

Philadelphia Comprehensive HIV Prevention Plan 2011

Executive Summary

Prepared for the Philadelphia HIV Prevention Planning Group (PPG)
and the
Centers for Disease Control (CDC) Atlanta, GA.

Authored by:

OFFICE OF **HIV** PLANNING
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Philadelphia Comprehensive HIV Prevention Plan

Executive Summary

The Philadelphia HIV prevention plan details the continuing progress towards the Prevention Planning Group (PPG) and the Centers for Disease Control (CDC) goals. The comprehensive decision making is documented through the work of the PPG's committees. The plan also reviews Philadelphia's epidemiologic profile and community services assessment to assist in identifying prioritized target populations and their respective science-based prevention interventions and activities. An annual membership survey supports in the monitoring and evaluation of the goals and objectives of the HIV prevention community planning body and documents ways to constantly improve the group's work.

The complete HIV prevention plan contains approximately 380 pages with information related to the HIV prevention needs in Philadelphia. This Executive Summary provides a synopsis of the complete plan. Several data sources were evaluated, analyzed, and synthesized to create the document. The plan has four key sections, with each section addressing the various components of the community planning process. There are two additional pieces that are not included in this executive summary. These are the Appendix and Supplemental pieces to the plan. The Appendix includes key decision making information such as the PPG's ground rules and bylaws, worksheet examples that assisted the PPG in their decision making, a list of the recommended science-based interventions by their population demographics, the proposed activities to be conducted during the 3 Year Plan (2011-2014), and the health department's draft ECHPP models. The Supplemental pieces to the plan include an integrated epidemiological profile that is approximately 350 pages, a review of literature on HIV prevention interventions and risk behaviors, and an integrated resource inventory for HIV care and prevention in the Philadelphia Eligible Metropolitan Area. All of this information adds comprehensive insight into the prevention needs of the community.

The information contained in the Philadelphia HIV prevention plan was written by the Office of HIV planning and made possible through the dedicated hard work of members of the Philadelphia PPG and with the assistance of the Philadelphia AIDS Activities Coordinating Office (AACO). Both parties have spent countless hours of commitment in planning for the well-being of their community. This executive summary is a brief reflection of this work. For the full plan and corresponding information, please visit www.hivphilly.org or call the Office of HIV Planning at (215) 574-6760.

The following information provides an overview of each section and highlights key points to consider.



Section I – Who We Are

Overview

- ➔ Provides Membership Information
 - Demographic information on PPG members
 - Affiliation, expertise and at-risk community information

- ➔ Reviews the National HIV/AIDS Strategy (NHAS), CDC & PPG Goals and Objectives

- ➔ Reviews each PPG committee's role & their respective decision-making

- ➔ Reviews PPG affiliated workgroup's role & their respective decision-making

- ➔ Reviews other cross-collaboration work

Key Points to Consider

- ➔ The PPG endorses the NHAS strategy targets for 2015 to reduce new HIV infections, increase access to care and improve health outcomes for PLWHA, and to reduce HIV related health disparities.

- ➔ The PPG endorses the Philadelphia Health Department's Enhanced Comprehensive HIV Prevention Planning (ECHPP) efforts. The overall objective of this program is to identify coordinated HIV prevention, care, and treatment services that best impact on the reduction of new HIV infections.

- ➔ The PPG supports broad-based community participation in HIV prevention planning; identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction; ensures that HIV prevention resources target priority populations and interventions set forth in comprehensive HIV prevention planning; and ensures an effective resource coordination process.

- ➔ There are 28 active volunteer PPG members with expertise in HIV prevention, behavioral health, substance abuse treatment, social work, research, community advocacy and other disciplines.

- ➔ There are 4 active PPG committees:
 - Nominations/Membership Committee focuses on PIR (participation, inclusion, and representation) issues.
 - Literature/Education Committee oversees the development of strategies for prioritizing interventions.

- Planning/Priorities Committee oversees the development of strategies for prioritizing populations.
 - Monitoring Committee develops and evaluates the planning process and cycle.
- ➔ The PPG and its respective committees (mentioned above) spent the last few planning cycles reviewing their work and prioritizing effective prevention strategies for their high risk populations. This has resulted in a new HIV prevention plan for 2011-2012. This new plan is effective for a 3 year period, but will be updated annually, to ensure that it remains current with an evolving HIV prevention landscape.
- ➔ Work conducted by the PPG in the past few planning cycles included:
- Trainings and presentations on topics such as:
 - Data on the current state of the HIV/AIDS epidemic in Philadelphia
 - The latest results from the Youth Behavioral Risk Survey (YRBS) in Philadelphia
 - Federal policy updates on HIV/AIDS prevention and care in the era of health care reform
 - The Ryan White HIV/AIDS Treatment Extension Act
 - The Pennsylvania’s Department of Health’s resource registry
 - The STD’s Partner Services guidelines
 - The Program Collaboration and Service Integration (PCSI) Initiative, ECHPP, and NHAS
 - And reviews of the social determinants of health, health behavior theories, HIV prevention provider panel discussions on the interventions currently being provided in Philadelphia, various sections of the prevention plan, the conflict of interest policy, the prioritization process, the concurrence process, and the PPG membership survey.
 - Elections for the community co-chair elect position.
 - Group work to discuss, select target populations and interventions.
 - Approval of a list of social drivers (determinants of health) that impact HIV risk taking behavior.
 - Approval of a prioritized list of target populations at risk for HIV in the community.

- Approval of a list of science based interventions reviewed by the Literature and Education Committee.
- Approval of the following six prevention strategies based on the National HIV/AIDS Strategy: HIV status awareness, Prevention with Positive, Effective Behavioral Interventions, Structural/Policy Interventions, Local Interventions, and Perinatal approaches.
- Approval of a recommended funding range for the six prevention strategies.
- Voting to alter the name of the body from the Community Planning Group (CPG) to the Prevention Planning Group (PPG) to align with the requirements of the funding opportunities announcement (FOA).
- Discussion on how to get more populations, such as youth, involved in the planning process.
- Filling out annual PPG membership surveys.
- Annual review of the PPG's work, plan, and concurrence process.

📌 Work conducted by the Monitoring Committee in the past few planning cycles included:

- Establishing how to best utilize PPG members and their expertise during priority setting.
- Assigning the Planning and Priorities Committee to focus on populations and Literature and Education to focus on interventions during the prioritization process.
- Developing a three year calendar in conjunction with OHP to map out the work necessary to update the HIV prevention plan by 2011-2012.
- Suggesting relevant trainings to aid in the prioritization process.
- Making process changes to help reduce lost time, such as adjustments to the agenda and providing written reports to the chairs of committees to replace the standard verbal committee reports.
- Shifting the planning cycle from a 5 year cycle to a 3 year one to ensure all the decisions remains timely.
- Reviewing the bylaws and making the necessary changes as needed.

- Engaging in joint discussions with other committees regarding allocations.
 - Overseeing concurrence discussions.
 - Actively working with other committees on the re-prioritization of populations and interventions for the 2011-2012 HIV prevention plan.
- ➔ Work conducted by the Nominations Committee in the past few planning cycles included:
- Reviewing applications and approving new members to the PPG.
 - Removing members with excessive attendance violations.
 - Ensuring new member orientation is user friendly and that individuals are comfortably engaged in the process.
 - Working on filling membership gaps via outreach methods.
- ➔ Work conducted by the Literature and Education Committee in the past few planning cycles included:
- Co-chair elections.
 - Reviewing the AED guidance on prioritizing interventions.
 - Examining research articles and meta-analysis literature reviews on the interventions most effective in reaching the various target populations.
 - Selecting factors to conduct intervention reviews based on available data.
 - Reviewing all the entries in the compendium of HIV prevention interventions and via the CDC website and in some cases contacting the primary intervention researcher.
 - Reviewing local data results from an online prevention provider survey as they related to the interventions being examined.
 - Review and consideration of current HIV interventions already implemented in the region via prevention provider panel discussions.
 - Working with the PPG to determine the weights of the factors selected.
 - Rating, scoring and ranking interventions using the AED based worksheets.

- Identifying a final list of interventions for the PPG to approve based on an average ranking score.
- Identifying other prevention strategies for the prevention system that promote HIV status awareness and linkages to care.
- Reviewing structural/policy interventions, strategies for prevention with positives, and local interventions.
- Assisting other committees in the development of a funding range for allocations.

➡ Work conducted by the Planning and Priorities Committee in the past few planning cycles included:

- Clarifying the current list of priorities.
- Receiving presentations on epidemiology data including national and local HIV incidence estimates, unmet need, substance use, mental health, and geographic gap analysis.
- Reviewing data and other statistics as they relate to potential HIV risk taking behaviors.
- Creating a list of social drivers/social determinants of health that may impact HIV risk taking behavior such as homelessness, poverty, incarceration, mental health issues, drug addictions, STDs, limited English proficiencies, etc.
- Creating a target population list based on data analysis.
- Establishing a list of factors to set priorities for the target populations such as HIV and AIDS incidence and prevalence.
- Emphasizing the importance of Syphilis as a key indicator despite the lack of information and making a note to request that the health department collect this data moving forward.
- Defining factors and developing examples of how the factors can be measured via scales.
- Developing a worksheet using the AED model as guidance that allowed PPG members to assign a weight value to each factor.
- Presenting the “weighting of factors” worksheet to the PPG for completion.
- Rating the factors to obtain a score, in order to rank the target populations.

- Defining high risk negatives as they relate to the prioritized target populations.
- Adjusting the Injection Drug Use (IDU) categorization to Sharing Infected Injection Paraphernalia (SIIP). The terms are used interchangeably throughout the document.
- Linking social factors to specific target populations and emphasizing the reduction of stigma.
- Endorsing the National HIV/AIDS Strategy and the Enhanced Comprehensive HIV Prevention Planning (ECHPP) strategies and their parallels with the PPG's plan.
- Assisting in the determination of allocation percentages for the target population based on the epidemic.

Prevention with Positives

- The PPG has collaborated with the Ryan White Part A Planning Council (RWPC) since 2003 to ensure that there is cross-communication and system-wide integration efforts between HIV prevention and HIV care wherever possible. A work group known as Points of Integration was responsible for this task and is made up of members of both planning bodies. This work group met to flush out recommendations for the Grantee to consider for integration. The work conducted by the Points of Integration Committee in the past few planning cycles included:
 - Developing four models of integration in the care settings of support groups, substance abuse treatment (inpatient and outpatient), and case management in 2005.
 - Developing a model around counseling and testing as the central roadmap for individuals entering into the system. Depending on the results of the individual's HIV test, the individual would be linked or referred to different services, whether prevention interventions, HIV care, prevention case management, etc.; also with the option of opting out of the system all together.
 - Recommending the use of Npep, when appropriate, as a means of HIV prevention in the Philadelphia care system.
 - Recommending linkages to care via the housing system.

- Emphasizing a demonstrated linkage and or the development of activities to enhance or integrate prevention messaging in CARE services where appropriate.
 - Recommending that where appropriate, care settings provide on-site HIV, STD and Hepatitis screenings as a part of routine screening. If not, linkages to HIV, STD and Hepatitis systems should occur.
 - Discussing Dr. Fenton’s grand rounds presentation at Drexel University on Program Collaboration and Service Integration (PCSI). Some initial barriers noted were lack of national guidelines, administrative requirements that restrict data sharing, differences in data collection systems, and lack of training, evaluation, and dissemination of best practices.
 - Recommending the use of a universal risk assessment tool for client intake and referral.
 - Recommending the use of the Prevention with Positives: Best Practice Guide as a standardized procedural tool for prevention with positives.
 - Endorsing the work of the Program Collaboration and Service Integration (PCSI) workgroup and its efforts to continue the integration conversation in Philadelphia.
 - This group will continue to be involved in the cross-collaboration discussions as requested by the various entities and will meet as necessary.
- ➔ The Positive Committee of the Ryan White Planning Council’s mission is to support and enhance the participation of PLWHA in community planning, in both the PPG as well as the Philadelphia EMA Part A Ryan White Planning Council.
- The committee meets monthly and discusses topics related to community planning, including training on epidemiological data, service provision, and how to best participate in community meetings.
 - The Positive Committee Co-Chair reports on the group’s activities at all PPG meetings and also brings PPG activities and discussions to the committee when appropriate.
 - The Positive Committee offer input on Prevention with Positives, as well as other prevention-related topics, whenever the general PPG body requires their expertise during the prioritization process.

Outreach and Cross Collaborations

- ➡ Community representation at the PPG has remained a priority for this group and outreach to members of other service areas, such as hepatitis, STD, and corrections continue on an ongoing basis.

- ➡ General recruitment efforts occur on an ongoing basis to fill in any membership gaps. Recruitment involves giving out membership applications and general information about the PPG and its activities.

- ➡ OHP staff also participate in the annual HIV Prevention and Outreach Summit during Philadelphia AIDS Education month when possible.

- ➡ Despite funding cuts that led to the disbanding of the Young Adult Roundtable, the PPG continually considers the special HIV prevention needs of youth in the community through outreach, communication and feedback efforts. Additionally, the PPG continues to include representatives whose primary area of expertise is youth.

- ➡ The PPG receives ongoing updates for planning and partnership purposes from national meetings such as the Urban Coalition of HIV/AIDS Prevention Services (UCHAPS), Communities Advocating for Emergency AIDS Relief (CAEAR), Suburban HIV/AIDS Coalition (SHAC) in the Pennsylvania suburbs, AIDS Coalition of Delaware County (ACDC) and the State PPG.



Section II – Community Services Assessment

Overview

- ➔ Provides needs assessment data
 - Prevention Provider Survey
 - Prevention Provider Panel Discussion
 - Philadelphia EMA Town Hall meetings
 - HIV case management interviews and surveys
 - AACO's Population Workgroup Results
 - Philadelphia Prevention System Overview

- ➔ Summary of the Integrated Resource Inventory for the Philadelphia EMA

- ➔ Summary of the Integrated Epidemiological Profile for the Philadelphia EMA

- ➔ Provides a geographic gap analysis
 - Gender distribution biology and genetics
 - Ethnic population distribution
 - Social and physical environment
 - Behavioral health
 - Sexually transmitted diseases
 - HIV/AIDS epidemic

- ➔ Includes a technical report on the association between HIV/AIDS rates and geographic areas of severe need in Philadelphia

Key Points to Consider

Needs Assessment Results

➤ *Prevention Provider Survey (n=56):*

- Twenty-four respondents estimated serving between 500 to over 1,000 prevention clients in 2008.
- Thirteen respondents estimated serving more than 200 HIV positive or AIDS diagnosed clients.
- Top prevention services provided by the respondents were basic HIV/AIDS education, safer sex information, client assessment and skills building.
- Top care services provided by the respondents were case management, support group, advocacy/peer counseling and mental health treatment.
- Older adults, teenagers, minorities, heterosexuals and homeless were listed as underserved populations by the respondents.
- Heterosexuals, youth, older individuals, MSM and minorities were observed as emerging populations at a high risk for HIV.
- When asked to report what risk behaviors were seen in these emerging populations, unsafe sex was by far the most common answer followed by IDU.
- Stigma, lack of understanding about HIV risk, fear, and not thinking a service was needed were barriers listed as affecting a client's ability to access services.
- Poverty, mental health issues, having STD's, homelessness, being unemployed, stigma, violence, and addictions were among the list for common factors contributing to a clients risk for acquiring HIV.
- Some services noted as difficult to obtain included housing, C&T results, education, and funding.
- More cultural sensitivity, more opportunities to network, more effective outreach and more trainings were listed as things that would help a provider serve their clients better.

- Some internet based prevention strategies used by some agencies included: web based outreach, use of social networking sites, text messaging programs, online informational videos on safe sex, and web based social marketing initiatives.
- Approximately 19 different HIV intervention strategies were selected by the respondents and reviewed. The majority of these interventions were deemed effective in changing a client’s risk behaviors.
- Fifty-seven percent of the respondents directly reported their PEMS data to the CDC.

➔ *Prevention Provider Panel Discussions:*

- With the intervention, *Protocol-Based Counseling*, success of the intervention was directly linked to the skill set and knowledge of the staff providing the service. Panelists found the intervention difficult to begin, as protocol-based counseling includes only a framework rather than formal materials or training. This intervention worked best for youth.
- With the intervention, *Safety Counts/ Safety Counts TIP*, success was based on adaptation and flexibility. The agencies found that it was sometimes difficult for clients to return to the organization on a monthly basis for all nine sessions and found it necessary to compress the timing of the sessions in order to increase retention a general interest from clients around Hepatitis C, and considered this portion of the intervention to be particularly successful. Incentives were also necessary for success.
- With the intervention, *Healthy Relationships*, success was based on its highly interactive structure and was found to be particularly effective with the deaf and hard-of-hearing population due to the highly visual nature of the intervention. Some limitations included outdated videos and needing significant time and money for recruitment.
- With the intervention, *MPOWERment*, success was possible because youth had an opportunity to take on leadership roles and mentor others, and participants were able to change and develop the program to meet their needs. So, despite outdated materials and videos, participants were able to discuss topics of interest to them. It was noted that participants did not always consistently attend sessions.

- With the intervention, *Comprehensive Risk Counseling and Services-CRCS*, success was based on having a client centered approach and providing services at various times of the day. Difficulties included lack of marketing opportunities. Retention was challenging and more training was needed.
 - Panelists were challenged in finding sensitive and competent resources for LGBTQ youth.
 - Panelists also cited specific difficulties when working with mentally challenged clients. Those providing CRCS should make considerations for each client’s learning style and level of health literacy.
 - Panelists noted that it would be important to register clients for syringe exchange as a part of harm reduction.
- With the intervention, *Video Opportunities for Innovative Condom Education and Safer Sex-VOICES*, adaptation to populations other than heterosexuals was difficult. Outdated, non-culturally competent videos were also a concern. It was noted that it was particularly important to use a facilitator that was both comfortable and had experience speaking about sex in a group setting.
- With the intervention, *Community PROMISE-Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community*, panelists reported that the intervention was empowering and therapeutic for both those providing role model stories and the underrepresented communities that received them. Difficulties included the intervention expense, lack of evaluation, limited availability of training and technical assistance, and retention. Panelists agreed that it was important to provide this intervention along with other interventions, and that HIV testing and condom distribution were key elements of the intervention.
- With the intervention, *Many Men, Many Voices (3MV)*, panelists agreed that the intervention allowed them to reach many underserved populations, such as transgender groups, sex workers, and ballroom youth. All panelists recruited at least in part using online tools. Panelists found training to be readily available, but reviews were mixed as to whether the program was most effective as a three-day retreat or weekly sessions. Retention was higher for the retreat program, but many individuals were unable to commit to an entire weekend.
- With the intervention, *Becoming a Responsible Teen-BART*, the program was adapted for high schools. Small groups and role playing worked well.

Evaluation showed an increase in condom use and delays in sexual encounters, although facilitators still found challenges with self-esteem issues. Facilitators were also unable to attend formal training.

- With the local intervention, *Preventing AIDS through Live Movement and Sound-PALMS*, panelists used theater to facilitate prevention messaging. Facilitators needed a strong acting background in addition to a strong HIV background, which was difficult to provide. Attrition had also been a difficulty. Evaluation showed improved attitudes toward PLWHA and HIV testing, as well as increased condom use. The program incorporated STD screening, and partnered with agencies providing counseling and testing services as well as linkage to youth primary care.

➡ *Town Hall Meetings (n=140):*

- There were a total of 117 individuals who filled out the survey in 2010. Respondents were asked about the use of HIV prevention services during the past year. Of the HIV positive participants in the survey, the top three prevention services used by the consumers were condoms or safe sex kits (72%), information on safe sex practices (56%), and information on disclosure (43%). The remaining prevention services used were information on substance use (32%), street outreach (22%), partner notification (21%), information on needle exchange programs (13%), information on HIV counseling for pregnant women (9%), and safer injection/bleach kits (8%).

➡ *Case Management Key Informant Interviews and Surveys (n=27 - interviews, n=31 - surveys):*

- A total of 16 agencies from the EMA resulted in 27 case manager interviews and 31 surveys collected in 2008.
- Of the 30 HIV case managers interviewed, 7 case managers mentioned that all of their clients were using drugs and/or alcohol, 5 respondents mentioned their clients had mental health problems and, 4 mentioned homelessness as a special need for their clients.
- 37% of the case managers estimated that between 20-35% of their client base had substance abuse problems, while 33% estimated between 75-95% and 30% estimated between 40-70% of their clients had substance abuse problems.

- 40% of the case managers estimated that between 80-99% of their clients had mental health problems, while 33% estimated that between 55-75% of their clients had mental health issues. Additionally, 27% of the case managers estimated that between 25-50% of their client base had mental health problems.
- 93% of case managers noted that most of their clients had 'medium to high needs'.
- 85% of the case managers articulated that they provided some sort of HIV prevention to their clients.
- For the services that many clients needed but did not get, housing was mentioned 19 times, while mental health and drug and alcohol services were mentioned 6 times respectively.

➔ *AACO's 2009 Population Workgroup Results* (n=unavailable):

The top 3 areas identified by the *Heterosexual* work group were:

- More funding for mobile testing.
- Better collaboration to target hot spots with other providers and make use of census track data to inform the work.
- Develop innovative and collaborative efforts with other providers.

The top 3 areas identified by the *MSM* work group were:

- Develop new creative strategies outside of current list of DEBIs.
- Research best practices in different areas and adapt to Philadelphia.
- Develop strategies to collaborate with other systems including mental health and substance abuse.

The top 3 areas identified by the *Youth* work group were:

- Make use of non-traditional access points to provide testing and prevention services to youth.
- Work with and establish coordinated conversations with other stake holders i.e., School District of Philadelphia, Juvenile Justice Center, Boys & Girls Clubs, etc.

- Improve collaboration and communication among youth HIV prevention providers including better ways to promote agencies and their services.

➡ *Philadelphia HIV Prevention System Overview:*

- The currently funded Philadelphia HIV Prevention System distributes resources among the prioritized target populations and science-based interventions in the following manner:
 - AACO allocated approximately 50% of the HIV prevention funding to programs targeting heterosexuals, about a third to MSM and 19% to IDU. Most recipients were HIV negative (80%) and 67% were adults.
 - AACO allocated 50% of the HIV prevention funding to CTR programs, about 34% went to HE/RR, 15% to CRCS and 1% went to HC/PI. Approximately, 20% of the funding went to home grown GLI's.
- There were 144 new positives that received their results indicating a 71% return rate.
- Most tests were performed on males (33,977) with 286 positive results and a sero-positivity rate of .84. There were 40,728 tests given to Black/African American clients, with 277 positive results and a sero-positivity rate of 0.68. By age, most clients were between 25-34 years old (16,179) with 100 positives and a .62 sero-positivity rate.
- Most tests were taken by heterosexuals (37,185) followed by MSM (9,273). There were 125 positive results for the Heterosexual group with a sero-positivity rate of .34 and 139 positive results for the MSM group with a sero-positivity rate of 1.50.
- There were 889 newly reported HIV positive individuals. Of that total, 359 were offered PCRS, and 237 agreed to it. From that effort, 317 partners were elicited, with 177 partners being notified of their possible exposure risk. This resulted in 83 partners receiving an HIV test, 18 of whom received a newly identified, confirmed HIV positive test. There were 59 partners with a previously confirmed HIV positive test.
- The top three HIV testing sites were in zip codes 19146 (10,515 tests), 19136 (9,367 tests), and 19107 (7,361 tests). The top three zip codes of the client's residence were in 19132 (3,380 clients), 19134 (3,009 clients) and 19140 (2,959 clients).

- There were 31,831 clients who identified as heterosexual, most resided in 19132, 19134, and 19140. There were 6,898 clients who identified as MSM, most resided in 19146, 19143, and 19107. For those clients who identified as IDU (2,116), most resided in zip codes 19134, 19133 and 19140.

Integrated Resource Inventory

- ➔ The resource inventory has been prepared as a tool for consumers, providers and other interested parties to learn about the HIV/AIDS resources available in the Philadelphia eligible metropolitan area.
 - The full inventory is over 450 pages with over 396 entries listing HIV care and prevention service providers throughout the region.

Integrated Epidemiological Profile

➔ *Section I: Demographics.*

- In 2009, the City of Philadelphia had the largest concentration of minority populations within the EMA with approximately 56%, while representing 30% of the EMA's total population.
- Overall, females outnumber males by a small percentage, approximately 3.39%, with White females age 50 and over representing the single largest segment of the population in the EMA at 10.76%.
- More females than males had some college, an associate's degree, a bachelor's degree or a graduate or professional degree.
- Asian Pacific Islanders had the highest percentage of linguistically isolated households.
- Philadelphia had the highest percentage of the general population below the poverty level with 24.96%, or 374,226 persons.
- The majority of supplemental security and public assistance recipient households were in Philadelphia.
- Philadelphia had the lowest median income of all nine counties with \$28,926.
- Of the total state population Pennsylvania had approximately 11% uninsured in 2009.
- Live births among teenagers have fluctuated over the last five years.
- The highest case rate per 100,000 for tuberculosis cases in 2009 was in Philadelphia at 10.2.

➔ *Section II: Indicators of Risk.*

- According to 2009 Behavioral Risk Factor Surveillance System (BRFSS), approximately 40% of adults had been tested for HIV disease. Over 24% were between the ages of 30 and 39 years old, and the majority were Black and tested at a private doctor's office, hospital or clinic.
- According to the Youth Risk Behavior Surveillance System (YRBSS), in 2007, 25.2% of the students in Philadelphia were offered, sold or given an illegal drug on school property by someone during the past 12 months.
- Treatment Episode Data Set (TEDS) data for the EMA in 2008 showed that the majority of the patients were males (69%), White (72%), unemployed (51.2%) and uninsured (51.5%). Treatment was for alcohol, followed by heroin/opiates, crack/cocaine and marijuana/hashish.
- The National Household Survey on Drug Abuse (NHSDU) estimated that in Pennsylvania, 41,000 of those 12 to 17 years old and 94,000 of those 18-25 were drug dependent during 2006 and 2007.
- The Uniform Crime Report (UCR) in 2009 showed that a total of 1,027 persons were arrested for prostitution and commercialized vice in Philadelphia.

➔ *Section III: Scope of the HIV/AIDS Epidemic.*

- In 2009, Philadelphia accounted for 73.76% or 20,720 of the total AIDS cases and 78.33% or 11,362 of those living with AIDS in the EMA.
- The majority were Black, Male and either MSM or Heterosexual.

➔ *Section IV: Service Utilization Patterns.*

- Philadelphia gave 44,391 HIV tests in 2007. Of those tested, 719 (1.6%) tested positive (73% males and 27% females); by race and ethnicity those testing positive were: White 13%, Black 67%, Hispanic 15.5%, Asian/Pacific Islanders 1.5%, and less than 3% were American Indian/Alaskan Native, Other or race not specified. By age, most positive tests were among those 35 to 44 years old, with a positivity rate of 2.75, in Philadelphia County. The primary exposure category was MSM.

- From the AACO implementation plan, the most used services were case management and primary medical.
- Most clients in both the Pennsylvania and New Jersey counties were between 40 and 49 years old, male and black.
- According to the National ADAP Monitoring Project, in 2009 neither New Jersey nor Pennsylvania reported having a waiting list for clients to access ADAP.

➡ *Section V: Measuring Unmet Need.*

- Unmet need was estimated for the city of Philadelphia by AACO. Unmet need was defined by HRSA as people who know their status but are not in primary medical care. The estimated number of individuals with HIV/AIDS not receiving primary medical in Philadelphia EMA in 2009 was 7,029 (27%).
- The Commonwealth of Pennsylvania, Department of Health, HIV/AIDS Epidemiology Section, Bureau of Epidemiology, Division of Infectious Diseases estimated unmet need for the southeastern region which includes the four Pennsylvania EMA counties. The total estimated number of PLWHA who know their status and are not in primary medical care was 8,027.
- Epidemiological data was provided in 2010 to address the next prevention plan's target population. Preliminary data reviews indicate that PLWHA, uninfected high risk sex or needle sharing partners, and minority IDU's, MSM's, and Heterosexual's over 25, continue to be at high risk for HIV.

Geographic Gap Analysis

- ➡ The Geographic Risk and Service Gap Analysis shows:
 - Philadelphia remains highly segregated by both income and race.
 - Neighborhood economics, as they intersect with race, severely affect PLWA.
 - Language barriers, cultural barriers, gender barriers, and residential segregation may keep members of specific minority groups from seeking HIV/AIDS services beyond their communities.
 - Racially segregated portions of the city experience social pathologies – higher levels of crime, more problems with housing, more complaints to city

departments, more births to teenagers and/or to women with late/no prenatal care, etc.

- Psychological stress and economic stress related to life in these neighborhoods can serve as barriers to care.
- In 2009, African American/Blacks represented the majority of the Gonorrhoea, Chlamydia and Syphilis cases in Philadelphia.
- In 2009 more HIV cases have occurred among those who identify as Black (67%).
- Currently 37% of the newly reported HIV cases by exposure were MSM, Heterosexual exposure was approximately 25%, and 11.35% were IDU/SIIP.
- Most of the areas with higher AIDS case rates are located in South Philadelphia, Center City, North and parts of West Philadelphia.
- Prevention providers need to adapt to these unique situations when providing services.

Association of HIV/AIDS Rates and Geographic Areas of Severe Need in Philadelphia

- ➔ The neighborhoods with the highest rates of PLWHA include: Center City, Schuylkill-Point Breeze, Millcreek-Parkside, Strawberry Mansion, Sharswood-Stanton, Poplar-Temple, Northern Liberties-West Kensington and Nicetown-Tioga.
- ➔ Rates of PLWHA are generally higher in Philadelphia geographic areas that have:
 - low socio-economic status
 - high concentrations of black residents
 - high death rates from homicide, AIDS, septicemia or other illness
 - high birth risk
 - high neighborhood instability
 - high crime rates of multiple types



Section III – Priorities and Recommendations

Overview

- Provides an overview of the six key HIV prevention strategies for persons living with HIV/AIDS (PLWHA), their high risk partners, and for high risk negatives.
- Describes the planning process for the prioritization of populations and interventions.

Priority population recommendations.

- Two part definition of those considered a high priority in Philadelphia.

Priority intervention recommendations.

Endorsement of the 22 strategies in Philadelphia’s Enhanced Comprehensive HIV Prevention Planning (ECHPP) document.

Funding range recommendations.

- Additional recommendations for addressing priority populations.

Key Points to Consider

The six prevention strategies are as follows:

1. Increase HIV status awareness
 - a. Provide routine opt-out HIV testing in clinical settings,
 - b. Provide HIV testing in non-clinical settings, and
 - c. Provide linkages to care services for people with HIV positive tests
2. Conduct prevention efforts with PLWHA
 - a. Provide behavioral risk screenings followed by risk reduction interventions for HIV positive persons
 - b. Implement on-going partner services for HIV positive persons
 - c. Provide STD, TB & Hepatitis C screenings for HIV positive persons, and
 - d. Provide Health Education/Risk Reduction (HERR) and Adherence interventions, linkage to and retention in care to PLWHA
3. Offer effective, science based interventions to high risk negatives
 - a. Provide behavioral risk screening followed by individual and group level interventions for high risk negatives
 - b. Provide community level interventions that reduce HIV risk
4. Create structural and policy interventions that impact change in the larger environment
 - a. Distribute condoms to the community
 - b. Pursue efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention
 - c. Generate social marketing campaigns to help eliminate stigma, change risk taking behaviors, and promote other relevant prevention efforts
 - d. Utilize other large scale impact prevention strategies, such as the use of online social media
 - e. Provide Pre and Post-Exposure Prophylaxis (PrEP, PEP) treatment within a health care setting for high risk exposures to HIV within a 48 hour period
5. Develop local interventions that are culturally appropriate and sensitive to the needs of the community
 - a. Offer interventions and or programs that are home grown, i.e. developed locally and that are science based and have an evaluation component
 - b. Provide syringe access programs to minimize transmission risks for injection drug users
6. Provide perinatal based interventions
 - a. Implement strategies for the prevention of perinatal transmission

- ➔ Seven steps in the AED guidance were followed to prioritize target populations and interventions. These steps included identifying populations and interventions, and then selecting factors which were then weighted and rated. This created a ranking score for each population and intervention reviewed.
- ➔ Social factors or social determinants of health are critical when considering how to effectively provide HIV prevention to communities at risk.
- ➔ PLWHA were ranked as a top priority for the PPG, followed by, MSM, High risk Heterosexual males, and SIIP (IDU) Males. See full list below:

Final Prioritized List of Target Populations

1. PLWHA
2. Men who have Sex with Men (MSM)
3. High Risk Heterosexual Males
4. SIIP (IDU) Males
5. High Risk Heterosexual Females
6. Transgender (TSM, TSIIP)
7. SIIP (IDU) Females
8. Perinatal

- ➔ HIV prevention messaging for secondary prevention and re-infection should be focused on the number one prioritized population of PLWHA, followed by high risk negatives as defined in Part A & B below:

A) Persons known to be at high risk for acquiring HIV infection through:

- The shared use of infected injection paraphernalia (e.g. syringes, needles, cookers, spoons) by two or more people that may result in exposure to blood
- Unprotected vaginal, anal, or oral sex with a person known to be HIV+ that may result in exposure to semen (including pre-seminal fluid), vaginal fluids, and/or blood
- Unprotected vaginal, anal, or oral sex with a person with unknown or undisclosed HIV status that may result in exposure to semen (including pre-seminal fluid), vaginal fluids, and/or blood
- The shared use of infected injection paraphernalia and/or unprotected vaginal, anal, or oral sex with a member of a population or geographic community with high sero-prevalence that may result in exposure to semen (including pre-seminal fluid), vaginal fluids, and/or blood

Population Grid*			
	Men	Women	Trans
PLWHA			
Uninfected high risk sex or needle sharing partners of PLWHA			
IDU (SIPs)	African Americans (25+) Latinos (25+)	African Americans (25+) Latinos (25 +)	African American TSM under the age of 40
MSM	African Americans 13-24 & 25-64 Latinos 13-24 & 25-64 Caucasians 25-64	N/A	
High Risk Heterosexuals	African Americans 13-24 & 25-64 in North & West Philadelphia	African Americans 13-24 & 25-64 in North & West Philadelphia	

**Please note that any other populations that fit into the criteria shown in part A & B of this definition, but not listed, can also be considered at risk for HIV.*

B) And, persons who reside in geographic areas impacted by the following underlying social drivers thereby experiencing greater disparity (as suggested by the PPG & PHMC's severe need report **):

- Low socio-economic status
- High neighborhood instability
- Lack of literacy/educational opportunities
- Lack of access to health care and poor health outcomes
- High birth risk
- High rates of HIV/STDs
- High death rates from homicide, AIDS, septicemia or other illnesses
- High rates of substance use
- High rates of mental illness
- High crime rates of multiple types
- History of incarceration
- Homelessness
- Immigration/Undocumented Status
- Disability
- Cultural values and norms
- Stigma

The following neighborhoods are considered at highest risk in Philadelphia (as suggested by PHMC's severe need report): **Sharswood-Stanton** (Lower North Philadelphia), **Millcreek-Parkside** (West Philadelphia), **Strawberry Mansion** (North Philadelphia), **Poplar-Temple** (North Philadelphia), **Nicetown-Tioga** (North Philadelphia) and **Hunting Park-Fairhill** (North Philadelphia).

*****See additional details on social drivers & severe need in the CSA Section of the prevention plan.***

There are 17 approved science based interventions that should be considered when providing prevention services in Philadelphia. Comprehensive Risk Counseling Services (CRCS) should be given to all five risk populations based on a client's personal needs. All interventions should focus on the end goal of reducing new infections, increasing access to care and improving health outcomes as suggested by the National HIV/AIDS Strategy.

Final Approved List of Prioritized Interventions for Philadelphia

Population: HIV-Positive Mean: 230.109

Recommended Interventions	Score
Project HEART	231
Willow	250
Healthy Living Project	251
Partnership for Health	254
Teens Linked to Care	265
CRCS	274
Healthy Relationships	279

Population: MSM Mean: 260.329

Recommended Interventions	Score
Teens linked to Care	265
CRCS	274
Healthy Relationships	279
Many Men, Many Voices	280
Brief Group Counseling	283
Community Promise	300
Prison Case Management	320

Population: High Risk Heterosexuals Mean: 230.056

Recommended Interventions	Score
Safer Sex Skills Building	233
Female and Culturally Specific Negotiation	235
Project FIO	243
VOICES/VOCES	243
Willow	250
Sister-to-Sister	253
Focus on the Future	264
Light	267
CRCS	274
RAPP	290
Safe in the City	293
Community Promise	300
Prison Case Management	320

Population: IDU/SIIPS Mean: 247.357

Recommended Interventions	Score
Strive	263
SHIELD	268
CRCS	274
Community Promise	300
Safety Counts/ Safety Counts-TIP	304
Prison Case Management	320

Population: High Risk Youth Mean: 254.199

Recommended Interventions	Score
Teens Linked to Care	265
BART	289
Be Proud! Be Responsible!	290
Street Smart	294
PALMS Project	298
Community Promise	300.523
CUIDATE	300.577
SiHLE	300.577
Teen Health	311
CRCS	274

➔ The PPG’s six approaches to prevention, including the above mentioned interventions should be viewed in conjunction with the following **22 strategies** proposed by the Philadelphia’s **ECHPP plan** when providing HIV prevention services to the community in Philadelphia:

1. Implement routine, opt-out screening for HIV in clinical settings
2. Implement HIV testing in non-clinical settings to identify undiagnosed HIV infection
3. Target condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection
4. Provide Post-Exposure Prophylaxis (Pep) to populations at greatest risk
5. Implement efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment
6. Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care

7. Implement interventions or strategies promoting retention in or re-engagement in care for HIV positive persons
8. Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV positive persons
9. Implement interventions or strategies promoting adherence to antiretroviral medications for HIV positive persons
10. Implements STD screening according to current guidelines for HIV positive persons
11. Implement prevention of perinatal transmission for HIV positive persons
12. Implement ongoing partner services for HIV positive persons
13. Implement behavioral risk screening followed by risk reduction interventions for HIV positive persons (including those for HIV-discordant couples) at risk for transmitting HIV
14. Implement linkages to other medical and social services for HIV positive persons
15. Target condom distribution to HIV negative persons in the general population who are at risk of HIV infection
16. Conduct HIV and sexual health communication or social marketing campaigns targeted to relevant audiences
17. Support clinic wide or provider delivered evidence base HIV prevention interventions for HIV positive patients and patients at highest risk for acquiring HIV
18. Conduct community interventions that reduce HIV risk
19. Support behavioral risk screening followed by individual and group level evidence based interventions for HIV negative persons at highest risk of acquiring HIV; particularly those in an HIV sero-discordant relationship
20. Integrate hepatitis, TB, and STD testing, partner services, vaccination and treatment for HIV infected persons, HIV negative persons at highest risk for acquiring HIV, and injection drug users according to existing guidelines
21. Target use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis
22. Support syringe access services

Funding Range Recommendations by Prevention Type

HIV Status Awareness - 40 to 50%

1. Routine opt-out testing in clinical settings
2. Testing in non-clinical settings
3. Demonstrated linkage to care for people with positive tests

Prevention with PLWHA - 15 to 20%

1. Behavioral risk screening followed by risk reduction interventions for HIV positive persons
2. Implement on-going partner services for HIV positive persons
3. STD, TB & HepC screening for HIV positive persons
4. HERR

DEBIs & EBIs - 15 to 20%

1. Behavioral risk screening followed by individual & group level interventions for high risk negatives
2. Community interventions that reduce HIV risk.

Structural Interventions & Policy - 8 to 10%

1. Condom Distribution
2. Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention (other examples)
3. Social marketing campaigns
4. PEP
5. PrEP

Local Interventions - 8 to 10%

1. Interventions and or programs that are home grown/developed locally, are science based, and have an evaluation component
2. Syringe Access

Perinatal - 9%

1. Implement prevention of perinatal transmission

- ➡ Special consideration should be paid to those hard to reach populations with unique concerns such as non-gay identified MSM, the Transgender community, the visually impaired and deaf and hard of hearing populations, those with limited English proficiencies, and the incarcerated.
- ➡ The PPG set aside 8% of the funds for “innovative programs” focusing on populations that are disproportionately affected by HIV/AIDS, regardless of HIV status.
- ➡ The PPG is always looking to expand its membership and openly invites stakeholders from Ryan White, SAMHSA, HOPWA, STD, TB, HEPc, the State, and other interested parties to join them in planning for HIV prevention services in Philadelphia.



Section IV – Monitoring and Evaluation

Overview

- ➔ Monitoring the community planning process
 - PPG membership survey results

Key Points to Consider

- ➔ There were 16 respondents to the PPG membership survey with an average attendance of 7 meetings and an average length of membership of 2 years.
- ➔ The majority of respondents indicated that community planning supports broad based community participation.
- ➔ The majority of respondents indicated that community planning identifies priority HIV prevention needs in each jurisdiction.
- ➔ The majority of respondents indicated that community planning ensures that HIV prevention resources target priority populations and prevention activities that are set forth in the plan.
- ➔ The PPG needs to focus on ensuring that the new members on the planning body are clear on the process steps necessary to accomplish their prioritization of populations and interventions, since they are engaging in the midst of a multi-year cycle.
- ➔ Membership improvement is needed in the areas of corrections and substance use.



