prevention Project (PPP). PPP's Director of Evaluative Research, who directs HIV-prevention evaluation planning and research projects statewide, has a faculty position at the University's Graduate School of Public Health and extensive experience in program and systems evaluation. In the past, he has worked as Evaluation Associate at a large, national private foundation; and has consulted on HIV-prevention and health-related evaluations to numerous non-profit and governmental agencies, including the Brazilian Ministry of Health's countrywide HIV and STD prevention program. In 2001, The PA Department of Health and PPP, through the Director of Evaluation, plans to recruit and provide orientation for local evaluators who can provide local evaluation expertise to regional and community HIV-prevention projects across Pennsylvania. Such an effort should serve to decentralize the task of providing HIV-prevention evaluation support and technical assistance to community agencies.

(3) Ensure that priority HIV prevention needs are determined based on an epidemiological profile and needs assessment.

The Year 2000 Update of the Epidemiological Profile of HIV/AIDS in Pennsylvania is the final attachment to this document. To assist the HIV/AIDS prevention and care planning processes gain more access to empirical data that can be used to plan and develop prevention and care services in Pennsylvania this update extends the analyses conducted and presented in the 1999 Epidemiological Profile of HIV/AIDS in Pennsylvania. In addition, to HIV/AIDS incidence data presented in 1999, the primary objectives of the year 2000 update are to determine and describe: (1) Changes over time in the likelihood of death among cases diagnosed with AIDS and to highlight the resulting changes in survival time after diagnoses with HIV/AIDS in Pennsylvania; (2) Changes over time in estimated prevalence of HIV in the general population and the geographic distribution of estimated HIV prevalence in Pennsylvania; (3) The geographic distribution of AIDS prevalence in Pennsylvania; and (4) The geographic distribution of recent changes in AIDS incidence in Pennsylvania.

The Epidemiologic Profile of HIV/AIDS in Pennsylvania that was revised and issued in 1999 consisted mostly of data describing changes over time in the HIV/AIDS epidemic in Pennsylvania. More specifically, the data presented in 1999 focussed on showing change over time using AIDS incidence data along with some surrogate data (mainly STD data) to describe attributes of the HIV/AIDS epidemic pertaining to a) person, b) place and c) time. Thus, the data presented showed: a) which population-transmission groups are affected [*person*, i.e. which groups of persons are affected, by demographic distribution (age groups, race/ethnicity, geographic location and sex) and by probable modes of transmission]; b) which parts of the state are affected (*place*, i.e. as in

geographic distribution); and c) changes over *time* in the epidemic's impact on the affected geographic parts of the state and the population-transmission groups.

In the 2000 and 2001 planning years, we are updating the Epidemiologic Profile of HIV/AIDS in Pennsylvania to include more data on the four epidemiologic analyses of disease occurrence that are addressed by the four objectives indicated above. In the absence of data on newly diagnosed recently infected HIV cases, we are using these additional data to describe more fully and infer the likelihood of new HIV infections in various geographic areas and their affected population-transmission groups AND at the same time describe the likelihood of growth in the population that is living with HIV/AIDS in Pennsylvania. The inferences that can be made from these data will enable HIV/AIDS prevention and care planners to better determine which population-transmission groups and geographic areas should be prioritized for resources for preventive and care services. Unlike in the past when data were presented in separate profiles for care and prevention planning to meet the needs of the separate funding processes, this update of the Epidemiologic Profile takes cognizance of the integrated nature of the continuum of prevention and care services. We are thus updating the Epidemiologic Profile with data that is relevant for an integrated approach to prevention and care planning.

In 1995 four diverse groups of at-risk youth were founded across the state (Allentown, Erie, Pittsburgh and York) to assist in Pennsylvania's need assessment process. The project has since grown to 8 groups across the state. Two new groups, one oriented toward HIV-positive and one toward rural youth will be formed over the next year. Over the past 5 years the Roundtables have evolved from simply a means of gathering need assessments from youth to a mechanism by which youth are ensured *parity, inclusion and representation* in the community planning process.

Relevant to the statewide project:

Using data from Roundtable process evaluations obtained from CPG members and from Roundtable members, the following additional project goals for year 2000 were established:

- Identify critical components of peer-based prevention education programs for youth
- Examine public school HIV prevention education policies in PA
- Design an original HIV prevention intervention for sexually-active youth
- Originate 2 new Roundtable groups among rural youth, young IDUs (in recovery), or youth living with HIV/AIDS.

Relevant to the Consensus Statement, which will continue through 2001:

In 1998 Roundtable members met in Harrisburg for a planning summit, which resulted in the Roundtable Consensus Statement, a document that highlights needs, barriers and target youth populations for HIV prevention in Pennsylvania (visit the Roundtable Website at www.stophiv.com to view the document). In 1999 the Roundtable Consensus Statement was updated. This year, Roundtable members elected to again update and to expand the document. Their goals include:

Plans for Needs Assessment during CY 2001:

The PA Department of Health and the Planning Committee have embarked on a major update of need assessment data. Extensive need assessments were conducted among a number of at-risk populations and groups between 1994 and 1996, with periodic, smaller-scale updates in subsequent years. The need assessment process and findings have been reported in previous Prevention Plans.

Beginning in 2000, a large-scale update process was initiated at the recommendation of the Planning Committee. Throughout 2000 and 2001, needs assessment will occur according to three major risk categories: IDUs, MSMs (including MSM/IDUs), and heterosexuals with HIV risks. Racial diversity of the samples will be assured. Needs of sub-populations within these three major categories will also be attended to. For example, young (13 to 25 year-old) IDUs, rural IDUs, and women IDUs are sub-populations given special attention in the need assessment process; data about the needs of these sub-populations will be added to data about other IDUs in Pennsylvania.

PPP is coordinating this need assessment process. To plan the assessment process, PPP staff has acquired the voluntary services of a number of consultants, including representatives of target populations, who are able to address assessment of needs of each target population. PPP will also subcontract with health planners/practitioners to actually collect information about needs of each population. To date, planning for need assessment of IDUs has occurred. Data collection on MSMs and heterosexuals will take place in late 2000 and 2001. If data for special-needs populations, such as transgendered, seriously mentally ill, homeless, and incarcerated persons, as well as illegal immigrants, may be planned for later 2001 if adequate data on these populations are not collected in the current round of assessments.

At this writing, the planning process for assessment of IDUs has entailed the following steps:

- Synthesis of past need assessment findings and updated literature search on HIV-prevention needs pertaining to IDUs.
- Recruitment of and meeting with researchers and service planners to recommend a framework for assessing needs/barriers based on the above synthesis and literature. This process resulted in a suggested plan to focus on assessment of needs of “traditional” IDUs, who have interacted at some level with HIV-prevention and/or rehabilitation services in which HIV/AIDS and prevention may have been addressed; young IDUs; women who are IDUs; and IDUs living in rural areas. It was believed that more was known about the needs/barriers pertaining to the “traditional” sub-population, and that need assessment may focus on more intensive information about interventions that may have been effective or ineffective in meeting the needs of this group. Less was known about the three remaining sub-populations, therefore, more fundamental information about needs and barriers would need to be collected pertaining to them.
- Presentation of above preliminary recommendation to the Evaluation and Planning Sub-Committee of the Planning Committee, then the full Planning Committee; and recruitment and meeting with a panel of health/service planners, rehabilitated IDUs,

and researcher-practitioners to review the above recommendation and begin planning. Consensus was gained regarding the preliminary recommendation, and the planning panel used the above framework to design need assessment questions and protocols. This panel was facilitated by two PPP staff and included seven researcher/providers in Pennsylvania and one researcher/provider in San Francisco. Of the seven Pennsylvanians, two were former IDUs themselves, and three were members of Planning Committee. This process resulted in a list of needs assessment questions for each of the above sub-populations of IDUs, and a research plan for collecting data from IDUs and, when appropriate and necessary, their providers across the state. This plan included recommendations for individuals who may be engaged to collect data through focus groups and interviews.

- Recruitment and feedback from an even larger panel of IDU service-providers and rehabilitated IDUs regarding the above need assessment protocol. This larger group included individuals across Pennsylvania, as well as one consultant in the state of Indiana who is an expert in rural IDU needs. Adjustments to protocol are being made based on feedback.

The following steps are planned for the latter half of 2000, during which data gathering will occur:

- Contracting with and training of individuals to conduct the assessment of IDU needs/barriers.
- Data collection, analysis, and reporting. Draft reports will be issued to all the above individuals engaged in the planning process, as well as the PA Department of Health and Planning Committee for feedback.
- Written final report presented to the PA Department of Health and Planning Committee.

The entire planning and implementation process will be replicated for assessing needs/barriers of MSMs (including MSM/IDUs) and heterosexuals at risk of HIV. As stated above, special-need populations will be included where appropriate in the entire data gathering process. However, if, by the culmination of the need assessment process in the first half of 2001, ample information is not collected pertaining to special-need populations such as transgendered, mentally ill, homeless, and incarcerated individuals and illegal immigrants, a future need assessment process' are planned.

(4) Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

In the current planning year, the Planning Committee embarked on a new process of prioritizing *target populations* that will lead to a subsequent process for prioritizing *interventions* to each target population. The following is a summary of aims and target dates, culminating in a new process for prioritizing interventions. (A full explanation of this new process may be found in the Appendix to the Prevention Plan update in the form of a memo to the Planning Committee. This memo explains the detailed process and timeline, which received consensus from the full Committee):

AIM 1: Rank and prioritize across and within target populations/transmission groups based on the data we already have available (i.e., HIV/AIDS epidemiological data, relative size of target populations, needs indicator data including public funds currently allocated to each group and number of factors that are barriers to prevention, etc.). Target date: August 2000.

AIM 2: Rank and prioritize subgroups within each target population/transmission groups based on the above factors, but blending in more objective needs indicator data on other factors about each target population/transmission group (e.g. gap analysis data, presence of social factors that correlate with HIV risk, access issues or barriers to prevention resources). Target date: August 2001.

AIM 3: Rank and prioritize HIV prevention interventions for each target population/transmission group. Target date: (Plan for prioritizing issued by August 2001).

To reach Aim 1 regarding prioritization of target populations with use of epidemiological and other data, the epidemiologist assigned to the Planning Committee convened a Peer-Review Panel of epidemiologists with the responsibility of: 1) discussing the strengths/drawbacks of two approaches to achieving this aim, 2) reviewing other states' procedures for prioritizing, and, 3) assigning weights to more objective or "hard" macro-variables (e.g., HIV/AIDS epidemiological data). The Peer-Review Panel summarized their insights/suggestions and submitted them to the Planning Committee for review, discussion, and final ratification of the approach and results. Based on the epidemiological data available for the current planning cycle, the recommendations of the Panel was implemented and accepted by the Committee for prioritizing target populations. As additional data become available in 2001, the same process of prioritization will be used that will include these new data. The expert epidemiologists will continue to be called on for advice as this plan is implemented in 2001.

To reach Aim 2 concerning the integration of social/behavioral science indicators, PPP's Director of Evaluative Research, who also coordinates the need assessment process, will compile a group of social-behavioral scientists to serve on a panel. Their task will be to recommend a weighting and ranking system that will relate to micro-variables (e.g., social factors and barriers that relate to HIV risk). This system will be approved by the Planning Committee and be incorporated in the 2001 planning cycle. An initial list of variables has been compiled by a smaller group of social/behavioral science researchers and reviewed, revised, and approved by a Prioritization Task Group of the Planning Committee. Data collection related to these variables has been integrated into the need assessment process described in II.C.1.c above. A preliminary plan has also been drawn that involves integration of perspectives of individuals at-risk of HIV, providers of HIV-related services to target populations, and the Planning Committee members, as these perspectives relate to use of social indicator data to assist in prioritizing target populations. Additionally, gap analysis data that ensue from the new uniform data collection and reporting system described in II.B., will be incorporated into the prioritization process.

Based on the results of Aims 1 and 2, Aim 3 concerning prioritization of target populations will occur. A plan for this prioritization process will be proposed in the course of the 2001-planning year.

This entire plan for prioritization incrementally builds improvement into the prioritization process over several years. The Planning Committee will issue a new two-year Plan in 2001 that will use an improved system of prioritization. By the time that a new five-year Plan required by the CDC in 2003, the entire process for prioritizing populations and interventions will have been tested and established.

Cursory examination of cost effectiveness for HIV prevention reveals that between \$6.7 billion and \$7.8 billion was spent in 1996 to treat HIV-positive Americans, according to findings published in the *Journal of Acquired Immune Deficiency Syndromes*. The study, conducted by the U.S. Agency for Healthcare Research and Quality, estimated that it costs roughly \$20,000 to \$24,700 for each HIV-positive person. Unlike most national HIV-related cost estimates, which are “patient-based”—determined by examining a sample of people with HIV—the AHRQ study utilized data that was “payer-based,” showing the flow of funds from payers to care providers, and “provider-based,” showing funds actually received by care providers. The estimates ranged from \$7.8 billion under provider-based method to \$6.7 billion using the patient-based method. The estimate does not include funds provided through publicly or privately financed clinical trials or those from charities (Reuters Health, 8Aug'00).

CDC scientists have developed important tools for estimating the economic impact of HIV prevention programs, taking into consideration the effective combination drug therapies now available. The economic model estimates lifetime treatment costs (based on the newest treatment scenarios) and balances these costs against the current national investment in HIV prevention to determine what level of success is needed to save the nation money. The cost effectiveness of interventions is an important issue in decisions about resource allocation. According to Kelly et al. (1994), for an HIV prevention intervention to be cost effective it must also be effective in producing behavior change. The prioritized interventions approved by the Committee are based upon behavior theory that has shown demonstrated effectiveness.

As the Committee evaluation process moves toward outcome-based methods those evaluations will help illuminate the effectiveness of HIV prevention interventions in producing behavior change. It is difficult to comprehend the direct impact of HIV prevention programs upon keeping individuals HIV-negative; however estimates may be made in relationship to reducing the cost of treating individuals for HIV infection related issues. As resources permit the Committee will continue to examine the intricacies of and utilize the concepts of HIV-prevention cost effectiveness within their community HIV prevention planning process.

(5) Foster strong, logical linkages (i.e. connections) between the community planning process, the comprehensive planning HIV prevention plan, the application for funding, and allocation of HIV prevention resources.

The Committee's Funding Guidelines Subcommittee reviewed information from the National State and Territorial AIDS Directors on fostering strong logical linkages between the Plan allocation of HIV prevention resources and the grant application procurement of HIV prevention services. The Subcommittee observed that sample states followed the Macro Inc. format and instrument suggested in Chapter 5: Evaluation Linkages Between the Comprehensive HIV Prevention Plan and Resource Allocation within the Resources for Evaluating CDC HIV Prevention Programs. Therefore, they adopted the suggested instruments for their planning process.

That process commenced with the development of numerous tables. The initial table lists the Comprehensive Plan Recommendations. The second table lists interventions funded within the jurisdiction for each of the priority populations. The third table lists interventions by priority population and whether they do or do not match a recommendation within the Plan. The final table integrates the previous information into one table reflected on pages 21-29 of this document.

The development of necessary information for a comprehensive review is at varying stages; therefore, the Committee was not able to fully complete the tables. However, the process and review of the information has been very informative. To quote one long-term Committee member, "I have never reviewed our Plan in such depth and understood it better." In particular this process has illuminated the gaps and clearly provides a direction for future planning.

The inclusion of uniform data from HIV prevention interventions funded by other resources such as the Commonwealth will be available in a comparable manner. This process will continue to be refined over the next year to include more information on HIV prevention efforts from all sources in order to provide the most comprehensive perspective of HIV prevention efforts in the Commonwealth.

Section II: Cross-Program Activities

The Department of Health's HIV, STD, and TB Programs are combined into a single Bureau of Communicable Diseases. There are three Divisions within the Bureau: Division of HIV/AIDS, Division of TB/STD, and the Division of Immunization. The realignment has impacted on collaboration in sharing of staff to accomplishing administrative activities (e.g., contract monitoring, budget development, and in improving overall interaction and sharing of information among staff from the programs.

Collaborative activities include the following:

- Individual program contracts with county and municipal health departments have been combined into block contracts.
- HIV counseling and testing is offered in all STD and TB clinics statewide. TB testing is offered to all HIV positive clients.
- Training in HIV prevention counseling has been provided to all STD, TB and HIV staff.
- The Bureau of Drug and Alcohol programs requires training in HIV prevention, STD and TB for all drug treatment staff.
- The Department's Community Health Project has resulted in multi-program teams to conduct quality assurance and contract monitoring visits to contractors who provide HIV, STD and TB services.
- A single contract with AT&T was instituted to provide AT&T Language Line interpreter services to counselors in all HIV, STD and TB clinics.
- The Division of HIV/AIDS works cooperatively with the Bureau of Drug and Alcohol Programs to provide HIV counseling and testing in over 100 drug treatment facilities.
- HIV field staff who provide viral load and CD4+ T-Cell testing have been trained in the utilization of the STD Management Information System (MIS) software. The STD MIS software is used to collate and analyze data on HIV positive individuals who receive viral load and CD4 testing from the State Health Department.
- Relevant satellite broadcasts on HIV prevention are provided to staff from all programs

Cross-program activities also include HIV counseling and testing in county prisons. HIV prevention staff in the Department's six Health Districts and in the five County and three Municipal Health Departments work on an ongoing basis with the administration and health care staff in the 66 Pennsylvania county prisons. HIV staff provide inservice HIV education for prison staff and inmates as a way to establish a working relationship with the prisons. HIV education is usually followed by a request for HIV counseling and testing services for inmates.

Some county prisons have been set up to provide HIV counseling and testing to inmates. Health care staff at these prisons attend training in HIV prevention counseling and completing of appropriate paperwork. Currently the collaboration between HIV prevention program field staff and administrators and health care staff at county prisons has resulted in the routine provision of HIV counseling and testing services to inmates at 59% (39) county prisons statewide.

All agencies receiving public funding (both federal and state funds) collaborated in initiating a uniform system of data collection and reporting pertaining to HIV prevention and education interventions. These agencies included:

- Agencies receiving funding through the CDC's 99004 funding to the PA Department of Health for HIV prevention-related activities:
 - Six statewide demonstration projects targeting discrete populations at risk of HIV.
 - Nine County and Municipal Health Departments and their subcontractors receiving funds from the PA Department of Health through CDC 99004 funding, as well as other state-generated funds.
- Agencies receiving funding through other state sources:
 - Seven Regional Ryan White Coalitions and over 100 of their subcontractors delivering HIV prevention/education interventions.
 - Council of Spanish-Speaking Organizations and their subcontractors delivering HIV prevention/education interventions.

PA Department of Health staff coordinating Drug and Alcohol programming also participated in meetings regarding uniform data collection and reporting with the intention of eventually creating data collection, analysis, and reporting that would coordinate with the statewide HIV prevention/education data system.

The above agencies met in March 2000 to begin coordinating plans for uniform data collection and reporting. All agencies receiving funds through the CDC's 99004 funding are already required to report data uniformly, following the CDC's guidelines for Intervention Plans and Process Monitoring. Plans have been set for fall 2000 to reconvene all the above agencies for, among other things, to decide on a timetable for integrating non-CDC funded agencies into this data system.

Section III: Linkages Between Primary and Secondary HIV Prevention Activities

According to CDC guidance primary HIV prevention is defined as halting the transmission or acquisition of HIV infection. Secondary prevention is defined as halting or delaying the onset of illness in an HIV infected individual.

Coordination and cooperation between primary and secondary HIV prevention activities will be strengthened by collaboration between the Planning Committee and the seven Regional Ryan White Coalitions. These latter Coalitions, to a large extent, address the integration between primary and secondary prevention in that they subcontract with both HIV/AIDS care and services providers and HIV prevention/education providers. Collaboration between the Planning Committee and these Coalitions are enhanced by two processes initiated by the Committee and PA Department of Health:

- A statewide, uniform data collection system for HIV prevention/education interventions. The Coalitions have been part of the process of formulating this data collection and reporting system, and are in an ideal position to integrate this system with a new data collection/reporting system that they are compiling relating to HIV/AIDS care and services.
- The new prioritization process which will build in assessment of (geographical) regional epidemiological and gap-analysis data. Regional analysis of these data, spearheaded by the Planning Committee, will assist regional Coalitions in determining each of their primary and secondary prevention needs. Additionally, the statewide need assessment process, which takes into consideration regional differences, will provide a model for regional Coalitions to conduct their own geographic-based need assessments in the future.

The University of Pittsburgh, through a contract with the Division of HIV/AIDS, developed a directory of resources. The directory contains approximately 1,250 resources such as case management, medical, social services, and so forth, which is updated annually. Printed copies were initially distributed by the Department of Health (DOH) to the seven Ryan White HIV/AIDS Regional Planning Coalitions that fund case management services, and to the AIDS Factline staff. The AIDS Factline provides referral information to Pennsylvania residents by means of an 800 number.

Access to the directory is also available online at <http://www.stophiv.com>. The Website also provides information to CBO's and providers on potential funding opportunities as well as other services. HIV prevention program field staff located in the Department's six health districts and in the six county and four municipal health departments have Internet access. Internet access at state health centers, where the majority of HIV counseling and testing sites is located, varies, however. Some currently have access while access by the others is in process. Counselors at state health centers have phone access to HIV field staff who can locate resources on the Internet and in turn relay the information back to the counselors. The University of Pittsburgh and AIDS Community Alliance, through a grant from the National Library of Medicine, provided 25 computers and training on the use of the web for HIV prevention resources to local AIDS service organizations.

HIV prevention program field staffs have developed regional resource directories that are continuously updated. Because field staff are responsible for conducting the results counseling of all HIV-positive clients identified from publicly funded sites within their jurisdiction, the regional resource directories are critical in assuring that HIV-positive clients are referred to appropriate medical and social services.

Field staff are also responsible for documenting whether HIV positive clients follow-up with the referrals. The Division of HIV/AIDS has developed a form that is used by HIV counselors to document service referral to clients. The first page of the form is used by the client and counselor to develop and document the client's risk reduction plan. The second page is used to document service referrals.

Because field staff provide the majority of HIV positive clients with viral load and CD4+ T-cell testing identified at publicly supported sites, monitoring the follow through by clients to referral services becomes an ongoing process.

An ongoing goal is to maintain the stophiv.com Website:

***stophiv.com* Internet Project**

Introduction Since the opening of the *stophiv.com* web site in July 1997, the Internet site has undergone numerous changes and advancements. In July 1997, the Pennsylvania Prevention Project Internet site became publicly accessible at URL: <http://www.stophiv.com>. This site is now listed on over 700 search engines and directories, e.g., Excite, Infoseek, Lycos, Yahoo, etc.

Site Development

- 1. Online Service Provider Resource Directory.** The Pennsylvania HIV/AIDS Service Provider Resource Directory is a primary and secondary prevention continuum of care directory that assists clients, providers, family and friends in locating needed services. The Resource Directory contains over 1,250 HIV/AIDS service providers from across the Commonwealth of Pennsylvania covering a wide range of services. In November 1999, the project introduced additional interactive query functions for the directory. Clients are able to locate services and/or providers by clicking on a county of reference. After selecting a county, the database displays all of the services available in the county. The services are separated into the following categories: education and prevention, health care, support groups, screening and testing, case management, financial assistance, transportation and additional services. The new interactive query functions allow individuals to query the resource directory for specific services within a radius mile of their geographic location or zip code.

The resource directory is currently being updated. All the providers listed in the directory were sent provider profiles to update their records. Also, the *stophiv.com* web site has developed an online update section. This online section allows

individuals to update their records on-line at any time. Once an online update is received, a staff member of the *stophiv.com* web site will contact the agency to verify the data submitted. Follow-up postcards were sent to agencies that had neglected to reply to the request for updates urging them to respond to the survey. New agencies are continually being added to the directory. The directory is also published in hard copy for those agencies without access to the online version.

2. **Epidemiological Data.** This section of the site was revised in year 2000. The site contains, in a Web format, the Pennsylvania Department of Health, Bureau of Epidemiology's [AIDS Quarterly Statistical Summary](#). The on-line availability of the publication allows community organizations and program developers to have instant access to the latest AIDS statistics. New additions to this page include a listing of federal and state links to epidemiological data. The 2000 epidemiology section of the plan is also available for respondents. In November 2000, the 2001 Epidemiology Update will be available on this page.
3. **Personal Stories Page.** Research indicates that personal stories or perspectives are one of the most effective methods of prevention. The Pennsylvania Prevention Project is continuing to gather personal perspectives or stories related to HIV/AIDS. The stories are categorized and compiled anonymously on the Prevention Project's Internet site to help prevent the spread of HIV.
4. **Special Pharmaceutical Benefits Program.** Pennsylvania Prevention Project and the Pennsylvania Department of Public Welfare Special Pharmaceutical Benefits Program (SPBP) have made available online the SPBP eligibility and applications. The Special Pharmaceutical Benefits Program provides financial support for certain drugs and medical supplies for individuals with HIV disease or AIDS who have low to moderate income. The program also offers free viral load testing to eligible clients. The eligibility requirements are currently posted. A downloadable copy of the application was posted on the site in late – September 1997. The *stophiv.com* and the DPW are currently exploring ways in which the agencies can collaborate in the future.
5. **The Facts.** A "Facts and Myths" section has been developed to assure that individuals have access to general information about infection. The section was developed with information from the Centers for Disease Control and Prevention. The section contains information about frequently asked questions about AIDS, how individuals can and cannot become infected with HIV, a section for adults on how to talk to young adults about AIDS, and a list of national and state hotlines to acquire additional information.
6. **Treatment Page.** A treatment information page was developed this year for the *stophiv.com* Internet site. The site contains the current treatment guidelines and recommendations as published in the Center for Disease Control and Prevention's [Morbidity and Mortality Weekly Report](#) (Center for Disease Control and Prevention. MMWR.). This site is linked with the Pennsylvania/Mid-Atlantic AIDS Education and Training Center Website and the National AIDS Education and Training Center Website at the HIV/AIDS Bureau, Health Resources and Services Administration (HRSA).

Over the past two years, the PA Prevention Project *stophiv.com* collaborated with the Pennsylvania/Mid-Atlantic AIDS Education and Training Center in the development of the *Pennsylvania/Mid-Atlantic AIDS Education and Training Center's*

Online Question and Answer Service at the University of Pittsburgh Graduate School of Public Health. Pennsylvania/Mid-Atlantic AIDS Education and Training Center faculty and staff support the project. In addition, this project is fully funded by the Ryan White, Part F, Bureau of HIV/AIDS Division of Training and Technical Assistance. This web site provides the latest treatment information, as well as, giving health professionals across the state of Pennsylvania access to HIV/AIDS clinical specialists regarding care and treatment of people living with HIV/AIDS. It is the goal of the site to provide HIV-related consultative services to health care providers in rural and underserved areas, to facilitate access to state-of-the-art HIV related information, and to improve access to quality health care for people living with HIV/AIDS. The Pennsylvania/Mid-Atlantic AIDS Education and Training Center provides the service, which is a major priority of the National AIDS Education and Training Center Program.

7. **E-mail List serves.** The project developed and piloted a restricted bulletin board available to case managers, prevention specialists, and consumers of services in June 1998. This feature allowed individuals to have the capability to interact directly with other consumers and professionals from around the state. Initially, seventy-four case managers signed up for the message boards. Usage of the message boards has decreased significantly since its implementation. In August 1999, a needs assessment was administered with the current users of the system. From the needs assessment, users of the system indicated that it was too cumbersome to access. The users recommended an email-based system. In August 2000, a list server was created for the case managers and prevention specialists. The list servers allow members to E-mail a notice or question to the Internet server, which would distribute the request to all subscribers to the service. In turn, subscribers would receive the notice/message through their E-mail. Subscribers would not have to have Internet capabilities to utilize this service.
8. **Young Adult Roundtable Web Page.** The Internet staff continues to work with the members of the PA Young Adult Roundtable project to develop and maintain their web page which functions both as an educational piece for other young adults and serves as a communication link to the members of the Roundtables. The young adults wanted to develop a web site to improve the lines of communication between the Roundtables and to increase access to HIV prevention information to other young adults at risk of HIV infection. The web site is being developed solely on the part of the young adults. The Internet staff has only added technical support in the design of the site. The young adults have developed the content and all the graphics for the young adult site.
9. **Community Planning Update Newsletter.** The Internet staff has placed the editions of the Community Planning Update Newsletter online. This serves as a way to keep the community informed of the Community Planning process and the projects being implemented across the state.
10. **Pennsylvania Comprehensive HIV Prevention Plan.** The 1999 multi-year Plan and 2000 Plan Update are available online. The plan is downloadable in Adobe Acrobat format. Individuals accessing this page can view and print individual sections of the Plan or the

entire Plan. Of particular use at the local level and for HIV prevention community planning is the epidemiological profile.

11. **Links Page.** In an effort to make information more easily accessible, the Internet staff has created a page that provides links to other on-line services. All the sites on this page have been reviewed and evaluated by prevention specialists in regards to the site's content, graphics, language, and costs. Individuals accessing this page can choose to view all the links at once or select links dealing with specific subject areas.
12. **Funding Announcement List-Server.** The University of Pittsburgh has developed a funding announcement list server. Individuals with E-mail access can sign-up for the **service and their E-mail addresses is added to the list. When the University of Pittsburgh receives funding announcements, that information can be quickly and inexpensively be distributed to the subscribed list. There has been an overwhelming response to subscribe to this service.**
13. **Spanish Version of Web page.** Selected pages on the *stophiv.com* web site have been translated into Spanish. Phase one of this project has been completed which includes the translation of the main homepage and the Facts and Myths sections. Other pages are currently being translated.

The following counseling and testing goals and objectives also address linkages between primary and secondary HIV prevention efforts:

CT 1 OBJ 5: Addresses the evaluation of counseling and testing services looking at the appropriateness of referrals. This would include whether HIV positive individuals are appropriately referred to secondary prevention services in order to delay onset of illness, minimize the chance of infecting others, and so forth.

CT 1 OBJ 7: This objective addresses the evaluation of counseling and testing services that includes the referral of HIV positive individuals to needed resources.

CT 1 OBJ 8: This objective addresses the linking of behavior change models and treatment and care issues to primary and secondary prevention services.

CT 2 OBJ 1: This objective links counseling and testing of pregnant women and treatment to prevent perinatal transmission of HIV.

CT 2 OBJ 3: This objective addresses eliminating or minimizing the chance of infecting another.

6. Coordination of HIV Prevention Services and Programs

Coordination of HIV Prevention Services and Programs is in part accomplished through enhanced communication and planning between regions, agencies, and individuals to facilitate the accomplishment of state and local HIV prevention efforts. Pennsylvania is a large geographic area whose rural and urban communities reflect different needs and resources, and with a population representing diverse cultures. Coordination is intended

to maximize the use of local and state resources in order to strengthen HIV prevention efforts.

The Pennsylvania Prevention Project at the Graduate School of Public Health, University of Pittsburgh (PPP) provides a liaison with the nine independent county and municipal health departments (ICMHD). This collaboration further insures that HIV prevention community planning is interpreted and implemented within those jurisdictions in accordance with the comprehensive HIV prevention plan. This process creates a practical feedback loop of information and concerns between these jurisdictions and the HIV Prevention Community Planning Committee.

In addition, the Pennsylvania Prevention Project works with the State Health Improvement Plan (SHIP) to exchange information about community-based HIV prevention programs in order to create linkages and promote communication and collaboration. This is in part accomplished by creating communication between Committee members, other local HIV prevention leaders, and the local partnership members of the SHIP.

One source of information is the quarterly Community Update newsletter of the Division of HIV/AIDS, Pennsylvania Department of Health (DOH). This newsletter keeps the regional state health district offices, independent county and municipal health departments, Ryan White HIV/AIDS Regional Planning Coalitions, local partnership members, and others informed of HIV prevention efforts of the Committee, Pennsylvania Prevention Project, and the Division of HIV/AIDS.

Section IV: Target Populations and Interventions

All jurisdictions receiving Centers for Disease Control and Prevention (CDC) funding must establish a prioritization process. To support establishment of this process, the CDC provides guidance for establishing priorities. It envisions prioritization occurring in two ways: (1) prioritization of target populations at risk of HIV transmission and (2) prioritization of HIV-prevention interventions for each target population.

The following is the summary of the methods for the application of a proposed prioritization model: (1) Transmission categories and factors by which the categories would be ranked were established, (2) Categories within each factor were ranked and each factor assigned a relative weight compared to other factors in the model, (3) The rank for each factor was multiplied by the weight associated with the factor, resulting in a product score for that factor corresponding with the appropriate transmission category, (4) The product for each factor by transmission category was then entered into the respective cell in the transmission category column, (5) The total for each transmission category column were calculated; based on the sum of the column scores, the percentage for each transmission category were calculated and entered, (6) Each transmission category was stratified by race/ethnicity to establish population-transmission categories. Each transmission category sum of scores was thus stratified by race/ethnicity according to the relative percentage of incident AIDS cases (diagnosed in more recent years, 1995-1997) in each transmission category by race/ethnicity, (7) A combined composite was established from the population/transmission group cross tabulation, and (8) Each population/transmission group was ranked according to its percentage share of the total score for all population/transmission groups.

The first year of this three-year HIV prevention plan identified 13 priority populations. Based on more scientific data, primarily related to the epidemiological profile. The Year Two-Plan Update identified 11 priority populations. The Year Three-Plan Update includes the addition of surrogate data trends and survival data thereby creating 15 priority populations:

- 1) White Men who have Sex with Men (MSM) 20 to 49 years of age.
- 2) Black Injection Drug Users (IDU), mostly male, 13 and 39 years of age.
- 3) Black Male MSM/IDU 20 to 39 years of age.
- 4) White perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age.
- 5) White IDU, mostly male, 20-39 years of age.
- 6) White MSM/IDU 20 to 39 years of age.
- 7) Hispanic IDU, mostly male, 13 to 39 years of age.
- 8) Black heterosexual, mostly female with a history of Sexually Transmitted Diseases 13 to 39 years of age.
- 9) White heterosexual, mostly female sex partners of IDU with a history of STD 13 to 39 years of age (white females less than 13 years of age).
- 10) Black MSM 13 to 39 years of age.

- 11) Black perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age.
- 12) Hispanic Heterosexuals, mostly female sex partners of IDU 13-39 years of age.
- 13) Hispanic MSM/IDU 20 to 29 years of age.
- 14) Hispanic perinatal transmission, mostly female IDU or sex partner of IDU, 13-44 years of age.
- 15) Hispanic MSM 20 to 29 years of age.

The prioritization of HIV prevention interventions is described in more detail in national core objective 4 AIM-Three on page 8 of this application. This timeline establishes a process over the next two years. As the process builds, the criteria should be even more complete, therefore, more improved in subsequent years. When the next five-year planning cycle begins in 2003, this system of prioritization should be well tested and running smoothly.

As referenced on page 9 of this document the following tables reflect the recommendations of the HIV Prevention Plan by priority population and HIV prevention intervention:

	Interventions in the CDC Application	
Recommendation in The Plan	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target population 1:	White Men who have Sex	with Men (MSM) 20 – 49 years of age
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.</p>	<p>MSM Outreach Demonstration Project in Erie and Williamsport</p> <p>Allegheny County Health Department with state funds</p>	
Target population 2:	Black Injection Drug User	(IDU), mostly male, 13 – 39 years of age
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York and Lancaster targeting African American, Latino(a), and</p>	<p>IDU Demonstration Project in York & Lancaster</p> <p>Bethlehem health Bureau provides outreach to Latino(a) IDU with state funds</p> <p>IDU Demonstration Project in York & Lancaster</p>	

other people of color who use injection drugs (IDU) and their sexual partners.		
Recommendation in The Plan	Interventions in the CDC	Application
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target population 3:	Black Male MSM/IDU 20 -	39 years of age
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.</p>	<p>MSM Outreach Demonstration Project in Erie and Williamsport</p> <p>Allegheny County Health Department with state funds</p>	
Target population 4:	White Perinatal IDU or sex partner of IDU,	transmission, mostly female 13 - 44 years of age
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York and Lancaster targeting African</p>	<p>IDU Demonstration Project in York & Lancaster</p> <p>Bethlehem health Bureau provides outreach to Latino(a) IDU with state funds</p> <p>Theatre Demonstration Project</p>	

American, Latino(a), and other people of color who use injection drugs (IDU) and their sexual partners.		
Recommendation in The Plan	Interventions in the CDC Application	
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
<p>3. Reduce perinatal transmission of HIV targeting Latina and African American women in the Lehigh Valley.</p> <p>4. Convene regional, diverse work groups of providers, consumers, and community leaders who will identify possible deliveries of service to African American women and Latinas at highest risk for HIV infection in order to reduce information gaps.</p> <p>5. Reduce perinatal transmission of HIV targeting Latina and African American women in Lehigh Valley</p>	<p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p>	
Target population 5: White IDU, mostly male, 20 - 39 years of age		
<p>1. Have individuals who are injection drug users and those who engage in HIV risk-related sexual behavior develop a consensus statement, utilizing the Young Adult Roundtable Consensus Statement model</p> <p>2. Continue to advocate for needle exchange programs.</p> <p>3. Examine the need for access to drug and alcohol treatment for priority populations.</p> <p>4. Create harm reduction pilot projects</p>	<p>The Pennsylvania Prevention Project completed this report and presented it during the May 2000 Committee meeting.</p>	

Recommendation in The Plan	Interventions in the CDC Application	
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target population 6: White MSM/IDU 20 – 39 years of age		
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.</p>	<p>MSM Outreach Demonstration Project in Erie and Williamsport</p> <p>MSM Outreach Demonstration Project in Erie and Williamsport</p>	
Target population 7: Hispanic IDU, mostly male 13- 39 years of age		
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York and Lancaster targeting African American, Latino(a), and other people of color who use injection drugs (IDU) and their sexual partners.</p>	<p>IDU Demonstration Project in York & Lancaster</p> <p>Bethlehem Health Bureau provides outreach to Latino(a) with state funds.</p>	

Recommendation in The Plan	Interventions in the CDC Application	
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target population 8:	Black heterosexual, mostly STDs 13 – 39 years of	Female with a history of age
Target population 9:	White heterosexuals, Partners of IDU with a Years of age (white	mostly female sex history of STDs 13 –39 females less than 13)
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York an Lancaster targeting African American, Latino(a), and other people of color who use injection drugs (IDU) and their sexual partners.</p>	<p>IDU Demonstration Project in York & Lancaster</p> <p>Bethlehem Health Bureau provides outreach to Latino(a) with state funds.</p>	
Target Population 10:	Black MSM 13 – 39 years	of age
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of</p>	<p>MSM Outreach Demonstration Project in Erie and Williamsport</p> <p>Allegheny County Health Department with state funds</p>	

Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.		
Recommendation in The Plan	Interventions in the CDC	Application
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target Population 11:	Black perinatal IDU or sex partner of IDU,	transmission mostly female 13 – 44 years of age
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York and Lancaster targeting African American, Latino(a), and other people of color who use injection drugs (IDU) and their sexual partners.</p> <p>3. Reduce perinatal transmission of HIV targeting Latina and African American women in the Lehigh Valley.</p> <p>4. Convene regional, diverse work groups of providers, consumers, and community leaders who will identify possible deliveries of service to African</p>	<p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p> <p>Allegheny County Health Department African American outreach with state funds</p> <p>Urban League of Lancaster County supports outreach with state funds</p> <p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p>	

<p>American women and Latinas at highest risk for HIV infection in order to reduce information gaps. 5. Reduce perinatal transmission of HIV targeting Latina and African American women in Lehigh Valley</p>		
<p>Recommendation in The Plan</p>	<p>Interventions in the CDC ...that match recommendation in the Plan</p>	<p>Application ...that do not match recommendation in the Plan</p>
<p>Target Population 12:</p>	<p>Hispanic Heterosexuals, of IDU 13 – 39 years of age</p>	<p>mostly female sex partners</p>
<p>1. Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.</p> <p>2. Provide HIV prevention in the cities of York and Lancaster targeting African American, Latino(a), and other people of color who use injection drugs (IDU) and their sexual partners.</p>	<p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p> <p>Theatre Demonstration Project</p> <p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p> <p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p>	

Recommendation in The Plan	Interventions in the CDC Application	
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target Population 13:	Hispanic MSM/IDU 20 -29	years of age
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.</p>		
Target Population 14:	Hispanic perinatal female IDU or sex partner	transmission, mostly of IDU 13 – 44 years of age
<p>1. Reduce perinatal transmission of HIV targeting Latina and African American women in the Lehigh Valley.</p> <p>2. Have individuals who are injection drug users and those who engage in HIV risk-related sexual behavior develop a consensus statement, utilizing the Young Adult Roundtable Consensus Statement model</p> <p>3. Continue to advocate for needle exchange programs.</p> <p>4. Examine the need for access to drug and alcohol treatment for priority populations.</p>	<p>Perinatal Demonstration Project in Lehigh Valley</p> <p>IDU Demonstration Project in York & Lancaster</p> <p>Perinatal Demonstration Project in Lehigh Valley</p>	

5. Create harm reduction pilot projects	IDU Demonstration Project in York & Lancaster	
Recommendation in The Plan	Interventions in the CDC	Application
	...that match recommendation in the Plan	...that do not match recommendation in the Plan
Target Population 15:	Hispanic MSM 20 – 29	years of age
<p>1. Provide outreach in Erie, Williamsport, and Pittsburgh targeting men who have sex with men with special emphasis on men of color.</p> <p>2. Continue to support community leadership development and community-wide planning activities in the cities of Erie, Pittsburgh, Scranton/Wilkes-Barre, State College, Williamsport, and York targeting men who have sex with men and racial/ethnic minorities.</p>		Bethlehem City Health Bureau supports Hispanic MSM outreach with state funds.

The process of examining Plan recommendations and funding interventions has shed light on numerous concerns with the current Plan and subsequent Plan Update. Although the process is developing and will improve over time it is still evident that more focus upon targeting priority populations and priority interventions as well as developing clear, time specific goals and objectives is needed. The Committee will be developing a two-year Plan for the years 2002-2003 over the next year. This insight will provide a strong basis from which to commence that planning cycle.

In addition, the department of health funding grants to nine of the ten county and municipal independent health departments (Philadelphia is not included within this Plan) require the grantees to support prevention efforts targeted to the priority populations listed in the HIV Prevention Plan. Health departments may use local epidemiological data, local prevention resource allocation, and other relevant factors to determine what priority populations are most in need locally.

Section V: Goals, Objectives, and Activities for Target Populations

The Pennsylvania Prevention Project at the Graduate School of Public Health University of Pittsburgh utilizing CDC resources fund HIV prevention intervention demonstration projects throughout the Commonwealth. The following is a current summary of those projects with their goals and objectives.

Youth Theatre Demonstration Project

Individual and group level interventions targeted to youth and young adults 13 to 19 years of age potentially within the following priority populations: **(2)** Black Injection Drug Users (IDU), mostly male, 13 and 39 years of age, **(4)** White perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, **(7)** Hispanic IDU, mostly male, 13 to 39 years of age, **(8)** Black heterosexual, mostly female with a history of Sexually Transmitted Diseases 13 to 39 years of age, **(9)** White heterosexual, mostly female sex partners of IDU with a history of STD 13 to 39 years of age (white females less than 13 years of age), **(10)** Black MSM 13 to 39 years of age, Black perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, **(11)** Hispanic Heterosexuals, mostly female sex partners of IDU 13-39 years of age, **(12)** Hispanic MSM/IDU 20 to 29 years of age, **(13)** Hispanic perinatal transmission, mostly female IDU or sex partner of IDU, and **(14)** 13-44 years of age.

In light of the alarming epidemiological trends among young people, a youth/theater demonstration project was proposed in 1998 by Roundtable members and endorsed by the Pennsylvania Department of Health and the Pennsylvania HIV Prevention Community Planning Committee. The project was implemented in 1999 in three cities: Erie, Pittsburgh and Wilkes-Barre/Scranton area. This targeted demonstration project employs HIV risk-reduction principles and endeavors to meet the primary and secondary HIV prevention needs of gay, bisexual, African American and Latino/a youth between the ages of 13 and 24, through a *theater-based, peer-based, outreach* intervention.

This demonstration project is an adaptation of the Nite-Star theater program in New York City, but tailored to the needs and capacities of the Erie, Pittsburgh and Wilkes-Barre/Scranton communities, and developed through the vision and creativity of each subcontractor. Through small group theatrical presentations by peers, and a series of follow-up, facilitated discussions (led by an HIV prevention and group specialist and including the young acting company), high-risk youth in a variety of venues are targeted for this HIV prevention education and risk reduction interventions. Theatrical presentations and follow-up discussions include relevant risk reduction topics and strategies aimed at behavior change through enhanced self-efficacy and self-management skills: HIV/AIDS/STD education, HIV testing, HIV self-risk assessment, sexual assertiveness and problem solving skills development, communication and sexual negotiation skills development, and training in condom (male and female) use and in other modes of protection.

Although implemented in 1999 in three cities (Erie, Pittsburgh and Wilke-Barre), the project was terminated in Erie in 2000 due to capacity limitations of the Erie agency, as identified through site visits and feedback from Roundtable members. The demonstration project is currently in a “pilot phase” and is being implemented on several levels: The first two levels are small and large group HIV prevention **outreach education**. Pre-post test surveys will measure HIV prevention information learned by audience members after the production. The second two levels are individual and small group HIV prevention (behavior change) **outreach intervention**. The latter levels require a series of interventions over time with the same individuals (actors) and targeted (gay, African American and Latino/a) youth (ages 13-24) community groups. Pre-post test instruments will measure intended behavior change over time.

Sub-contractors for this demonstration project were required (through the RFP) to base the intervention component of their proposals upon behavioral science theory. Proposed goals, objectives and activities of the Youth Demonstration Project emanate from two theories. **Social Learning Theory** – which assumes the reciprocal interaction between the individual, behavior and the environment – posits that behavior change is achieved through modeling, a basic acting technique that is the foundation of this demonstration project. Young actors will perform as characters dealing with specific HIV prevention issues that are later discussed by the audience during a facilitated discussion. Audience members interact with characters who are queried as to alternative solutions to the issues they face. One sub-contractor will also engage audience members in (improvised) role-play, another fundamental technique of Social Learning theory.

Through a series of four to five subsequent visits with the same audience, this interactive process with peers will help audience members (and actors) to develop intentions to change risk behaviors as their understanding of personal risk increases and alternative solutions to risk behaviors are explored. This cognitive change process underlies the **Theory of Reasoned Action**.

Audience members (and actors) will change their risk behaviors over time through heightened expectancy and efficacy expectations (**SLT**) and perceived risks and benefits (**TRA**) of risk reduction behaviors.

During year 2000, the continued pilot phase of this demonstration project, the two subcontractors are seeking funding resources for this project beyond the three-year demonstration phase. In addition, they have requested the postponement of the small group intervention component until year 2001, and have identified the following goals and objectives:

Pittsburgh Playback Theatre

Track I: Actors/youth participants

- Document changes in behavior for the actors
- Three HIV Prevention Training to the youth participants.

- At the beginning of the rehearsal process survey the youth participants about their practices of HIV and STD prevention.
- Up to two times throughout the year again survey the youth participants about their practices of HIV and STD prevention and note any behavioral modification or risk reduction that the youth participants have utilized.
- Perform 20 Rehearsals throughout 2001.

Track II: Small Groups

- Perform for 6 small groups throughout 2001.
- At each performance survey the audience before and then after the performance to document knowledge gained through the performance and any intention of utilizing behavioral changes or risk reduction.

Track III: Large Group

- Perform for two large groups throughout 2001.
- At each performance survey the audience before and then after the performance to document knowledge gained through the performance and any intention of utilizing behavioral changes or risk reduction.

Wilkes University

Maintain a company of actors that represents the target population:

- Actors will provide performances and discussions for 1500 youth between 13-24 in Columbia, Lackawana, Luzerne, Pike, Wyoming counties between January and December 2001.
- All actors involved with the project in the first year will state in a written evaluation that they:
 1. Learned new information about HIV risks in the past six months.
 2. Practice safe sex, if sexually active.
 3. Can negotiate safe sex practices with a partner better than six months ago.
 4. Changed behavior or at least intend to change behavior that puts them at risk for HIV.
- At least 40% of all small group and large group audience members will state in a written post-performance test that they learned new information about :
 1. The risks of unprotected sex.
 2. Risk reduction with a variety of condoms.
 3. HIV testing methods and resources.
- At least 40% of small and large group audience members will state in a written post-performance test that they:
 1. Are satisfied with the length of the performance.
 2. Have experienced similar events/situations as the actors.
 3. Thought the situations and scenes seemed real.
 4. Thought that the post-performance discussion was helpful.
 5. Felt free to suggest other topics or subjects that were not covered in the discussion that should be.

Injection Drug Use Demonstration Project

AIDS Community Alliance

The STOPP Project: AIDS Community Alliance (ACA) in Lancaster established an individual and group level demonstration project in July 1999 targeting injection drug users and their sexual partners in potential priority populations: **(2)** Black Injection Drug Users (IDU), mostly male, 13 and 39 years of age, **(3)** Black Male MSM/IDU 20 to 39 years of age, **(4)** White perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, **(5)** White IDU, mostly male, 20-39 years of age, **(6)** White MSM/IDU 20 to 39 years of age, **(7)** Hispanic IDU, mostly male, 13 to 39 years of age, **(9)** White heterosexual, mostly female sex partners of IDU with a history of STD 13 to 39 years of age (white females less than 13 years of age), **(11)** Hispanic Heterosexuals, mostly female sex partners of IDU 13-39 years of age, **(12)** Hispanic MSM/IDU 20 to 29 years of age, **(13)** Hispanic perinatal transmission, mostly female IDU or sex partner of IDU, and **(14)** Hispanic perinatal transmission, mostly female IDU or sex partner of IDU, 13-44 years of age. Through a multi-agency collaboration, the project extends to three of several communities that comprise their area of service to individuals living with HIV and AIDS. Those communities are the city of Lancaster, Harrisburg, and Lewistown, each having a distinctive character and drug using population.

ACA set the following goals and objectives:

- Establishing contacts in five specific communities identified by the project advisory committee (collaborating agencies);
- Contacting regional drug and alcohol rehabilitation centers to explain the project and to recruit peer educators;
- Contacting all regional drug and alcohol centers to explain the project, to recruit peer educators, and to establish HIV counseling and testing schedules in those centers;
- Establishing goals and objectives of the community needs assessment jointly with the peer education committee;
- Scheduling all training dates with ACA staff (education training) and ADAPT training;
- Identifying, pricing, and preparing requests for all materials (pamphlets, condoms, supplies) necessary for the completion and success of the project.

York Health Corporation, Inc.

People Helping People: an individual and group level HIV prevention street outreach program for injection drug users and their sexual partners in the City of York in priority populations: **(2)** Black Injection Drug Users (IDU), mostly male, 13 and 39 years of age, **(4)** White perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, **(5)** White IDU, mostly male, 20-39 years of age, **(7)** Hispanic IDU, mostly male, 13 to 39 years of age, **(9)** White heterosexual, mostly female sex partners of IDU with a history of STD 13 to 39 years of age (white females less than 13 years of age), **(11)** Hispanic Heterosexuals, mostly female sex partners of IDU 13-39 years of age, **(12)** Hispanic MSM/IDU 20 to 29 years of age, and **(13)** Hispanic perinatal transmission,

mostly female IDU or sex partner of IDU. This project was established in July 1999 through the York Health Corporation, Inc. (YHC), a comprehensive health care agency in the city of York founded in 1970 as a non-profit, federally qualified health care center. YHC serves clients in the York County area with offices in center-city York, Lewisberry, and Hanover. YHC is also the most comprehensive HIV primary care provider in the York community, offering professional interdisciplinary care, including medical and dental services and the services of a clinical social worker, to its clients. In 1985, YHC began community-based HIV counseling and testing services. During the 1998 calendar year, 727 individuals received HIV counseling and testing with 105 individuals received primary health care as a result of a HIV-positive test result. In addition 82 individuals received social services only.

YHC set the following goals and objectives:

- development of accurate descriptions (tasks, duties, and responsibilities) for outreach staff; upgrading of staff positions and salaries;
- Recruitment, hiring, training and development of outreach staff;
- Maintenance of ongoing relationships with key stakeholders in the community related to HIV prevention;
- Maintenance of contact with and the establishment of a presence at human service agencies in the community;
- Establishment of a relationship with community gatekeepers; development and implementation of an incentive program for gatekeepers;
- Participation in community events in order to heighten awareness of the project;
- Implementation of ongoing staff supervision and staff development and training program;
- Identification of additional and future program funding sources.

Men Who Have Sex With Men Demonstration Project

AIDS Resource

Out and About: This individual and group level intervention plan for the demonstration project was developed based on a literature review of effective models of intervention, one-on-one discussions with members of the MSM Community Leadership Development, and need assessment data from the community-wide planning group. The literature review revealed that no interventions exist specifically targeting young African American men who have sex with men. The organization basically sought to determine the feasibility of a prevention program for the Williamsport area to target (3) Black Male MSM/IDU 20 to 39 years of age and (10) Black MSM 13 to 39 years of age.

The three goals of the project were to:

- Create a community advisory board to assist in the assessment of the feasibility of an HIV-prevention project to targeting young African American MSMs;
- Gather information about the base-line knowledge of LGBT youth issues among youth-serving agencies and establish training plans for the staff;
- Articulate a model for YAAMSM prevention.

Serenity Hall

SHOUT Outreach MSM Demonstration Project: this group and individual level intervention is an HIV prevention outreach program in the Erie community for Men who have Sex with Men in target population **(3)** Black Male MSM/IDU 20 to 39 years of age and **(10)** Black MSM 13 to 39 years of age. This project was established in July of 1999 with Serenity Hall, Inc, an agency that provides comprehensive services including detoxification, inpatient rehabilitation, outpatient treatment, partial programs, halfway services, and community outreach. This agency has built a strong outreach component reaching the injection drug using community and has been active in the Erie community promoting for more than twenty-five years. In 1999, Serenity Hall developed this outreach project targeting MSM of color, utilizing the Shout Outreach Model.

SHOUT Outreach MSM established the following goals and objectives:

- To establish a working relationship within the MSM community and the larger community in which the targeted population resides or interacts;
- To increase exposure and access to HIV/AIDS information among 200 MSM who are African American or Latino;
- To provide HIV/AIDS testing and counseling, education and prevention to 10 MSM within the African American and Latino communities;
- To refer 20 MSM for clinical or social support;
- To provide an assessment of the project;
- To develop and implement a plan to provide intensive education and prevention appropriate for the MSM population.

Perinatal Demonstration Project

New Directions Treatment Services-The Living Project: This individual and group level intervention targets **(4)** White perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, **(11)** Black perinatal transmission, mostly female IDU or sex partner of IDU, 13 to 44 years of age, and **(14)** Hispanic perinatal transmission, mostly female IDU or sex partner of IDU, 13-44 years of age. to prevent perinatal HIV transmission. The project was established in July 1999 through the New Directions Treatment Services, a narcotic addiction treatment program in the Lehigh Valley. Founded in 1980 as a nonprofit, independent agency, New Directions serves clients in the Lehigh Valley with offices in Allentown and Reading. The HIV/AIDS services began in 1988 with counseling and testing and in 1990, a full-time street outreach educator was employed to expand the program. New Directions Treatment Services provides a variety of programs including street outreach and presentations on HIV/AIDS, medical treatment and case management of HIV positive drug treatment patients, and HIV counseling and testing of both agency patients and the general public. The agency has developed collaborative relationships among organizations and agencies in the community. Included are the clinics, social service departments, and HIV/AIDS case managers at Lehigh Valley and St. Luke's Hospitals, Allentown and

Bethlehem Health Bureaus (Independent Municipal Health Departments), the AIDS Service Center, Latino AIDS Outreach, the Hispanic AIDS Education Consortium, and Lehigh Valley Community Mental Health Center.

The 1990 Census showed that in the cities of Allentown, Bethlehem, and Easton, 11.8% of the population were of Hispanic origin and 5.1% were African Americans, yet Latinos and African Americans represent 67.5% of all reported diagnosed AIDS cases in the region. The Latino community constitutes the majority of cases. Women in the Lehigh Valley represent 32% of all cases. At New Directions, 38% of heroin addicts in treatment are women and most of those women are of childbearing age. While the actual number of HIV cases acquired through perinatal transmission is been small, there are women who are infected with HIV now and a number who are at high risk for infection based on the current demographics of the disease in the Lehigh Valley.

Project goals and objectives:

- Recruiting, hiring, training, and development of staff;
- Identifying and securing office space and provide furniture, phone service, and other office infrastructure as needed;
- Obtaining educational materials, such as brochures and posters, for use by project staff for outreach and peer education;
- Identifying specific census tracts within the Lehigh Valley to receive outreach and other services;
- Identifying and training peer educators;
- Establishing and maintaining going relationships with key stakeholders in the community related to HIV.

Section VI: Additional 2001 Programmatic Goals and Objectives

Counseling, Testing and Partner Notification

During the months of July and August 2000 a small group comprised of the Counseling and Testing Subcommittee, other interested Committee members, and the Chief of the Counseling and Testing Section, Division of HIV/AIDS met to review current counseling and testing goals and objectives. The following objectives were modified as indicated by the **[bold, underlined, brackets]**:

CT 1 Obj 2: On a continual basis, recognize the possibility of any community stigma directed at HIV/AIDS facilities, and annually discuss, document and implement an evaluation process toward **[decreasing]** stigma for priority populations.

CT 1 Obj 3: **[Initiate a discussion]** with the PA Department of Insurance to discuss methods for promoting coverage for HIV/AIDS prevention counseling and HIV antibody testing services in provider facilities and drug and alcohol treatment.

CT 1 Obj 4: Expand the accessibility of HIV non-blood testing processes for priority populations into at least 25% of the public HIV counseling and testing sites. **[This objective has been accomplished]**

CT 1 Obj 5: **[Insure the ongoing evaluation of publicly funded HIV counseling and testing services that address the following: confidentiality, use of the client-centered counseling approach, culturally sensitive service delivery, counselor training and evaluation, quality assurance, cost effectiveness and appropriate referrals]**. This objective was modified to more accurately reflect the resources and capabilities of the Counseling and Testing Section.

CT 1 Obj 6:**[Maintain HIV counseling and testing services in county correctional facilities where they are already established and continue to]** explore the establishment of counseling and testing in facilities where service is absent.

CT 1 Obj 8:**[Continue]** ongoing training for publicly funded counseling and testing site counselors to include the CDC update on the **[Fundamentals of HIV Prevention Counseling and the referral of clients to needed services]**.

CT 2 Obj 2: Convene regional, diverse work groups of providers, consumers, and community leaders who will identify possible deliveries of service to African-American women and Latinas at highest risk for HIV infection in order to reduce information gaps statewide by **[31 December 2001]**.

CT 2 Obj 3: Ensure that all facilities (insurance, health care organizations) in PA which provide/impact women's health services, particularly prenatal and obstetrical care, have access to mailings, information and/or teleconferences sponsored by DOH, promoting the accepted standard of practice regarding HIV infection and pregnancy. **[This**

objective was accomplished and discussion of handing it over to the Women's subcommittee for continuation was conducted].

CT2 OBJ 4: Develop highly visible, culturally sensitive, marketing strategies in collaboration with a broad partnership network that encourages teens, Latina, and African-American women to seek early prenatal HIV screening and information. **[This objective was accomplished and discussion of handing it over to the Women's subcommittee for continuation was conducted]**.

CT 4 OBJ 4: **[Expand access to voluntary and anonymous HIV antibody testing to at least 50 agencies that use such efforts as street outreach and satellite testing of individuals or other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults by December 2001]**.

CT 4 Obj 6: **[Explore the feasibility of having 50% of counseling and testing sites established through the use of Letters of Agreement provide well advertised, weekend and/or evening hours twice a month by 31 December 2001]**.

Health Education and Risk Reduction

The Women's Initiatives Subcommittee and a small work group of other interested Committee members met in July and August 2000 to make recommendations about HIV prevention and women. Following are their recommendations:

It was noted that the majority of information within the current Plan and Plan Update primarily address women almost exclusively as women of childbearing age and focus upon vertical-transmission of HIV.

- ✓ First, sexual health services in general need to be addressed. Second, transgender individuals, particularly male to female, need to have their concerns identified and addressed for HIV prevention.
- ✓ The concepts of harm reduction, particularly the deregulation of syringe laws, need to be examined. The intersection of drug abuse and HIV risk-related sexual behaviors also need to be addressed.
- ✓ Women who use alcohol and other drugs, transgender women, women who are partners of Men who have Sex with Men, the mature population of women (over the age of 55), women 13 to 25 years of age, domestic violence, sexually active African American women, sex industry workers, socio-economic status, and HIV infected women, do not appear to be addressed very well.

- ✓ Possible pilot projects could be incorporated into the next Plan development. In particular Transgender women, mature women, young women, and HIV infected women.
- ✓ Health professionals frequently do not know how to act towards transgender populations. Transgender persons could be involved with almost any one of the previously listed groups of women.

Capacity Building

The following goals and objectives within capacity building efforts have been updated or modified as indicated:

CB 2 OBJ 2: Assist community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to assess, provide, and integrate HIV/AIDS, STD, TB, Hepatitis B and C, and other blood-borne illness prevention with drug and alcohol prevention and treatment services:

The Bureau of Drug and Alcohol Programs of the Pennsylvania Department of Health funds 180 treatment programs in 12 Single County Authorities (counties or joiners of counties) to provide HIV early intervention services. Those sites provide on-site HIV antibody testing and counseling services integrated with blood borne illness prevention efforts. In addition ongoing training and technical assistance is offered to drug and alcohol treatment facilities about blood borne illness prevention and treatment. Licensing standards for staff require six-hours of HIV/AIDS and four-hours of STD and other blood borne illness prevention training. Free Hepatitis B vaccine is made available to any drug and alcohol facility that has a nurse available for administration as well as vaccine is available through the state health district offices.

CB 3 OBJ 1: Facilitate a dialogue between the County Wardens Association and/or County Commissioners Association, private correctional providers and the Ryan White HIV/AIDS Regional Planning Coalitions, to collaborate with community-based organizations to implement effective training and resource programs for HIV prevention which would include counseling and testing resources:

A small work group was established during this years-planning process to explicitly make recommendations about HIV prevention and incarcerated populations. Following are their recommendations:

- ✓ Since not all prisons were providing HIV antibody testing and counseling it is recommended that the number of institutions that are be increased, particularly as that relates to the use of OraSure.

- ✓ The Committee needs to have data on current HIV infection rates within the state prison system. An official request needs to be sent through proper channels to share such data to assist in the effective HIV prevention within the prison system.
- ✓ It is recommended that the peer education program for prisoners as developed by the Pennsylvania/Mid-Atlantic AIDS Education and Training Center be presented to the Committee at a future meeting.
- ✓ There is a lack of community resource information at a county level for release of inmates by prisons and state correctional institutions. There needs to be a list of all the local, state, federal, and private juvenile and adult institutions in the Commonwealth. This leads to the possible development of a resource manual.
- ✓ The continuity of care proposal developed for the Centers for Disease Control was not funded. Hence it needs to be removed from the Plan and if feasible resubmitted in the near future.
- ✓ The Department of Corrections does not have representation on the HIV Prevention Community Planning Committee as well as no representation from the Department of Public Welfare, which oversees the juvenile facilities. These gaps are considered serious and need to be addressed.
- ✓ Former inmates who are HIV-positive are not being necessarily linked to local HIV case management. This needs to be addressed with the Integrated Council and the Ryan White HIV/AIDS Regional Planning Coalitions.

Section VII: Coordination of HIV Prevention Services and Programs

Coordination of HIV Prevention Services and Programs is in part accomplished through enhanced communication and planning between regions, agencies, and individuals to facilitate the accomplishment of state and local HIV prevention efforts. Pennsylvania is a large geographic area whose rural and urban communities reflect different needs and resources, and with a population representing diverse cultures. Coordination is intended to maximize the use of local and state resources in order to strengthen HIV prevention efforts.

The Pennsylvania Prevention Project at the Graduate School of Public Health, University of Pittsburgh (PPP) provides a liaison with the nine independent county and municipal health departments (ICMHD). This collaboration further insures that HIV prevention community planning is interpreted and implemented within those jurisdictions in accordance with the comprehensive HIV prevention plan. This process creates a practical feedback loop of information and concerns between these jurisdictions and the HIV Prevention Community Planning Committee.

In addition, the Pennsylvania Prevention Project works with the State Health Improvement Plan (SHIP) to exchange information about community-based HIV prevention programs in order to create linkages and promote communication and collaboration. This is in part accomplished by creating communication between Committee members, other local HIV prevention leaders, and the local partnership members of the SHIP.

One source of information is the quarterly Community Update newsletter of the Division of HIV/AIDS, Pennsylvania Department of Health (DOH). This newsletter keeps the regional state health district offices, independent county and municipal health departments, Ryan White HIV/AIDS Regional Planning Coalitions, local partnership members, and others informed of HIV prevention efforts of the Committee, Pennsylvania Prevention Project, and the Division of HIV/AIDS.

Section VIII: Technical Assistance

The Academy for Educational Development through consultation with the Pennsylvania HIV Prevention Community Planning Committee recommended Larry Ray, Executive Vice President, Institute for Organizational and Personal Transformation, Inc. (I-OPT, Inc.) of Washington, DC to provide an all day training on Committee identified concerns with communication, conflict resolution, and group consensus. The Training and Development Subcommittee will be exploring taking the foundation of this training and developing it into practical application specific to the operation of the Committee in November and January.

In January 2000 Jeff Levy, Ph.D., Assistant Research Professor at the Center for Health Services Research and Policy, George Washington University presented the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) managed care-purchasing specifications for the prevention and medical management of HIV/AIDS. Carol S. Ranck, R.N., (former original Committee member), Director of Special Needs Division of the Bureau of Managed Care Operations, Office of Medical Assistance Programs, Pennsylvania Department of Public Welfare presented the Pennsylvania managed care program.

Large portions of people with HIV and at risk for HIV get their care through Medicaid. Medicaid is the single largest payer of medical services for people with AIDS. More than 50% of adults and more than 90% of children with AIDS are on Medicaid. Early detection of HIV infection means earlier and less expensive medical treatments in the long-term. Medicaid can and should pay for prevention services. The lack of prevention services in a Medicaid setting is a problem of execution, not coverage. Managed care provides an opportunity to have public health set the standard for prevention. Medicaid is Entitlement and HIV-related Medicaid spending has increased by 33% over the past five years, while Centers for Disease Control and Prevention HIV-related funding has increased by 10% over the past five years.

Prevention elements in the system are: (1) risk assessment on the initial visit and regularly thereafter, (2) education concerning risk reduction, (3) testing and counseling, (4) condoms, (5) drugs to prevent perinatal transmission, and (6) referral to partner services. Prevention Planning groups can encourage Medicaid to provide prevention services through Managed Care Organizations. Specifications can become reality by creating relationships among public health departments, prevention planning committees, Medicaid agencies, and managed care organizations. They can provide good models of primary care-based prevention. They can foster service relationships between managed care organizations and funded community-based organizations.

An adhoc subcommittee on HIV Prevention and Managed Care was formed. They recommend that the Department of Health explore methods to provide technical assistance to community-based AIDS services organizations to foster relationships for managed care organizations in order to provide HIV prevention services to their clients.

The Pennsylvania Prevention Project will work with the Center for Health Services Research and Policy, George Washington University, Special Needs Division of the Bureau of Managed Care Operations, Office of Medical Assistance Programs, Pennsylvania Department of Public Welfare, and the Ryan White HIV/AIDS Regional Planning Coalition community-based AIDS service providers to provide HIV prevention and managed care technical assistance during the next year.

Section IX: State-Funded HIV Prevention Activities

This attachment is included to provide reviewers the opportunity to understand the array of prevention services provided in the Pennsylvania Department of Health using non-CDC (state) funds. This information should provide a greater appreciation of the full scope of state services especially those that address needs and priorities established by the HIV Community Prevention Planning Committee.

Of the \$7.7 million available state dollars, a significant amount is dispersed to contractors throughout the state for community level interventions. A synopsis of these programs and the amount allocated follows.

The Council of Spanish Speaking Organizations of the Lehigh Valley receives funding to oversee street outreach projects in four cities with noticeable Latino population Reading, Lancaster, Bethlehem and Harrisburg. (\$140,000)

A multimedia campaign was developed to promote testing among women of childbearing years in an effort to reduce perinatal transmission. (\$100,000)

The Department maintains a toll-free hotline, which operates seven days/week and is available to handle calls related to HIV transmission, the location of counseling and testing sites, etc. (\$171,000)

The Pennsylvania AIDS Education and Training Center received state funds to provide one-day prevention counseling trainings to private sector providers. (\$50,000)

The Division of HIV/AIDS cooperates with the Bureau of Drug and Alcohol Programs to provide substance abuse treatment centers the opportunity to cross train staff on HIV issues. (\$75,000)

All of the ten independent County and Municipal Health Department (IHDs) receive state funds. Traditionally, CDC dollars were used for counseling and testing, and the state monies for health education/risk reduction activities. There has been some overlap in recent years. The departments are listed in descending order according to the amount of state dollars they receive. A brief description of activities is included because unlike the coalitions, these services generally are performed in-house with the exception of Philadelphia and Allegheny. Philadelphia- a significant portion of their funds is subcontracted to established and grass roots agencies, many of which have a minority focus. Erie County- minority outreach focus; also work with school districts; radio and TV programs; and education and testing for female sex workers. Allegheny county- street outreach; prevention services to the minority community and disadvantaged/ incarcerated women through contracts with the Pittsburgh Coalition Regional Abuse, the Housing Authority and Mon Yough Community Service; education and training of HIV for county prison staff; Pittsburgh police, school health educators

and health care workers; and the provision of an annual STD/HIV symposium. York City- outreach to Latino population; presentations to staff and “residents” of drug treatment programs, the prison and halfway houses for female offenders; and the development and distribution of literature. Bucks County- school-based initiatives; prevention in alternative schools and teen specific drug and alcohol facilities; outreach in gay bars; women’s initiatives at women’s shelters, homeless shelters and a women specific drug and alcohol facility; and training’s for police, fire companies, emergency room staff and ambulance companies. Chester County- outreach in public housing projects; after school programs; and one on one sessions with soon to be discharged prisoners. Montgomery County- HIV education programs in schools and the county prison, training of drug and alcohol staff; and small group outreach in women’s shelters, halfway houses, etc. Allentown City- targeted and general education. Bethlehem City- concentration on outreach to the Latino community and among IV drug users, women and children. Wilkes Barre has successfully linked with the local drug and alcohol center, who programs all community counseling, etc. Health Departments are allocated approximately \$1.2 million to perform these services.

Finally, all seven Ryan White Planning Coalitions are funded with state dollars to provide prevention/education services to priority populations in their regions. Most of these funds are allocated to community based organizations for service provision. The Coalitions, and the amount of state funds they received in FY 1999-00 for prevention (administrative dollars are not included) are as follows:

The Philadelphia AIDS Consortium	\$1,101,286
AIDSNET Coalition	462,030
Northeast Coalition	308,925
North Central Coalition	288,507
Northwest Coalition	298,613
Southwest Coalition	497,590
South-central Coalition	591,457

Section X: Program Evaluation

Five-Year, Strategic Evaluation Plan, 1999-2003

Introduction

The process of developing a five-year, strategic evaluation plan was initiated by the Pennsylvania Department of Health in December 1998. Since then, a comprehensive evaluation plan was included as a draft in the 2000 Comprehensive Prevention Plan submitted to the CDC in September 1999. This draft has been finalized and is included below.

The following Plan is divided into two parts:

- I. An Overview of the Evaluation Plan includes:
 - An explanation of the stakeholders involved in the *development* and *implementation* of the Evaluation Plan.
 - An outline of the components of the Evaluation Plan and a general timeline for initiating and implementing each component or type of evaluation.
 - The philosophy, purposes, and potential barriers to overcome with reference to evaluation of HIV prevention/education interventions in Pennsylvania.

- II. A Detailed Outline of the specific objectives to be achieved by particular types of evaluation over a five-year period, with timetables for each type of evaluation.

Part I. Overview of Evaluation Plan

A. Stakeholders:

A number of stakeholders have been involved in compiling this Evaluation Plan as follows:

- The PA Department of Health's Division of HIV/AIDS (Division) staff is ultimately responsible for the establishment of a comprehensive HIV Prevention Evaluation Plan. Staff involved are those who oversee HIV prevention/education programming (including a staff person responsible for prevention/education activities funded with state dollars, but implemented through the Ryan White Regional Coalition structure and another staff responsible for the state's Council of Spanish Speaking Organizations, which also receive funds for HIV prevention/education through state funding streams). Division staff is ultimately responsible for evaluation planning and implementation, and has contracted with the University of Pittsburgh to facilitate this planning and implementation process in the initial years, at the Division's direction. After the first several years of implementing the Evaluation Plan and when program evaluation has been further institutionalized in the prevention planning process, the Division will both oversee *and* facilitate the process of evaluating HIV prevention activities and interventions, and will likely draw on experts as needed for conducting discrete evaluation activities.
- The HIV Prevention Planning Committee has been participating in devising the Evaluation Plan. The Committee has reached consensus on methods for evaluating its own prevention planning process and plan development. The Committee also

reviewed the CDC's recommendations for assessing linkages between the Comprehensive HIV Prevention Plan and resource allocations for prevention interventions. The Committee adopted the process for assessing linkages that appears in the 2001 Prevention Plan, with expectations to build on this process in the coming planning year. The Committee has also reviewed and commented on the Department of Health's incremental drafts of the Intervention Plan, which is being used to collect prospective data on HIV prevention/education interventions. The Committee will continue to contribute to updates to the Evaluation Plan as needed. One important role played by the Committee is the representation of consumer perspectives in evaluation issues and decision making.

- Other community groups have also taken part in the construction of a draft Evaluation Plan.
 - Demonstration project staff, which represent community agencies implementing prevention interventions, have participated in planning meetings. Six demonstration projects have piloted and are implementing the Intervention Plan and positioned to begin process monitoring using the CDC-guided Process Monitoring Form. Project staff members have also attended evaluation training meetings to not only address data collection issues involved in the Intervention Plan and Process Monitoring, but also process and outcome monitoring of their respective projects. These six projects receive funding through 99004 funds.
 - Nine County and Municipal Health Departments and their subcontractors have piloted the Intervention Plan this planning year, and will begin process monitoring based on these prospective data in the year 2001. These nine health departments receive 99004 funds, as well as state funds, to implement various HIV prevention/education initiatives.
 - Seven Ryan White Ryan White Coalitions and their subcontractors also implement HIV prevention/education interventions through state funding. Coalition staff and various representatives of their subcontracting agencies have participated in meetings and activities focused on tailoring the Intervention Plan to the state's needs. These agencies will be using the Intervention Plan and corresponding Process Monitoring Forms in the near future. Various Coalition staff have also participated in HIV-prevention evaluation training provided by the Division in an effort to increase coordination of HIV-prevention evaluation approaches and collaboration between agencies supported through various funding streams.
 - The Council of Spanish Speaking Organizations and their subcontractors specifically serve Latino/a communities in various regions of the state with concentrations of these communities. The Council and their subcontractors receive state funding to provide HIV prevention/education specifically to those at-risk of HIV in the populations they serve. The Council and various agencies have been involved in the process of tailoring and implementing the Intervention Plan, and will be using the Intervention Plan and the corresponding Process Monitoring Form in the near future.
 - In addition to the above, other agencies have been part of evaluation planning with hopes of integrating evaluation approaches and systems in the future. For instance, a representative from Drug and Alcohol-related programs have

attended and contributed to planning meetings, and the Philadelphia prevention planning and programming participants have been invited to collaborate in building towards statewide integration in evaluation approaches.

- As stated above, the University of Pittsburgh staff has facilitated the process of devising the Evaluation Plan. The Director of Evaluative Research of the Pennsylvania Prevention Project (PPP) is also a faculty member at the University of Pittsburgh Graduate School of Public Health. He will continue to facilitate the planning and implementation process, while training Division staff will eventually facilitate all aspects of program evaluation. This will include planning and designing assessments; collecting, managing, and analyzing data; making program decisions based on these data; and making decisions about the use of outside experts for carrying out aspects of evaluations that need particular expertise.

While the Department of Health is ultimately responsible for the development and implementation of an Evaluation Plan, it understands that stakeholders will be most apt to see the value of evaluating prevention programs and activities if they are involved in decision making about the evaluations of activities or programs in which they have a stake. Therefore, decisions about evaluation are made by consensus among stakeholders of the activity or program being evaluated.

The following summarizes the various stakeholders and their participation by the types of evaluations that are part of the Evaluation Plan:

Type of Evaluation	Stakeholders and Roles
Evaluation of community planning process and prevention plan development.	Community Planning Committee members will continue to participate in the evaluation of the planning process; and co-chairs will complete a co-chair survey concerning the process. [Note: In addition to the Committee process evaluation, all Committee members will participate in any future assessments of the Comprehensive HIV Prevention Plan, as well as assessment of Committee/Planning outcomes. These outcomes are given evidence in linkages between the Plan and allocations (see below) and gap analysis, which shows evidence that Committee recommendations were or were not incorporated in actual interventions.]
Intervention Plans.	Community prevention/education providers (both CDC-funded and other providers who have agreed to use the Intervention Plan) and the Community Planning Committee has had input in designing the Intervention Plan. The University of Pittsburgh has been facilitating the design and implementation; the Division of HIV/AIDS is ultimately responsible for implementing and evaluating Intervention Plans.
Evaluation of linkages between comprehensive HIV prevention plan and application for funds, and between Comprehensive HIV Prevention Plan and resource	The Funding Guidelines Subcommittee commenced this process in 2000; however due to lack of sufficient data from all sources (that should in part be resolved with uniform data collection) this process is ongoing and should vastly improve in subsequent years.

allocation.	
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<p>Process monitoring</p>	<p>Community prevention/education providers; consumer groups; the Community Planning Committee; and other stakeholders in prevention/education interventions provide feedback about data needs that may be fulfilled by process monitoring, as well as monitoring approaches. Provider agencies implement monitoring; the University of Pittsburgh continues to help facilitate decision making on data needs and monitoring designs; the Division is responsible for oversight and facilitation of the entire process monitoring method.</p>
<p>*Outcome monitoring and process evaluation.</p> <p>*Note: Outcome monitoring, which is a periodic or ongoing check on whether providers are likely to meet outcome objectives, including tracking whether clients are progressing toward meeting client outcome objectives, is not required by the CDC. Also, process evaluation, or a descriptive assessment of the implementation of program activities, is not required by the CDC. However, these types of evaluation are included in the Pennsylvania Evaluation Plan since they occur among some discrete HIV-related projects.</p>	<p>Community prevention/education providers who participate in process monitoring are also encouraged to develop plans for outcome monitoring and process evaluation if these activities seem to be appropriate given agencies' resources and planning needs. To this end, an optional section has been included in Pennsylvania's version of the Intervention Plan (attached) that provides a section for program goals and objectives, and proposed plans for monitoring and evaluating the project based on these objectives. The Division coordinates technical assistance for agencies desiring to implement outcome monitoring and process evaluation.</p> <p>Additionally, The HIV Counseling, Testing, Referral, and Partner Notification Program, also coordinated by the Division, has embarked on a large-scale, nationally recognized, multi-method process evaluation. Methods and instruments used for this evaluation—for example, a Client Satisfaction Survey that is implemented periodically statewide—are added to a compendium of examples of process evaluations. These models are made available to other agencies that wish to implement process evaluations of their particular HIV prevention/education interventions.</p>
<p>*Outcome evaluation.</p> <p>*Note: A pilot outcome evaluation was already conducted on a Young Adult Mentoring Project that was implemented at selected sites statewide. The evaluation used a time-series design (no comparison or control group). Though the outcome evaluation gave indication of successful participant outcomes, a process evaluation showed need to reassess the role and inordinate time commitment of key project staff (mentors) that were necessary for program success. Based on these findings, the project has been placed on hold, at least temporarily, for reassessment and design.</p>	<p>Outcome evaluation will be conducted on the Perinatal HIV Prevention Demonstration Project. The agency implementing the project will also implement the evaluation with the assistance of an outside (objective) contractor/evaluator. The Division, PPP staff who support the demonstration project, project staff, and evaluators will collaborate on the evaluation design, as well as monitoring the evaluation itself. The Division is ultimately responsible for oversight and facilitation of outcome evaluation, as well as any future impact evaluation that may be initiated by 2003.</p>

B. General Timeline:

The following is a timeline for the implementation of the various types of evaluations, as well as dates that data is due to the CDC relative to each evaluation type. More specific timetables for implementation and reporting are included in Part II of the Evaluation Plan

Type of Evaluation	Implementation	Date Data is Due to the CDC
Evaluation of community planning process and prevention plan development.	Community process evaluation was implemented prior to 1999, but a co-chair survey was added in November 1999. Evaluation will occur annually	Data was provided in September 1999; data including co-chair survey information will be included in September 2000.
Intervention Plans.	Piloted among Demonstration Projects in December 1999 and draft Intervention Plan implemented as part of agency grant renewal in July 2000. Intervention Plan piloted among County and Municipal Health Departments in July/August 2000. Intervention Plan will be piloted among Ryan White Coalition subcontractors and Council of Spanish Speaking Organization agencies in 2001. Interventions will be updated annually.	First report due September 2000. Ongoing annual reporting thereafter.
Evaluation of linkages between the Comprehensive HIV Prevention Plan and application for funds, and between the Comprehensive HIV Prevention Plan and resource allocation.	Linkage between Prevention Plan recommendations and Application for Funds accomplished August 2000. Linkages between Prevention Plan and resource allocation scheduled for April 2001 reporting of year 2000.	Report on Plan/Application linkages due September 2000. Report on Plan/Resource Allocation Linkages due April 2001. Ongoing annual reporting in September and April thereafter.

Process monitoring.	Currently, all funded providers conduct process monitoring, though not all report data in a uniform fashion. Some conduct outcome monitoring and process evaluation. Uniform Process Monitoring , using the Process Monitoring Form, will be implemented among the Demonstration Projects and County/Municipal Health Departments in January 2001. Other (non-CDC) funded agencies will incrementally begin using the Process Monitoring Form.	First report due September 2001. Ongoing annual reporting thereafter.
Outcome monitoring and process evaluation.	Demonstration Projects will implement outcome monitoring and process evaluation as appropriate to each project in 2001. Counseling and Testing Client Satisfaction Survey, which is part of a larger process evaluation, is implemented on a periodic basis statewide.	Reporting is not required by CDC, but will be included in regular annual updates of activities.
Outcome evaluation.	Outcome evaluation plan/design for Perinatal HIV-Prevention Demonstration Project due September 2001.	Report due September 2003.

C. Philosophy, Purpose, and Potential Barriers:

An important early step in developing an evaluation infrastructure and comprehensive Evaluation Plan is to determine the uses of evaluation. Key questions to answer include, “Will assessment be used primarily to inform funders of contract compliance and success of programs? Will assessment be used as part of a learning process? Will it be used by prevention providers to improve programs? Will evaluation feed into future prevention planning?”

Pennsylvania stakeholders or partners have adopted a “Utilization-Focused” Evaluation approach, which is the systematic collection of data about activities, characteristics, and/or outcomes of programs done *for* and *with* specific, intended primary users for specific intended purposes. An underlying principle is, “If the evaluation is not useful to anyone, then why implement it?”

Partners have agreed that the primary purpose of evaluation should be to provide information about program activities, barriers, attainment of objectives, and intended and unintended outcomes that would aid in continually improving programs. Related is the use of evaluation findings as information for further planning of HIV prevention interventions and activities. It was agreed that evaluation should yield such information for multiple constituents, such as program staff, program planners, HIV prevention/education advocates, potential funders, consumers/clients, policymakers, and others.

In the midst of gathering data to improve programs and plan, accountability may be assured. That is, subcontractors can account for its work to the PA Department of Health. The Department of Health can provide an aggregate accounting of statewide activities and outcomes to the CDC. Ultimately, this statewide data will be useful to the CDC as it provides information to the Office of Management and Budget and Congress regarding the uses of federal funds designated for HIV prevention.

Further, providers, who themselves are funded by various funding streams, suggested that uniform and complementary evaluation approaches could be a vehicle for providing coordination between and among a number of agencies concerned about HIV prevention/education. Furthermore this could raise the level of professionalism, credibility, and accountability among these agencies and in the eyes of their clients.

Of course, implementation of a statewide Evaluation Plan has potential barriers that could impede the success of the plan. In regular meetings leading to the five-year Evaluation Plan, stakeholders shared these concerns as possible barriers that an effective evaluation system must address:

- Uneven resources and capabilities among a large number of agencies to collect, manage, and report data.
- The possibility of creating irrelevant and non-user-friendly data collection forms and approaches.
- The possibility that agency staff may hold fears and biases about evaluation, data collection, and ways that data may be used for decision making.
- Possible difficulty in obtaining/maintaining a high quality of data.
- Possible “midstream” changes in data collection requirements.
- The possibility that evaluation and data collection will “drive” the program, rather than programs “driving” data needs and appropriate evaluation approaches.

Most if not all of these barriers may be avoided or eliminated earlier rather than later with careful planning and adequate resources for carrying out an Evaluation Plan. To this end, the Division has embarked on a strategic and comprehensive five-year plan that will serve to meet the goals and purposes set forth by partners, while identifying and eliminating barriers when they arise.

Part II. Detailed Outline of Evaluation Plan

The following provides a detailed outline for each type of evaluation activity. For each activity, the purposes of the evaluation, assessment methods, scope of evaluation, staffing and resources, and a timeline are provided. A narrative discussion of ways that implementation and data will be managed relative to each evaluation activity appears after the respective table.

Evaluation of community planning process and prevention plan development:

Purposes	Methods	Scope	Staffing and Resources	Timeline
<p>1. Assess the process of the HIV Prevention Planning Committee (the CDC-guided Community Planning Core Objectives provide the basis of variables to be assessed).</p> <p>2. Assess the composition of the Community Planning Committee (with reference to geographic distribution, agency/other representation, expertise, sex/gender, age, race/ethnicity, and HIV exposure).</p>	<p>1. Committee Member Anonymous Survey; Facilitated Committee Member Discussion Groups; Co-Chair Survey</p> <p>2. Anonymous survey that includes questions about characteristics of Committee members.</p>	<p>1. The survey will be administered among all Committee members, and all members will be given the opportunity to participate in the discussion groups; both co-chairs will complete the respective survey.</p> <p>2. The survey will be administered among all Committee members.</p>	<p>1. PPP staff will administer the member survey, analyze data, and issue a written and oral report to the Committee; outside consultants, preferably former Committee members skilled in group facilitation, will administer two separate discussion groups; each co-chair will complete and submit the Co-Chair Survey.</p> <p>2. PPP staff will administer the member survey, analyze data, and issue a written and oral report to the Committee; data will be translated to CDC's "Profile of Community Planning Group Members" report form.</p>	<p>1. All evaluation methods will be administered in November of each planning year; discussion groups will be part of the regular November Committee meeting.</p> <p>2. Survey administered with other process evaluation methods in November of each planning year.</p>

Evaluation of community planning process and prevention plan development, continued:

Purposes	Methods	Scope	Staffing and Resources	Timeline
<p>3. Assessment of the Evaluation Plan and its use in planning actual HIV prevention/education interventions</p>	<p>3. In the past, Committee members conducted an assessment of the Evaluation Plan once this plan was issued. Specifically, a content analysis of the plan was conducted, and a tally was made regarding the goals, objectives, and activities that were actually addressed in implemented activities after the Plan was issued. As data collection improves and becomes more uniform across CDC-funded and non-CDC-funded interventions, the gap analysis that results from these data provide a way of showing whether Plan recommendations are addressed or not. Further, the Linkages exercise, described below, provides further evidence of implementation of Plan recommendations.</p>	<p>3. All Committee members will participate in a final assessment of gaps between actual interventions rendered and recommendations in the Prevention Plan; the Funding Guidelines Subcommittee will, in cooperation with the Division, assess the linkages as described below to assess the correspondence between Plan recommendations and HIV prevention/education interventions rendered.</p>	<p>3. PPP staff will coordinate gap analysis and present data to the full Committee. The Committee will assess the correspondence between Plan recommendations and actual rendering of interventions. A task group of the full Committee, in coordination with the Division, will continue to assess linkages, as described below.</p>	<p>3. Uniform data regarding CDC and non-CDC funded interventions will be initiated, but not complete for 2001 planning. Assessment will be made of correspondence between Plan recommendations and actual interventions rendered with respect to, at least, CDC-funded interventions in August 2001. Full gap analysis data will be available to use for this purpose in August 2002. Linkages data began to be assessed in August 2000, Linkages data will become more complete in 2001, permitting improved assessment.</p>

Implementation and data management: As suggested in the table above, data from the written Committee Member Surveys are anonymous. Members are provided with the survey and a return mailing envelope at the annual November meeting and instructed to return it to the University of Pittsburgh by mail, with no identifiers attached. Members who may be absent from that meeting are mailed a survey, a return envelope, and instructions for returning the survey anonymously. Data from the survey are entered into a statistical software program for processing and analysis. Qualitative data are coded and likewise entered into a computer software program. Co-Chair surveys are not anonymous since only two Co-Chairs exist and demographic information identifies the Co-Chair. Data from this survey is processed in the same way as the member survey.

Discussion groups are recorded and transcribed word-for-word. One University transcriber solely transcribes the tape and does not reveal the identity of Committee Member participants or other information deemed by Committee Members to be confident in the printed transcript. (At the beginning of discussion groups, participants are told that they can request that the tape be shut off for a short time period for “off-the-record” comments, and that they can request that particular contents of the tape be kept “off-the-record” after group has been conducted.) A University researcher skilled in qualitative methods analyzes transcripts and results are written in summary form. These data are compared, contrasted, and integrated with survey data, and presented in a final written report, which the full Committee and Co-Chairs review for accuracy. If parts of the report are found to be inaccurate, Committee members may request that data be revisited and the report be revised appropriately. Committee members give final approval of the parts of the report involving member responses; and Co-Chairs give final approval of the accuracy of related data.

Gap analysis data will be garnered from the upcoming Process Monitoring Forms that will be implemented in January 2001. Data will be limited in 2001 to the six demonstration projects and nine County/Municipal Health Departments and their subcontractors. A full gap analysis will not be able to be conducted until the majority of agencies conducting HIV prevention/education interventions through funding other than the federal 99004 funding begin reporting data uniformly through Process Monitoring. Therefore, assessment of the implementation of Plan recommendations in actual interventions across the state will be limited until 2002 when these other agencies begin reporting HIV prevention intervention data uniformly.

The linkages assessment is described below.

The Planning and Evaluation Sub-Committee annually reviews the appropriateness and adequacy of the assessment of the HIV Prevention Community Planning Process before implementation the following year.

Intervention plans:

Purposes	Methods	Scope	Staffing and Resources	Timeline
<p>Determine agency plans to provide HIV prevention/education in their communities and use these prospective determinations to help assess adequacy and appropriateness of proposed interventions with respect to target populations, scientific/best-practice basis of interventions, and overall soundness of proposed approaches.</p>	<p>Implementation of Pennsylvania's version of the Intervention Plan (see Attachment).</p>	<p>In stage 1, all CDC-funded (Demonstration Projects and County/Municipal Health Departments and subcontractors) will use Intervention Plans to report on the subsequent year's prospective activities.</p> <p>In stage 2, non-CDC-funded Ryan White Coalitions and subcontractors, and the Council of Spanish Speaking Organizations and subcontractors, will use Intervention Plans.</p>	<p>The Division is ultimately responsible for preparing agencies to implement and use Intervention Plans in HIV prevention planning. The Division has contracted with PPP to facilitate the process working with agencies in designing the Intervention Plan and preparing agencies to use the Intervention Plan. PPP is initially undertaking data collection, aggregating, and reporting tasks; but the Division over time will likely assume these tasks. Planning/provider agencies assign at least one staff person to coordinate Intervention Plan activity as a regular task in the administration of HIV prevention/education programs. Joint meetings are held in Harrisburg, which, to a large extent, is centrally located to all state agencies.</p>	<p>August 2000: Demonstration Projects and County/Municipal Health Departments submit Intervention Plans as a pilot stage in implementing this process.</p> <p>October 2000: Those who have piloted Intervention Plans provide feedback on the process of using these Plans; feedback is provided for the purpose of improving the process as well as to prepare other agencies to begin using Intervention Plans.</p> <p>December 2000: Non-CDC-funded agencies provide an initial estimate of a timetable for instituting the Intervention Plan among their subcontracting agencies.</p> <p>By March 2001: Non-CDC-funded agencies develop timetables and plans (including training plans) for implementing the Intervention Plan among their subcontractors.</p>

Implementation and data management: Demonstration Projects and County/Municipal Health Departments have piloted Intervention Plans. Each pilot involved a different draft of the Intervention Plan, with incremental improvements to the Plan based on pilot experience. Intervention Plans have been completed and returned on either hardcopy or in a word-processed file, which was transmitted electronically through e-mail. Demonstration projects represent single agencies, therefore, submit cohesive Intervention Plans for their respective agencies' prevention projects. County/Municipal Health Departments submit plans for their own HIV prevention/intervention activities funded through the PA Health Department with either state legislator or CDC funding. Some County/Municipal Health Departments also have subcontractors that implement HIV prevention/education programming. Each health department aggregates their and their subcontractors' information before submitting these data.

Because there have been relatively few agencies submitting Intervention Plans to date, data are aggregated manually by PPP staff. The plan, however, is to computerize the Intervention Plan, using a software package that will aggregate data automatically as it is submitted electronically to a central source. Of course, narrative data will and should accompany the Intervention Plan. Qualitative data from these narrative descriptions will be used to provide context for proposed interventions and, in turn, will be incorporated in narrative reporting to the CDC from the PA Department of Health. As mentioned above, PPP staff is facilitating the adoption and implementation of the Intervention Plan to date. This facilitation has been closely monitored and supported by Division personnel directly responsible for the corresponding agencies using the Intervention Plan.

Agencies who have adopted or will be adopting the Intervention Plan have collaborated in a series of meetings, telephone conferencing, and email and fax correspondence as a way of constructing the actual Intervention Plan and coordinating its implementation. These forms of communication will continue to occur until all agencies are using the Intervention Plan effectively. Agencies that began using the Plan earlier will assist agencies that will subsequently use the Plan.

Evaluation of linkages between comprehensive HIV prevention plan, application for funds, and resource allocation:

Purposes	Methods	Scope	Staffing and Resources
<p>1. Assess the linkages between the Comprehensive HIV Prevention Plan and the Department of Health's CDC funding application.</p> <p>2. Assess the linkages between the Comprehensive HIV Prevention Plan and resource allocation for interventions.</p>	<p>1. Compare the recommendations in the Plan by target populations to the interventions proposed in the CDC funding application, using the CDC-provided forms.</p>	<p>The Funding Guidelines Subcommittee has completed the CDC recommended forms for the current Plan recommendations and CDC funding guidelines.</p> <p>That process will be expanded to a wider scope of reviewing HIV prevention interventions funded by other resources to gain the most comprehensive perspective of HIV prevention.</p>	<p>PPP staff will work closely with the subcommittee as well the Division staff to assist in creating the most comprehensive view of HIV prevention efforts in the Commonwealth.</p>

As implied above, the Funding Guidelines Subcommittee will continue to compare Plan recommendations with interventions proposed in the funding application.

To gather and compare data for assessing linkages between Plan recommendations and actual resource allocation for interventions, resource allocation from Process Monitoring Forms will be used to derive percentages of allocations by target populations. Until all agencies (CDC and non-CDC funded) delivering HIV prevention/education interventions implement the Process Monitoring system, however, estimates of resource allocation by target population will be gathered from agencies.

Process monitoring:

Purposes	Methods	Scope	Staffing and Resources
<p>Document and report intervention characteristics describing:</p> <ul style="list-style-type: none"> • The target populations served. • The services that were provided. • The resources used to deliver these services. 	<p>Implementation of Pennsylvania’s version of the Process Monitoring Form (see attached Intervention Plan; though this is not the same as the Process Monitoring Form, the shaded areas of the Intervention Plan will give indication of the variables that will be included in the Process Monitoring Form. Both forms will be presented in a similar format).</p>	<p>In stage 1, all CDC-funded (Demonstration Projects and County/Municipal Health Departments and subcontractors) will participate in process monitoring and use the Process Monitoring Form to aggregate and report data for the respective year’s actual HIV prevention/education intervention activities.</p> <p>In stage 2, non-CDC-funded Ryan White Coalitions and subcontractors, and the Council of Spanish Speaking Organizations and subcontractors, will be integrated into this process monitoring system and begin using the Process Monitoring Form.</p>	<p>Same as indicated above under “Intervention Plan.”</p>

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Implementation and data management: Implementation and data management will occur in a very similar way to that described for the Intervention Plan. A difference is that agency-level data collection forms are likely to be computerized and available online, and eventually will be linked to an electronic version of the Process Monitoring Form. In essence, agencies should be able to enter discrete client- and group-level data, which will easily be aggregated in electronic Process Monitoring Forms. This process, however, will not likely be available until the later part of 2001 and, therefore, will not be used for the first round of process monitoring conducted by the Demonstration Projects and County/Municipal Health Departments. Plans for such electronic coordination will be forthcoming in the update to this Evaluation Plan in 2001.

<p>immediately after test results for obvious reasons of sensitivity to clients. Through follow-up contact with Department of Health field staff, clients who test positive will carefully be asked if they would like to participate in the satisfaction assessment. Field staff will be trained to implement this survey.)</p> <p>3. Conduct a meta-analysis of all past CTRPN process evaluation findings to recommend quality improvement to the CTRPN system and future evaluation needs. (Past methods have included, in addition to the ongoing client satisfaction survey, a CTRPN staff mail survey and randomly selected site visits and a participant observation component in which paid and trained actors participated in the counseling and testing process to assess the quality of services.)</p>	<p>3. Synthesize all past process evaluation findings, comparing findings across methodologies.</p>	<p>3. N/A</p>	<p>and results-counseling surveys will develop a pilot the survey for HIV positive clients. She will also assist PPP staff in training field staff to carefully implement the survey among HIV-positive CTRPN clients. Division staff will oversee the entire process.</p> <p>3. PPP's Director of Evaluative Services will conduct the meta-analysis with oversight and assistance from the Divisions CTRPN staff and the Counseling and Testing Sub-Committee of the Prevention Planning Committee.</p>
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To conduct the Counseling and Testing Client Satisfaction Survey, the Division of HIV/AIDS selects and notifies 50 sites each time the survey is administered. PPP mails a survey packet to each of these sites. Each survey packet includes an appropriate number of satisfaction surveys relative to each site's historical pattern in terms of annual volume of tests rendered (e.g., over 2,000 surveys are mailed to 50 CTRPN sites in late October. Ample supplies are mailed, with no expectation that all surveys would be actually distributed. Typically, nearly 800 surveys are actually given to clients at these sites. Return rates have been between 35% and 40%, which are good rates given the fact that, with an anonymous survey, there is no possibility of following up and reminding clients to return surveys if they have not done so.)

Clients who choose to complete surveys mail these directly to PPP at the University of Pittsburgh, where survey data are computerized and analyzed. These surveys are coded so that they may be traced to the sites at which they were provided, and unused surveys are returned by sites to PPP so that client return rates may be established. Site information (i.e. the number of surveys distributed by sites and numbers of clients per site returning surveys) is kept confidential. Since individual surveys are anonymous, information cannot be traced to clients. Surveys are available in English and Spanish versions.

PPP generates a report on each client satisfaction survey about 4 months after the closing of each survey period (permitting ample time for all respondents to mail in surveys, as well as for data entry, cleaning, and analysis). Reports are distributed in draft form to the Division and the Counseling and Testing Sub-Committee of the Planning Committee. After feedback and necessary revisions, reports are finalized and made available through the Division. Findings are considered in review of Counseling and Testing Recommendations in the Annual Plan Update.

Outcome evaluation:

Goals	Methods	Scope	Staffing and Resources
Evaluate the achievement of desired client outcomes related to the Perinatal HIV Prevention Project.	Client outcome evaluation (exact methods to be determined).	Scope to be determined as part of evaluation design.	Division staff is ultimately responsible for all aspects of implementing the outcome evaluation. Perinatal demonstration project staff will be responsible for cooperating with an outside (objective) evaluator, to be determined, for designing and implementing the outcome evaluation. PPP staff, who directly guides and supports the Demonstration Project will also provide guidance for implementing the outcome evaluation and will provide facilitation locating an appropriate outside evaluator. The Division will allocate funding specifically for this evaluation.

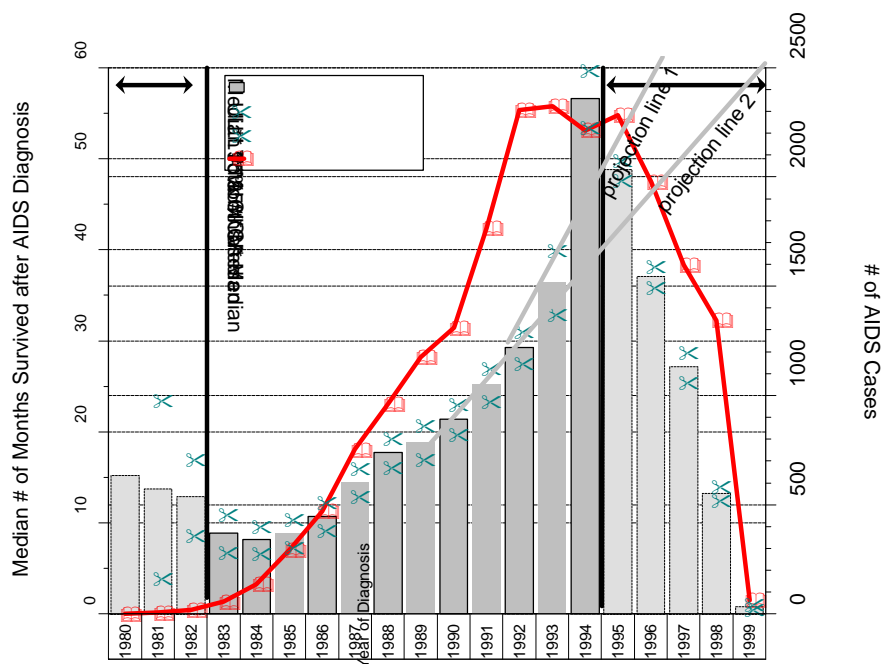
Implementation and data management: Management over-and-above that described above will be determined after the evaluation design is finalized.

EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN PENNSYLVANIA

An Empirical Resource for Prevention and Care Planning
Year 2000 Update

v.8.29.00

Improving Survival Time after Diagnosis with AIDS in Pennsylvania



Mo.^, Number of Months; S.E.^, Standard Error; CI*, Confidence Interval; ** UL, 95% CI Upper Limit; ***LL, 95% CI Lower Limit

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Bureau of Epidemiology
Pennsylvania Department of Health

Robert S. Zimmerman, Jr., MPH, Secretary of
Health
Tom Ridge, Governor

EPIDEMIOLOGIC PROFILE OF HIV/AIDS
IN PENNSYLVANIA
Contributors

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HIV/AIDS in Pennsylvania is prepared by the
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Year 2000 Update of the Epidemiologic Profile of HIV/AIDS in Pennsylvania.

Overall Aims and Objectives of Update:

To assist the HIV/AIDS prevention and care planning processes gain more access to empirical data that can be used to plan and develop prevention and care services in Pennsylvania, this update extends the analyses conducted and presented in the 1999 Epidemiologic Profile of HIV/AIDS in Pennsylvania. In addition to HIV/AIDS incidence data presented in 1999, the primary objectives of the year 2000 update are to determine and describe:

- 1) Changes over time in the likelihood of death among cases diagnosed with AIDS and to highlight the resulting changes in survival time after diagnosis with HIV/AIDS in Pennsylvania;
- 2) Changes over time in estimated prevalence of HIV in the general population and the geographic distribution of estimated HIV prevalence in Pennsylvania;
- 3) The geographic distribution of AIDS prevalence in Pennsylvania;
- 4) The geographic distribution of recent changes in AIDS incidence in Pennsylvania;

Background and Significance of the Update:

The Epidemiologic Profile of HIV/AIDS in Pennsylvania that was redeveloped and issued in 1999 consisted mostly of data describing changes over time in the HIV/AIDS epidemic in Pennsylvania. More specifically, the data presented in 1999 focussed on showing change over time using AIDS incidence data along with some surrogate data (mainly STD data) to describe attributes of the HIV/AIDS epidemic pertaining to a) person, b) place and c) time. Thus, the data presented showed: a) which population-transmission groups are affected [*person*, i.e. which groups of persons are affected, by demographic distribution (age groups, race/ethnicity, geographic location and sex) and by probable modes of transmission]; b) which parts of the state are affected (*place*, i.e. as in geographic distribution); and c) changes over *time* in the epidemic's impact on the affected geographic parts of the state and the population-transmission groups.

In the 2000 and 2001 planning years, we are updating the Epidemiologic Profile of HIV/AIDS in Pennsylvania to include more data on the four epidemiologic analyses of disease occurrence that are addressed by the four objectives indicated above. In the absence of data on newly diagnosed recently infected HIV cases, we are using these additional data to describe more fully and infer the likelihood of new HIV infections in various geographic areas and their affected population-transmission groups AND at the same time describe the likelihood of growth in the population that is living with HIV/AIDS in Pennsylvania. The inference that can be made from these data will enable HIV/AIDS prevention and care planners to better determine which population-transmission groups and geographic areas should be prioritized for resources for preventive and care services. Unlike in the past when data was presented in separate profiles for care and prevention planning to meet the needs of the separate funding processes, this update of the Epidemiologic Profile takes cognizance of the integrated nature of the continuum of prevention and care services. We are thus updating the Epidemiologic Profile with data that is relevant for an integrated approach to prevention and care planning.

Methods for Objective 1: Survival Analysis:

Study Population and Methods of Data Collection for Objective 1, Survival Analysis: The survival analysis is based on the Pennsylvania HIV/AIDS surveillance population cohort followed up from AIDS diagnosed through death. In Pennsylvania, as is also true in all the other states, HIV/AIDS surveillance is a legally mandated ongoing systematic collection of a) initial data on *all* diagnosed AIDS cases (i.e. identifying, demographic, probable mode of transmission, and AIDS-defining illness/conditions and follow-up data); and b) on progression of disease and c) vital status at regular intervals. The AIDS surveillance cohort used for these analysis included all cases reported through this ongoing system from 1980 through the present time (the PA Department of Health has initiated a process towards making HIV, severe immunosuppression and perinatal exposure to HIV reportable). The preliminary analysis included all adult AIDS cases diagnosed from 1980 through 1999. The final survival analysis cohort included all adult AIDS cases diagnosed in Pennsylvania before January 1995. The cohort was truncated on December 31, 1994 and all follow-up was censored on December 31, 1998, allowing for at least 48 months after the last diagnosis included in the final survival analysis. Thus, among the cases included in the final survival analysis, the cases that had expired had to have died on or before the date on which all follow-up was censored.

More detailed descriptions of the data collection methods may be requested from the HIV/AIDS Surveillance Section of the Bureau of Epidemiology, Pennsylvania Department of Health.

Main Outcome Measures for Objective 1: a) The percent censored for each year of diagnosis was given as the proportion of cases remaining alive at the end of the follow-up period for each year-of-diagnosis sub-cohort (% censored = 100 - fatality rate). b) The primary measure of survival time was given as the median number of months survived from AIDS diagnosis to death.

Data Analysis Methods for Objective 1:

Overall incidence of AIDS was stratified by year of diagnosis and overlaid over the incidence of death and percent censored in each year-of-diagnosis sub-cohort for the entire state. Similar analyses were performed within strata of geographic coalition area of residence at the time of AIDS diagnosis. Overall median survival time was estimated using the Kaplan-Meier method. The Kaplan-Meier procedure is a survival analysis method for estimating time-to-event models in the presence of censored cases (i.e. cases for which the end-point event has not yet occurred or been recorded as in cases that are still alive). The Kaplan-Meier survival analysis was used to estimate median survival times with standard errors and 95% confidence intervals for each time interval of diagnosis for the entire cohort and within strata defined by geographic planning coalition areas. The results of these analyses are presented in this update.

Additional analyses will be performed using life-table methods to determine the proportion of cases that remain alive after 12-, 24-, 36- and 48-months of follow-up. Adjusted analysis will also be performed using the Cox proportional hazards regression method; alternatively, the multiple logistic regression method will be used if the assumption of proportionality of hazards is not met.

Results for Objective 1: Survival Analysis:

Table 1.1. Median Survival Time by Year of Diagnosis for the Statewide AIDS Surveillance Cohort in Pennsylvania.

Year of Diagnosis	Median # Mo. [^]	S.E. ^{^^}	Median 95% CI of Median	Total # Cases	% Dead	% Censored (Alive)
1980	15.23	NA	NA	1	100	0
1981	13.73	4.98	(3.97; 23.50)	6	100	0
1982	12.9	2.12	(8.74; 17.06)	20	95	5
1983	8.9	1.08	(6.78; 11.02)	56	96.4	3.6
1984	8.2	0.76	(6.70; 9.70)	136	97.1	2.9
1985	8.9	0.77	(7.38; 10.42)	293	97.3	2.7
1986	10.73	0.79	(9.19; 12.28)	471	93.2	6.8
1987	14.53	0.78	(13.01; 16.06)	753	91	9
1988	17.73	0.81	(16.14; 19.32)	963	89.2	10.8
1989	18.87	0.95	(17.00; 20.74)	1176	85	15
1990	21.37	0.85	(19.71; 23.02)	1309	84	16
1991	25.23	0.93	(23.42; 27.05)	1766	77.7	22.3
1992	29.3	0.89	(27.55; 31.05)	2306	70.3	29.7
1993	36.47	1.81	(32.93; 40.01)	2324	59.6	40.4
1994	56.6	1.6	(53.46; 59.74)	2213	50.3	49.7
1995	48.77	0.54	(47.71; 49.82)	2283	36.5	63.5
1996	37.07	0.59	(35.91; 38.22)	1978	26.2	73.8
1997	27.13	0.84	(25.49; 28.77)	1596	17.9	82.1
1998	13.27	0.4	(12.48; 14.06)	1343	14.9	85.1
1999	0.83	0.13	(0.57; 1.09)	64	100	0

Mo.[^], Number of Months; S.E.^{^^}, Standard Error; CI^{*}, Confidence Interval;

➤ The number of cases diagnosed in each year of diagnosis is much smaller before 1983, resulting in wider confidence intervals around the point estimate for median survival time – this indicates that the estimates are less precise and the higher estimates during each of these years of diagnosis before 1983 are not reliably estimated.

➤ The likelihood of death in the time interval after 1994 is decreasing, the percent of cases that are censored (still alive at the end of follow-up) in each year of diagnosis after 1994 is greater than 50% and increasing - this suggests that median survival time for a larger proportion of cases cannot be reliably estimated as many of the cases have not been followed up for a sufficient period that would correspond to the

Figure 1.1. AIDS Incidence Overlayed over the Percent of AIDS Cases Presumed Alive (Censored) by Year of Diagnosis.

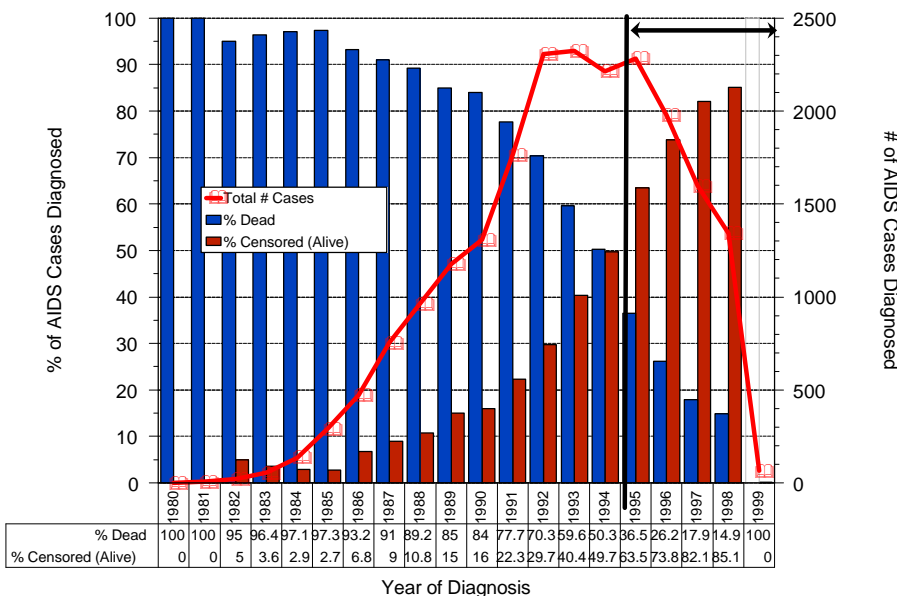


Figure 1.2. Median Survival Time by Year of Diagnosis for the Statewide AIDS Surveillance Cohort in Pennsylvania.

➤ Observed survival time after diagnosis with AIDS is improving consistently with each successive

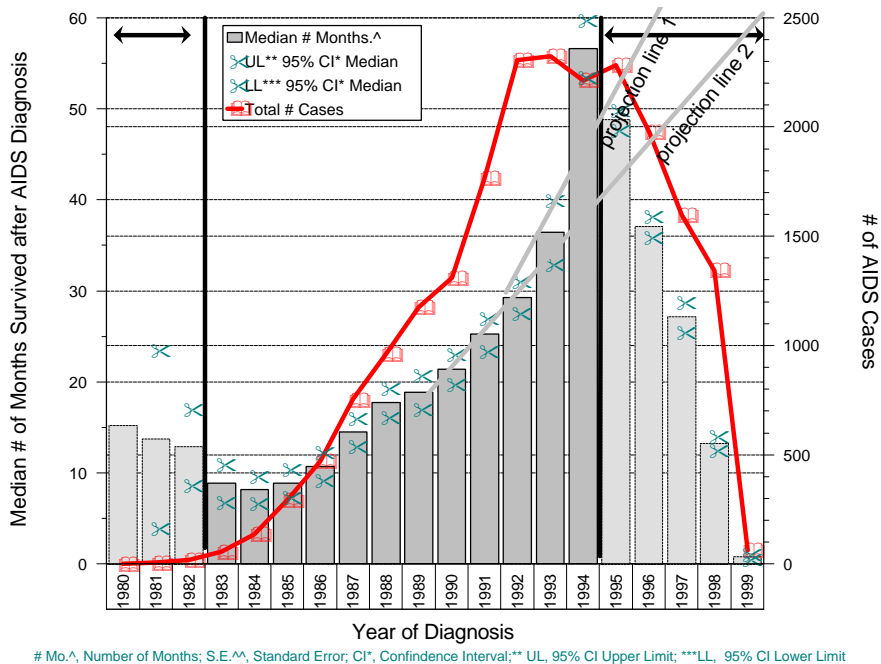
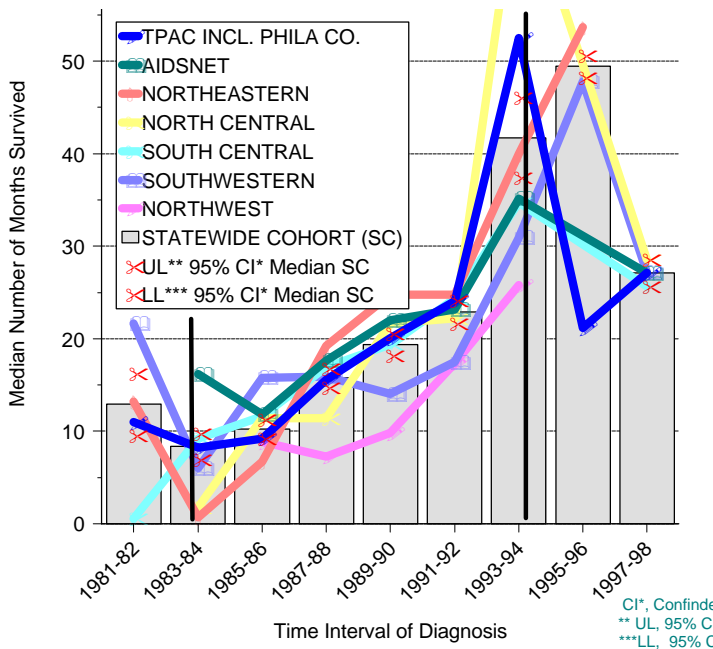


Figure 1.3. Median Survival Time by Year of Diagnosis by Geographic Planning Coalition Area in Pennsylvania.



- Observed survival time after diagnosis with AIDS is improving consistently with each successive 2-year interval of diagnosis for all planning coalition areas and for the statewide cohort;
- The overall statewide cohort's median number of months survived increased from 8.33 in 1983-84 to 41.73 in 1993-94;
- Increasing survival time may result in an increase in the

Methods for Objective 2: Estimation of Population Level Prevalence of HIV: Change Over Time and Geographic Distribution of Estimated HIV Prevalence in Pennsylvania:

Study Population and Methods of Data Collection for Objective 2, Estimation of Population Level HIV Prevalence: **The estimated population HIV prevalence rate and the number of persons living with HIV during successive years that correspond with the survey periods are based on data collected through the serosurveys of childbearing women; these serosurveys were conducted in sentinel birth-facilities across the state of Pennsylvania in 1990-91; 1992-93; 1993-94; 1994-95 and 1997.**

More detailed descriptions of the data collection methods may be requested from the HIV/AIDS Surveillance Section of the Bureau of Epidemiology, Pennsylvania Department of Health.

Data Analysis Methods for Objective 2, Population Level Prevalence Estimation:

The estimation of prevalence of HIV in the general population is performed using a multi-step method. The data inputs that must be known a priori include a) the overall statewide observed prevalence of HIV for the number of women testing HIV positive in the serosurvey of childbearing women; b) the estimate of the population of women of childbearing women in the state; c) the Male: Female ratio of living AIDS cases. The method assumes that: a) the prevalence of HIV among women in the childbearing survey is representative of the overall HIV prevalence of females ages 15-44 in the general population; b) the age distribution of HIV infected females is the same as that for living female AIDS cases; c) the distribution of HIV infection by sex, geographic coalition area, race/ethnicity; mode of transmission, etc, is the same as that for diagnosed AIDS cases. Given the a priori data and the assumptions indicated, we calculate the number of infected women in the general population of PA as “the product of ‘the estimated population size of women of childbearing age’ multiplied by ‘the observed overall HIV prevalence in the serosurvey of childbearing women’ “ divided by ‘the proportion of the total population of women who are of child-bearing age’. The number of males infected with HIV in the general population of PA is estimated as the product of the ‘estimated number of infected females’ multiplied by the ‘ratio of males to females among those living with AIDS’. The sum of the estimate of women living with HIV and the estimate of men living with HIV in PA gives the estimated total number of persons living with HIV in the state of PA. The proportion of living AIDS cases diagnosed in each coalition area multiplied by the estimated total number of persons living with HIV in PA gives the estimated number of persons living with HIV in the general population in each coalition area. The prevalence rate in PA or in each health district area is given by ‘estimated number of persons living with HIV’ in the given area divided by the number of persons in the given population.

Estimates of HIV prevalence in the general population corresponding with each survey period were calculated and plotted on a line chart to compare changes over time in estimated HIV prevalence. Estimates of HIV prevalence in 1997 were also mapped to demonstrate the geographic distribution of estimated HIV prevalence by Health District in Pennsylvania.

Results for Objective 2: Estimation of Population Level Prevalence of HIV:
 Change Over Time and Geographic Distribution of Estimated HIV Prevalence in
 Pennsylvania:

Figure 2.1. Estimated Prevalence Rate per 100,000 Population by Survey Year by Health District in Pennsylvania.

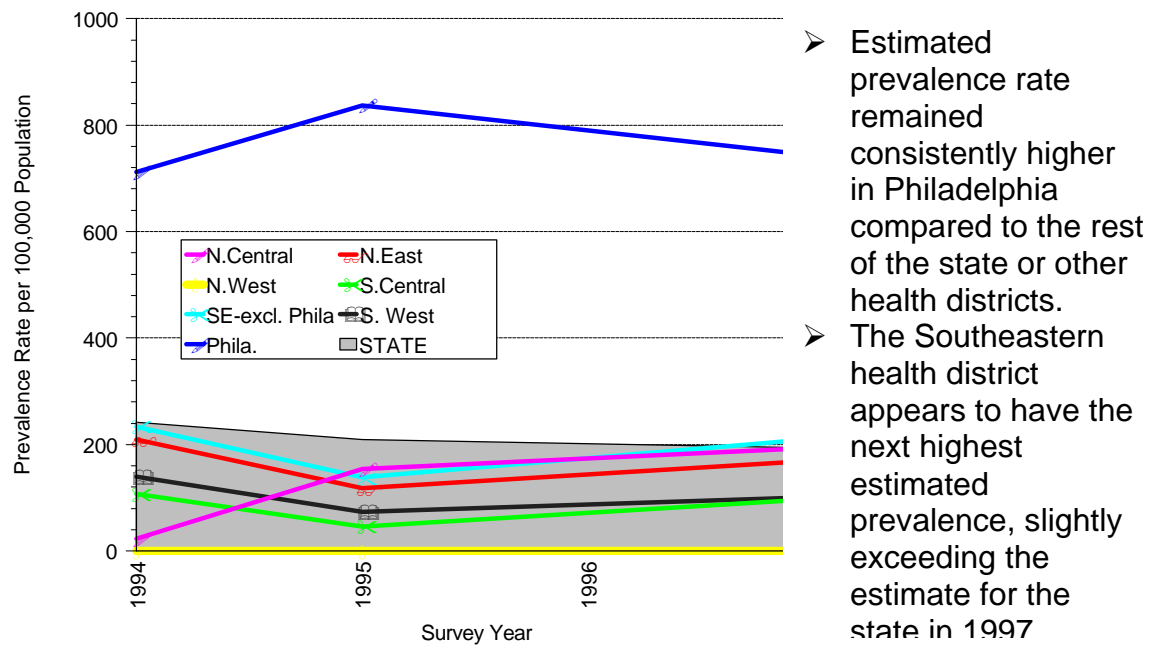
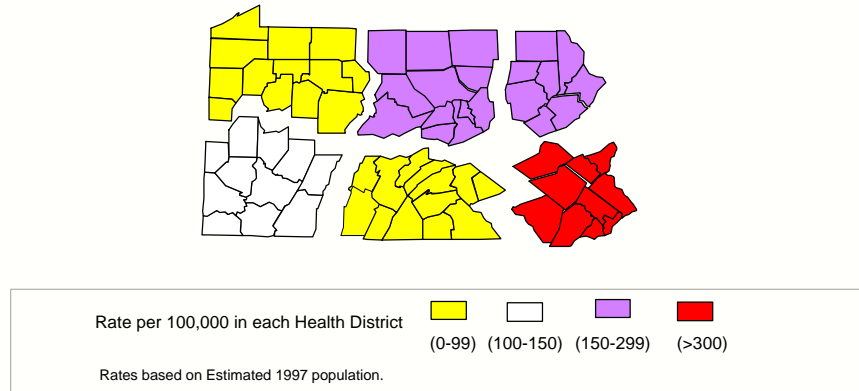


Figure 2.2.

Estimated Prevalence Rate of HIV in Each Health District for 1997

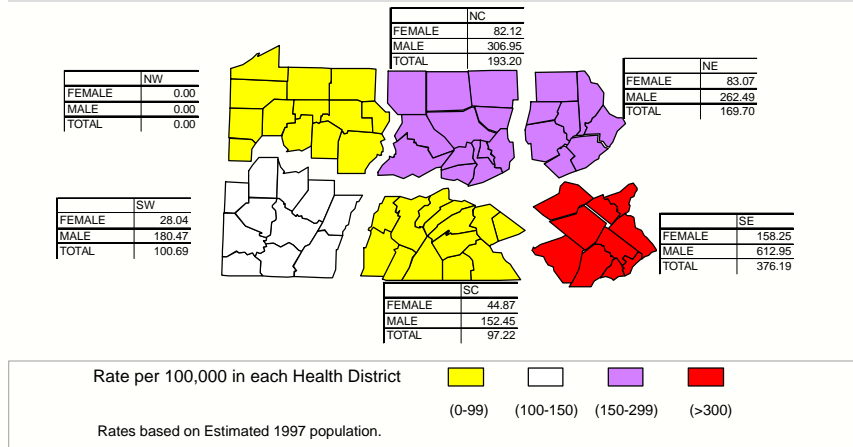


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Pennsylvania Department of Health

Figure 2.3.

Estimated Prevalence Rate of HIV in Each Health District for 1997

Rates in tables are based on adult HIV estimates only.

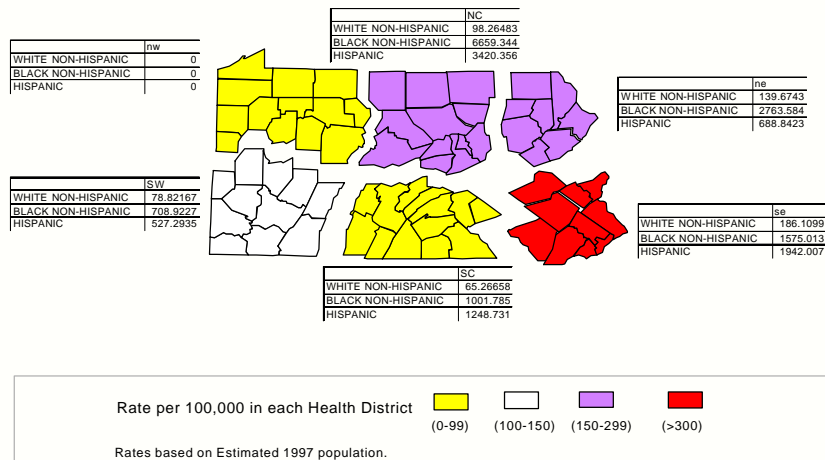


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Pennsylvania Department of Health

Figure 2.4.

Estimated Prevalence Rate of HIV in Each Health District for 1997

Rates in tables are based on adult HIV estimates only.



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Methods for Objective 3: The Geographic Distribution of AIDS Prevalence in Pennsylvania:

Methods: AIDS prevalence data were mapped to demonstrate the geographic distribution of AIDS prevalence by planning coalition area in Pennsylvania.

Results:
Figure 3.1.

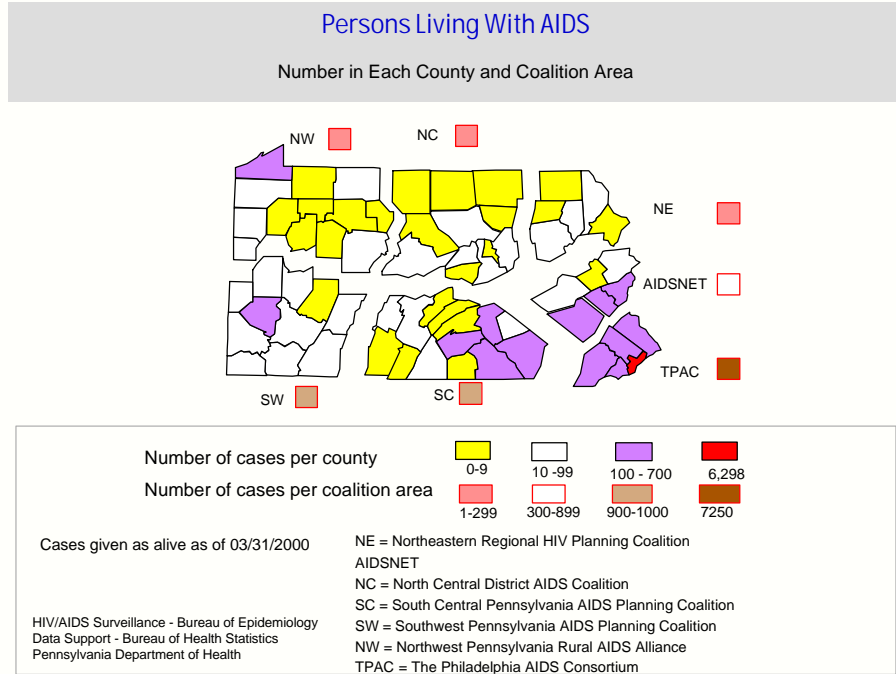


Figure 3.2.

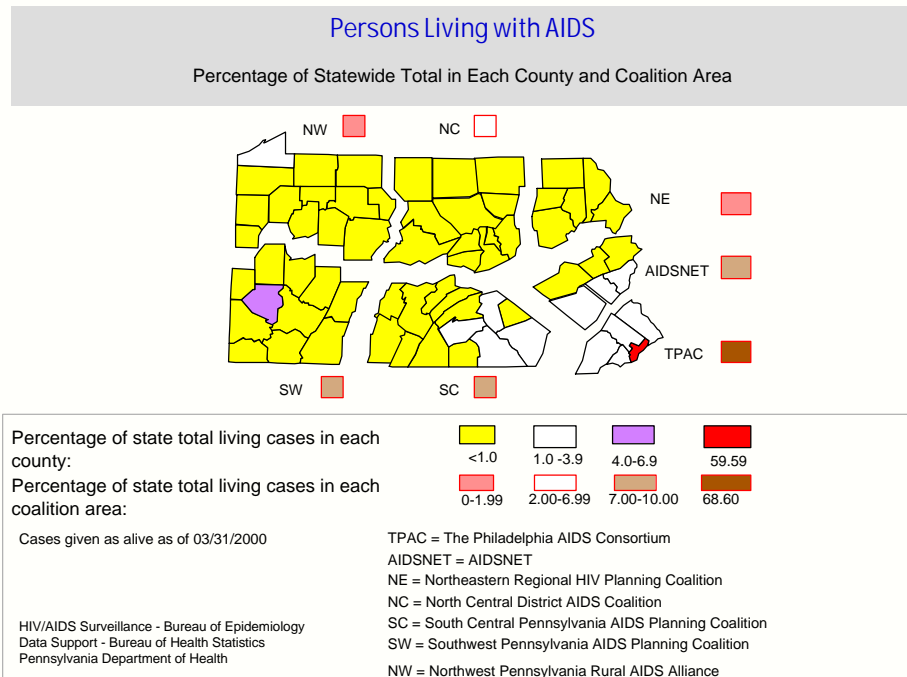


Figure 3.3.

Persons Living with AIDS
Rate per 100,000 in Each County and Coalition Area

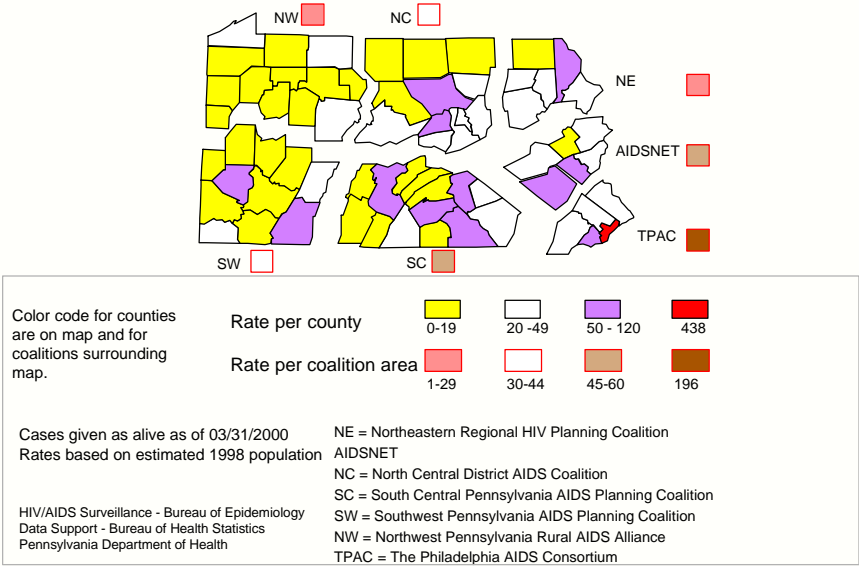


Figure 3.4.

Persons Living with AIDS
Rate per 100,000 in Each County and Coalition Area

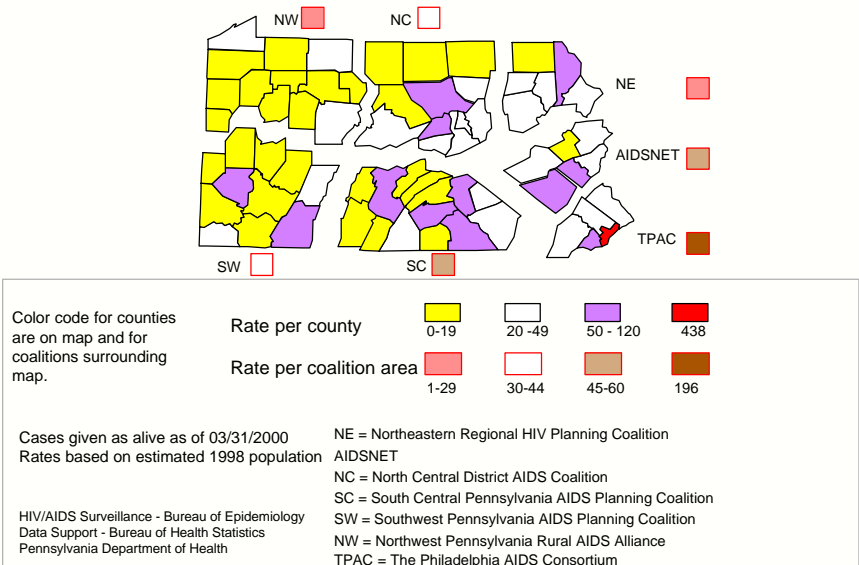


Figure 3.5.

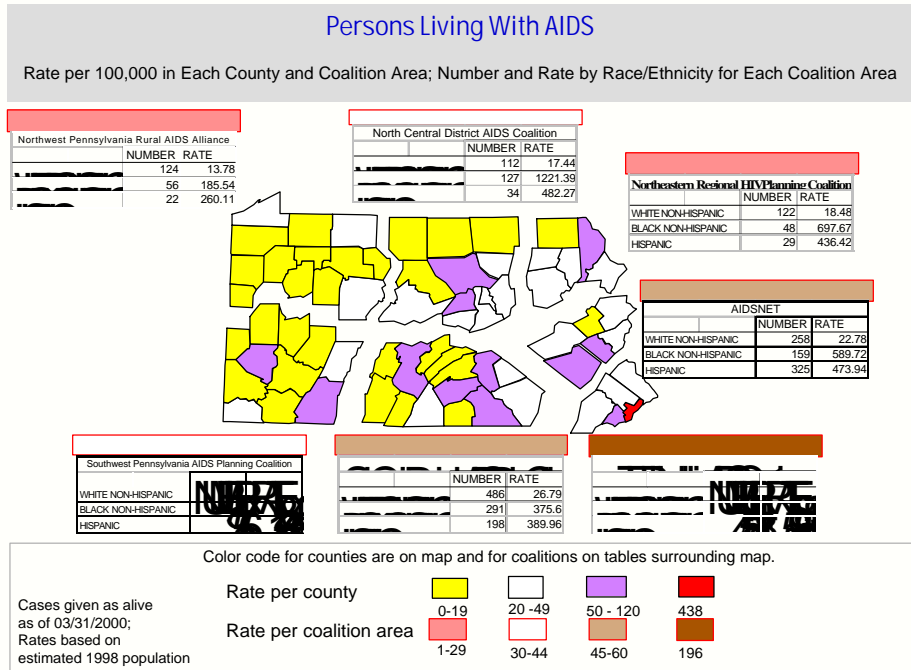
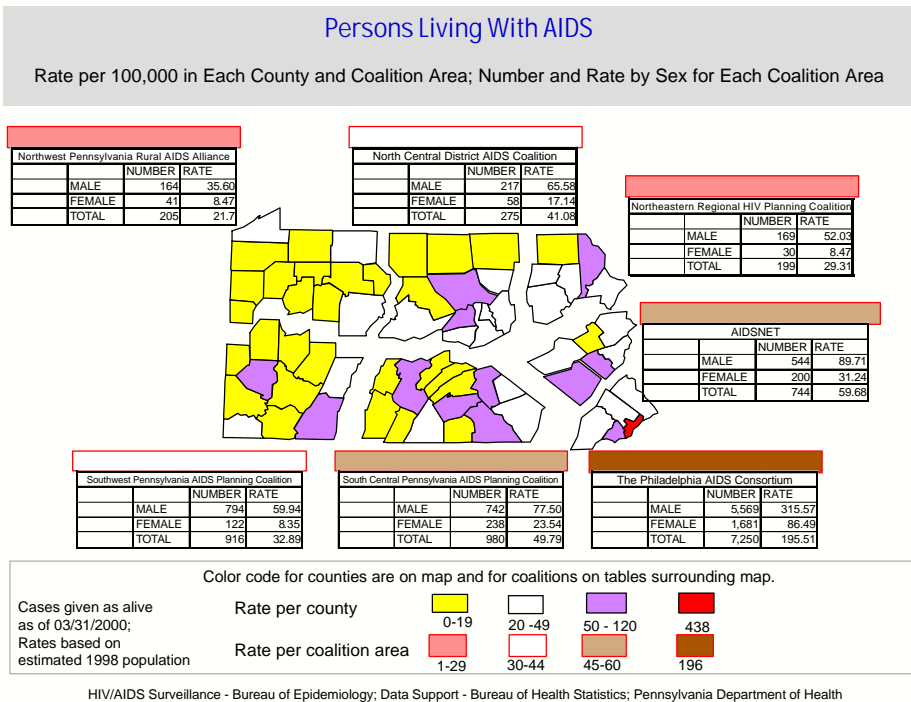


Figure 3.6.



Methods for Objective 4: The Geographic Distribution of Recent Changes in AIDS Incidence in Pennsylvania:

Methods: Average annual rates of change in AIDS incidence data were mapped to demonstrate the geographic distribution of recent changes in AIDS incidence in Pennsylvania.

Results:
Figure 4.1.

Average Annual Rate of Change/ Increase (%) in AIDS Cases between 1992 and 1997 in Pennsylvania by County of Residence

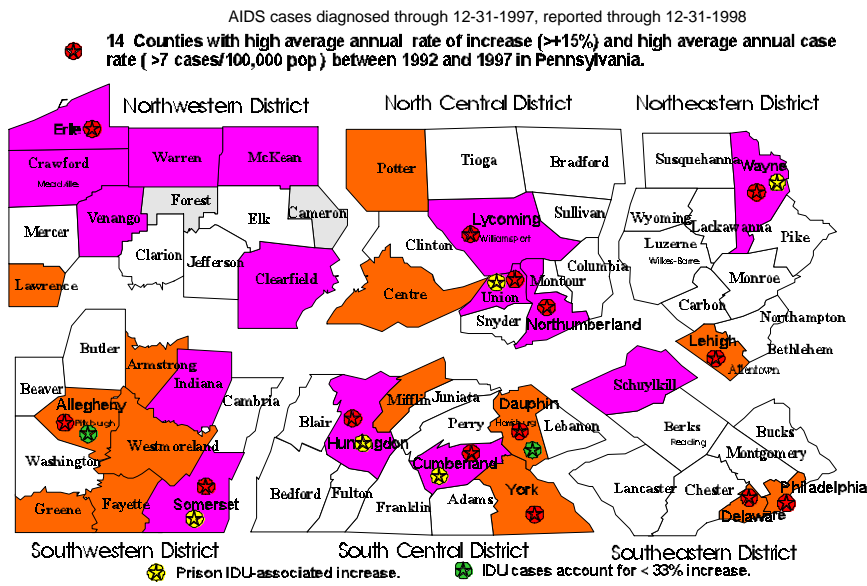


Table 4.1.

- The analysis of recent changes in the epidemic (as mapped and tabulated) indicates that 14 counties were identified as high outcome counties that had high average annual rates of increase in new AIDS cases (>+15%, between 1992 & 1997, 62nd percentile) AND also have high background average annual case rates (> 7 cases per 100,000 pop, 50th percentile): i.e. Allegheny...

Average Annual Rate of Increase (%) in AIDS Cases between 1992 and 1997 in Pennsylvania by County of Residence

➤ Average annual increases(%) due to IDU cases diagnosed from 1993 through 1997 (column 5 in table) accounted for at least half (50%) of the overall average annual increases(%) observed (column 4) in ten* (10) of the high outcomes counties i.e.: Cumberland**, Delaware*, Huntingdon**,

High Outcome** Counties with Indicators of Recent IDU-Associated Adverse Outcomes of the HIV/AIDS Epidemic in Pennsylvania, 1992 - 1997.

HIGH** OVERALL OUTCOME COUNTIES IN RECENT YEARS: 1993 THRU 1997.	HIGH OUTCOME** COUNTIES (Except for Allegheny & Dauphin counties, new IDU AIDS cases alone account for at least 33% of increases during the period 1993 - 1997)	OVERALL BACKGROUND	OVERALL	*AV. ANNUAL RATE OF CHANGE (%), DUE TO IDU CASES DIAGNOSED 1993-1997.	% CASES DIAGNOSED IN CORRECTIONAL FACILITIES AMONG IDU CASES DIAGNOSED 1993-1997.
		*AV. ANNUAL CASE RATE (PER 100,000 POP.) 1992-1997.	*AV. ANNUAL RATE CHANGE (%), DUE TO ALL CASES DIAGNOSED, 1993-1997.		
	*ALLEGHENY CO.	13.45	15.69	4.19	5.5
	CUMBERLAND CO.**	11.69	22.92	13.15	69.8
	*DAUPHIN CO.	23.30	15.18	4.24	1.7
	DELAWARE CO.	16.56	15.42	9.05	2.7
	ERIE CO.	7.69	20.55	6.87	34.6
	HUNTINGDON CO.**	13.89	25.74	19.42	85.0
	LEHIGH CO.	15.98	16.74	7.68	7.1
	LYCOMING CO.	16.18	19.29	13.42	24.6
	NORTHUMBERLAND CO.	8.37	19.57	12.20	28.6
	PHILADELPHIA CO.	74.34	16.32	8.48	1.4
	SOMERSET CO.**	10.60	34.08	25.26	66.7
	UNION CO.**	17.95	19.67	13.81	45.0
	WAYNE CO.**	20.42	20.11	12.57	52.4
	YORK CO.	12.47	18.25	8.82	.0

*Av. = Average; ^ Allegheny & Dauphin are the only two counties with high outcomes that are not largely accounted for by IDU cases. ** High outcome counties are defined as counties with high average annual case rates (>7.3 cases/100,000; 50th percentile) AND high average annual rate of change (> +15%; 62nd percentile) due to all cases diagnosed 1993-1997. ** Underlined, among counties with high IDU-associated outcomes, these counties have high % cases diagnosed in correctional facilities among IDU cases diagnosed in these counties, 1993-1997.

AIDS cases diagnosed through 12-31-1997, reported through 12-31-1998

➤ **Five** (5) of these counties with IDU-associated increases had high proportions (≥ 45%, column 6 in table) of IDU cases that were diagnosed in correctional facilities, i.e. Cumberland**, Huntingdon**, Somerset**, Union**, and Wayne**;**