

**Community Planning Group
Planning Priorities Committee
Meeting Minutes**

Monday, January 25th, 2010

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Andrew de los Reyes

Guest: Robert K. Burns

Staff: Joseph Ellis, Michael Milsop

Excused: David Acosta, Rick Feely, Denette Lineau, David Powell

Call to Order

M. Castillo called the meeting to order at 1:05 pm.

Approval of Agenda

After taking a moment to review the agenda, the group approved the document by general consensus.

Approval of Minutes (*December 7th, 2009*)

The group spent some time reviewing a draft of the minutes from their last meeting. A. de los Reyes noted that, on page three of the document, his job title was incorrectly listed. He clarified that his correct title was “Assistant Program Manager.” With the correction noted, the group approved the draft of the minutes by general consensus.

Report of Staff

M. Milsop reported that Dr. Fenton had recently given a lecture at Drexel University on the developing state of PCSI (Program Collaboration and Service Integration). He said that the new community planning guidance would likely include some language on PCSI because Dr. Fenton had stated his desire for the document to address it specifically. He reported that, although all the CDC disease systems were separate and would not have to merge, Dr. Fenton had stated that the systems would have to work together. A. de los Reyes added that language for PCSI would be included in future guidelines and RFAs and was already a standard in most applications for federal funding. He also noted that Philadelphia had already taken a number of steps towards integration measures and, therefore, would not likely have much difficulty adapting to any forthcoming mandates on the matter. Additionally, he noted that, although funding for the implementation of PCSI was likely, he had not yet heard of any specific information on the matter. M. Milsop also informed the group that, according to Dr. Fenton, new guidelines for the CDC portfolio of disease systems would make each of them more consistent with one another. A. de los Reyes supported the statement, saying that he believed the CDC was now fully aware of the discordance between the systems and working to correct it.

Report of Co-Chair

None

Discussion Items:

- **Plan Partner Services Presentation**

A. de los Reyes noted that, as discussed at the last PPC meeting, the purpose of his presentation was to provide the CPG with information on the most up-to-date version of the partner services guidelines, which had been released nearly a year and a half ago. He said that he hoped the presentation would clear up some of the misconceptions about PS (Partner Services) that were still held by many. He told the group that, although the guidelines were integrated for use by all of the disease systems, his presentation would only focus on issues related to HIV in order to keep the presentation at a manageable length. He then asked the PPC to suggest any revisions for the presentation that came to their minds (see handout for more details).

M. Castillo asked to what degree the new guidelines affected the existing PS at the time of their release. A. de los Reyes replied that, while there were some challenges, the process was not as difficult in Philadelphia as it was in other cities because of the strong STD control system that had already been in place.

A. de los Reyes told the group that the CDC had already put a great deal of work into developing the new guidelines before they asked CBOs for suggestions on further revisions. He felt as though most CBOs had already offered some form of PS, even though it was sometimes done unconsciously, in order to increase testing. However, he said that available data showed that PS were more effective when offered by a Health Department specialist instead of a CBO. He told the group that, even though positivity rates did not differ much when the services were offered by the Health Department or CBOs, he supported having the Health Department conduct the process in order to avoid straining the relationships between counselors and their patients.

In response to the statement that the new guidelines targeted program managers, M. Milsop said that, according to Sam Dooley, the Associate Director for Science and Program Integration who was in charge of the guidelines, different levels of staff workers would be responsible for different aspects of PS notification. A. de los Reyes replied that many different levels of staff would attend the training and that there would be a number of strategies used for partner notification, including use of the internet and collaborations between counselors and the Health Department. However, he said that he would follow up with Sam Dooley on the matter before delivering his presentation in February.

On the matter of whether patients or providers would be responsible for referrals to PS, R. Burns asked whether there was any data available to show that certain populations found one of the two options more agreeable. He noted that, because many African American MSM did not identify as gay, they would likely be less inclined to agree to provider referrals. A. de los Reyes replied that there was data on the preferences of populations in the guidelines and that he would provide the PPC with the information at their next meeting. However, he could not recall any specifics at the moment.

D. Acero pointed out that notification from providers could lead to domestic violence in some instances. A. de los Reyes agreed and reported that, unfortunately, there was not yet much investigation into whether there was a link between PS and domestic violence. However, he said that the guidelines required providers to ask about domestic violence because the authors were aware of its potential. He informed the group that, although the Health Department had a preferred approach for dealing with the matter, it was not always in line with the preferences of providers. He said that the discussion on a connection between domestic violence and PS needed to continue.

On slide 23, *HIV Partner Services PDPH/STD Control Snapshot 1/08 – 6/09*, A. de los Reyes noted that most of the 31 new diagnoses were newly infected. He said that he was working to get STAHRS data for confirmation but, preliminarily, it seemed that a vast majority of the diagnoses were new infections. He also clarified that not everyone interviewed had given the names of their partners for notification.

R. Burns asked whether information was available on the cost per service for each of the 352 partners elicited. A. de los Reyes replied that a medical epidemiologist was currently working on a cost/benefit analysis for the services. However, he said that, as there were only four full-time employees dedicated specifically for PS, the program was probably cost-effective by staffing measures. However, he noted that there would eventually need to be more staffing resources because four individuals would not be able to handle the services' future volume.

M. Castillo suggested including in the presentation a list of reasons why individuals would refuse PS. A. de los Reyes replied that PS did not collect such information. However, he asked the group whether they had any thoughts about why individuals would refuse the services. M. Castillo stated that youth would likely refuse PS because they feared the stigma attached to an HIV positive status. Additionally, she stated that some youth simply preferred to have anonymous sex. M. Milsop said that some individuals also rejected PS because they were unaware of how the law worked and feared prosecution for infecting others.

A. de los Reyes asked the committee whether they had any further suggestions for his presentation and whether they felt that its length was appropriate. The rest of the group offered no further suggestions.

- **Plan Process for Weighting Factors**

M. Milsop reminded the group that their next step in the prioritization process was to have the CPG weight the factors for prioritizing populations, which the PPC had selected at their last meeting. He explained that, once the factors were weighted, they would be applied to the draft list of prioritized populations to produce the final version. He then asked the committee how they wanted to explain the process to the CPG, noting that there were some exercises that could be used to give the CPG a chance to practice the process.

M. Castillo suggested that the PPC first review their factors and draft list of priority populations for the CPG, in order to give them a sense of where they were in the process. After that, she continued, the committee would explain the weighting process and its importance. M. Milsop suggested that the PPC explain each of the factors to the members of the CPG, so they would fully understand what they were weighting.

A. de los Reyes suggested sending out an email before the meeting that would prepare the CPG members for the weighting process. He noted that, by doing so, the group could cut down on the amount of explanation that would have to be included in their presentation. Although the rest of the group supported the idea of a preparatory email, they did not feel that it would be able to replace explanation in the presentation because some members might not review the information in the email. However, M. Castillo suggested giving a preview of the process at the February CPG meeting and then sending out an explanatory email before the March meeting, at which the weighting process would take place. The rest of the group supported the idea. M. Milsop said that he would develop a worksheet for the weighting process so that the group could review it at their next meeting.

Old Business

None

New Business

None

Review/Next Steps

- A. de los Reyes gave the group a preliminary version of his upcoming presentation on Partner Services so that the committee could discuss any potential revisions.
- The PPC also planned how they would undertake their upcoming process of weighting factors for prioritizing populations.
- The next meeting of the PPC is scheduled for Monday, February 22nd, from 1:00 – 3:00 pm.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 2:23 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*December 7th, 2009*)
- Factors for Setting Priorities for Target Populations
- OHP Meeting Calendar

COMMUNITY PLANNING GROUP (CPG)

Planning Priorities Committee

Meeting Agenda

Monday, January 25th, 2010

1:00 p.m. – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Co-Chairs

Discussion Items:

- **Plan Partner Services Presentation**
- **Plan Process for Weighting Factors**

Old Business

New Business

Announcements

Adjournment

*The next meeting of the Planning Priorities Committee is scheduled for
Monday, February 22nd, 2010 from 1:00 - 3:00 pm
At the Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia*

*Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org,
for updated committee meeting information.*

Please contact the office at least 5 days in advance if you require special assistance

**Community Planning Group
Planning Priorities Committee
Meeting Minutes**

Monday, December 7th, 2009

1:00 – 3:00 p.m.

The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: David Acosta, Marné Castillo (Co-Chair), Tony Daniel (Co-Chair), Andrew De Los Reyes, Rick Feely, Denette Lineau

Staff: Joseph Ellis, Monica Getahun, Michael Milsop

Excused: Dawn Acero, David Powell

Call to Order

M. Castillo called the meeting to order at 1:15 pm.

Approval of Agenda

After taking a moment to review the agenda, the group approved the document by general consensus.

Approval of Minutes (*November 10th, 2009*)

The group spent some time reviewing a draft of the minutes from their last meeting. Afterwards, they approved the document by general consensus.

Report of Staff

None

Report of Co-Chair

None

Discussion Items:

• **Reviewing Issues Raised during the CPG Presentation in November**

M. Milsop reminded the group that, during their presentation at the last CPG meeting, a few concerns had been raised about the committee's draft list of prioritized populations. One of the concerns, he continued, had been that Southwest Philadelphia was not specifically mentioned in the committee's geographical indicators of risk for Heterosexual populations. However, he noted that Southwest Philadelphia was a part of West Philadelphia, which had been included in the geographical indicators. He then directed the group's attention to a packet in the handouts containing maps of incidence rates by Census tracts in Philadelphia. He said that the committee could use the maps at the current meeting to determine whether they wanted to change any of their geographical indicators. However, he reported that K. Brady would have maps of 2008 data available by the following week. M. Castillo felt that the committee should simply clarify to the CPG that West Philadelphia included the zip codes in the Southwest part of the city with high incidence rates. She suggested providing the planning body with the

map of incidence rates with the zip code overlaid for clarity. The rest of the group supported her suggestion.

Moving on to the next concern raised at the CPG meeting, M. Milsop reminded the group that one individual had felt that the priorities for African American MSM should focus only on 20 – 29 year olds instead of all age groups because they had the highest incidence rate for the population. He then directed the group's attention to the handout entitled *Newly Diagnosed HIV among Men who Have Sex with Men (MSM)*, which he had obtained from K. Brady so that the committee could make a decision on the issue. He pointed out that the data in the handout was from 2006 – 2008 and was broken down by both age and race. Reading over the handout, M. Castillo noted that, while 20 – 29 year old African American MSM had the highest incidence rate, the population's other age groups also exhibited alarmingly high infection rates. D. Acosta agreed and added that, since the infection tended to pass from older to younger populations in the MSM community, it would be a mistake not to focus on the older age categories as well. M. Milsop added that older members of the population were more likely to quickly progress from HIV to AIDS after testing positive. He told the group that data on concurrent HIV/AIDS would become more important with the release of the next Ryan White guidance, which would call for closer adherence to the community prevention plan.

D. Acosta asked whether the information in *Newly Diagnosed HIV among MSM*, could be distributed to the CPG through email instead of waiting for the body's next meeting. However, M. Castillo felt that it would be important to explain how the information in the handouts supported the committee's decision. M. Milsop agreed and noted that, regardless of other concerns, the process would have to take place on record.

Looking through the *Newly Diagnosed* handout, M. Castillo suggested extracting the charts that were relevant to their discussion before the CPG meeting so as not to overwhelm the group with unrelated information. The rest of the group agreed and decided to use only the charts on race and age for their discussion with the CPG.

In response to a question by D. Acosta, M. Castillo clarified that, at the next CPG meeting, the committee would only respond to the issues raised last time and not deliver an entirely new presentation. M. Milsop supported the statement but suggested allowing time for discussion after the committee reported their decisions. The rest of the group agreed.

M. Castillo reminded the group that some individuals had expressed concern over the absence of Asian populations from the priorities. She said that, even though the committee had explained that the population had been left out because of its small infection rates, it might be worthwhile to talk about some of the population's issues with the CPG during the upcoming panel discussions. D. Acosta supported the idea, but suggested holding a presentation that focused on APIs' social and cultural factors since epidemiological data on the population was highly limited. He said that it was difficult to provide members of the population with prevention services, including testing, because their culture was not very accepting of open discussions on sexuality. M. Milsop

supported the idea of holding a conversation on API populations with the CPG; however, he reminded the group that the Lit & Ed Committee was planning the upcoming panel discussions only to collect data on prevention programs for their prioritization process. He then reported that Dr. Fenton had announced that a CDC consultation on APIs would soon be convened because national infection rates among the population had recently increased significantly. Additionally, he said that, while a discussion on APIs could enrich the application for prevention funding, the inclusion of 'culture' in the list of social drivers had already accounted for the difficulties of reaching the population in the prioritization. M. Castillo stated that she only wanted to address the concern about API populations that had been raised at the last CPG meeting. However, she noted that it would be important to ascertain how prevention services could better be suited to the needs of API populations. She asked whether any local groups would be helpful for facilitating such a discussion. M. Milsop stated that the care system had talked with some local groups for insights into API populations; however, he noted that none of the groups were HIV specific and therefore could only provide raw data on population sizes and languages but nothing epidemiological. M. Castillo suggested that the committee simply tell the CPG that they were looking into facilitating a discussion to address the lack of data on API populations. The rest of the group agreed.

M. Milsop told the group that some members of the CPG had been concerned about prioritizing uninfected, high-risk sex partners or syringe sharing partners of PLWH/A, as the CDC had suggested in the application, because the Surveillance Unit did not have any data on the population. He said that, as a result, he had obtained some data from local and state Partner Services to support the group's decision. As the committee began to read over the two handouts, he explained that he had sought out the additional state data because the city's had been underdeveloped. He then pointed out that the state's partner positivity rate was extremely high. A. de los Reyes told the group that, as the STD manager for Partner Services, he believed the handout with the local data was missing some information. He then offered to get local Partner Services data from the STD system for the PPC.

D. Acosta felt that Partner Services were being somewhat ignored because they were closely tied in with counseling and testing. As a result, he said that he advocated separating the two services and suggested that the PPC hold a conversation on the matter. M. Milsop agreed on discussing the matter further, saying that the recent release of the new Partner Services Guidelines could indicate that the services were being viewed differently. A. de los Reyes informed the group that, having been involved with the production of the new partner services guidelines, he felt that there would be some dangers in separating the services from testing because they were so closely tied together. D. Acosta clarified that he was only interested in doing something to show the importance of Partner Services so that it could be offered more consistently. A. de los Reyes supported the statement, saying that, for a program that had only been formalized in the past year, it had made some important changes. Commenting on the importance of the service, he noted that it had higher positivity rates than any other intervention in the city.

A. de los Reyes felt that Partner Services suffered from its problematic history, which caused some providers to be more resistant to the services. He explained that some patients had reportedly been told that they did not have to answer any of providers' questions about their partners or had been asked such questions in a way that discouraged them from answering. As a result, he believed that there needed to be greater collaboration between Partner Services and other prevention programs. He pointed out that the CPG could help in the process by strongly supporting the services, which he felt would hold sway with other providers. D. Acosta agreed with the statement, saying that the new guidance provided an opportunity to change the way that Partner Services were envisioned. M. Milsop suggested holding a discussion with the CPG about the new Partner Services Guidelines. A. de los Reyes agreed and offered to compile a presentation on the matter, saying that he could also discuss what other jurisdictions had done and what the current state of the services were in Philadelphia, even though the recent changes were only preliminary. The rest of the group agreed.

M. Castillo suggested telling the CPG that the PPC was preparing a full presentation on Partner Services instead of providing them with the information available in the handouts. The rest of the group agreed and A. de los Reyes said that he would try to have the presentation ready by the end of January.

- **Determining Factors to Be Used in Prioritization**

M. Milsop directed the group's attention to the handout entitled *Factors for Setting Priorities for Target Populations*. He said that, although the committee could select whatever factors they wanted for their priority setting, they could use those listed in the handout as examples. He then clarified that, after they had selected a list of factors to use, the CPG would have to approve the list before the committee started the weighting process.

Looking through the list, M. Castillo pointed out that a number of the group's selected social drivers were included in 'barriers to reaching the population,' the last suggested factor in the handout. D. Acosta said that he felt as though the developing prevention plan was not doing enough to address social factors in prevention, despite the many discussions that the group had held on the matter. M. Milsop reiterated that, after the populations had been prioritized, the committee would spend some time linking specific social drivers from their list to appropriate populations. M. Castillo pointed out that giving 'barriers to reaching the population' more weight could help to address the concern raised by D. Acosta.

Starting to go through the items on the list, M. Milsop asked the group whether they wanted to use AIDS data in their prioritization process since HIV data was now available. R. Feely said that AIDS data could be important for prevention efforts with PLWH/A and therefore suggested keeping the factor. For the next item, D. Acosta suggested not using AIDS mortality as a factor because he felt the data was more important to the care system than to prevention efforts. M. Milsop then clarified that, under the factors for HIV/AIDS surveillance, only AIDS mortality would be left out.

Continuing with the next set of factors, R. Feely asked for clarification on the difference between ‘key’ and ‘other’ indicators of risk behaviors. He noted that his organization sometimes had to rely on alternative sources of data, such as needs assessments, for information on Trans populations. M. Milsop explained that ‘other’ indicators of risk included items such as teen pregnancy, which could give some insight into risk but could also be misleading. He said that highly important risk indicators, such as STI infection, were under key indicators. He also pointed out that data from needs assessments would go under the factor ‘riskiness of population behaviors.’ The group also decided to keep ‘multiple high-risk behaviors’ because the factor would account for MSM who also injected substances. M. Milsop clarified that ‘other indicators of risk behavior’ was the only factor under Documentation of HIV Risk Behaviors that the group rejected.

D. Acosta suggested rejecting ‘size of target population’ as a factor because, for many populations, the actual number was impossible to obtain. The rest of the group agreed and then decided to keep the next two factors under Sociodemographic Characteristics.

A. de los Reyes asked the group whether they wanted to add a factor for individuals co-infected with HIV and one or more STIs. He said that dual infections needed to be paid attention to during planning because HIV was transmitted more easily when an STI was also present. However, he was not sure whether the factors would be an appropriate place for the recognition. M. Milsop said that it would be difficult for a prevention program to target dually infected individuals. However, noting the importance of such data, he said that something on the matter could be included in the narrative of the prevention plan. A. de los Reyes informed the group that, while his office had some information on dually-infected individuals, it was limited because testers either had to say that they were dually-infected or be tested for both infections. As a result, he suggested that the group simply keep dual infections in mind as they continued planning.

As the committee had completed selecting their factors, M. Milsop reiterated that the list was only a draft until after it was approved by the CPG. M. Castillo stated that she would like to cross-check some of the factors with the list of social drivers to ensure that data was available for all items. However, she said that the matter could be dealt with at the group’s January meeting. The rest of the group agreed and then decided to present the draft list of factors at the January meeting of the CPG.

Old Business

None

New Business

M. Castillo pointed out that the meeting agenda incorrectly listed the date for the group’s next meeting. The group clarified that the next meeting was scheduled for Monday, January 25th, from 1:00 – 3:00 pm.

Review/Next Steps

- The PPC reviewed issues that had been raised with the draft list of prioritized populations during the November CPG meeting. As part of the conversation, A. de

los Reyes agreed to provide the CPG with information on recent changes in partner services.

- The PPC also reviewed the AED Guideline's suggested factors for prioritizing populations and selected those which they felt would be most useful considering the data available to them.
- The next meeting of the PPC is scheduled for Monday, January 25th, from 1:00 – 3:00 pm.

Announcements

M. Milsop announced that the 2012 International AIDS Conference would take place in Washington, DC. D. Acosta informed the group that the June meeting of UCHAPS would take place in Philadelphia.

Adjournment

The meeting was adjourned by general consensus at 2:35 pm.

Respectfully Submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*November 10th, 2009*)
- Maps of HIV Counseling and Testing Sites and Newly Diagnosed HIV Infections by Census Tract
- Newly Diagnosed HIV among Men who have Sex with Men.
- State Data from Partner Services
- Local Data from Partner Services
- Factors for Setting Priorities for Target Populations
- OHP Meeting Calendar

Philadelphia Department of Public Health Partner Services Update

Presentation to:

Philadelphia Community Planning Group
Planning Priorities Committee

Drew De Los Reyes
Assistant Program Manager/Special Projects
STD Control
Andrew.DeLosReyes@phila.gov

January 25, 2010



Disclaimer

The views expressed in this presentation are those of the author and are not necessarily those of the Centers for Disease Control

Presentation Content

- Background
- Overview of the *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*
- Overview of CDCs Revision Process
- Partner Services in Philadelphia

PS – Functions¹

- Service
 - Persons with STDs/HIV: helps them notify partners and access services
 - Partners: helps them recognize risk, learn infection status, and access services
- Ethical
 - Addresses partners' "right to know" their risk
- Public Health
 - Provides information that may be valuable for reducing transmission at the community level



Why Partner Services?

- A rapid interview allows partners to be identified and notified of possible exposure as soon as possible so they can:
 1. Obtain HIV counseling and testing
 2. Take steps to avoid becoming infected^[1] or, if already infected, to avoid infecting others; and
 3. Access medical care and other services as soon after infection as possible².



[¹. If notification occurs within the 1st 72 hours of exposure, nPEP may be an option]

². MMWR, November 7, 2008/Vol. 57 / No. RR-9, Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection

Impetus for Revised Recommendations for Partner Services

- ~1.0 - 1.2 million persons living with HIV in the US ~25% are unaware
- ~56,300 new infections per year
 - ~54-70% from persons not aware of their infection
- Multiple, case-finding strategies needed
- Partner services increases
 - access to high-prevalence population
 - identification of HIV-infected persons

Impetus for Revised Recommendations for Partner Services

- Poor uptake of PS for HIV (~32% of reported cases interviewed)
- Two separate guidelines and training related to PS:
 - Duplication, discrepancies, and confusion
- Guidelines integration allows for:
 - Improved services at the client level
 - Economies of scale and improved coverage

Revision Process

- Cross-division workgroup
- Guidelines comparison
- Letter to stakeholders
- Literature Review
- National conferences listening groups
- PCRS program reviews
- Mini-consultations with PCRS stakeholders
- Focus groups with private sector clinicians
- Assessment of state PCRS legal and policy issues
- Consumer focus groups



Culminated in November 2006 Consultation

Key Features - I

- Health department model
- Integration of recommendations for HIV and other STDs
- Target audience → program managers
- Program design & management, not operational details
- Background and rationale
- Partner services for all persons testing positive for HIV

Key Features - II

- Emphasis on
 - Direct health department involvement (provider referral vs. self referral)
 - Active linkage to care and prevention services
 - Integration of services at the client level
 - Data security
 - Collaboration with external partners (e.g., providers, CBOs, CPGs)

Surveillance Program Connection

Programs should:

- Use surveillance and disease reporting systems to help identify persons with newly-diagnosed or reported HIV infection
- Strongly consider using individual-level data (if appropriate security and confidentiality procedures are in place)
- Work with providers--clients/patients should be offered PS as soon as possible after diagnosis.

Common Goals

- **For infected persons:**
 - Maximize access to partner services by providing all infected persons with support to ensure that their partners are confidentially informed of their exposure;
 - Maximize effective linkage to medical care, treatment, and prevention interventions to reduce the risk for transmission to others, and other services.
- **For partners of infected persons:**
 - Maximize the proportion of partners who are notified of their exposure;
 - Maximize early linkage of partners to testing, medical care, prevention interventions, and other services.
- **For the community:**
 - Reduce future rates of transmission by aiding in early diagnosis, treatment – or, in the case of HIV, linkage to treatment – and provision of prevention services to infected persons.

Notification Strategies

- Provider referral
- Self referral
- Contract referral
- Dual referral
- Third-party referral

Insufficient data regarding effectiveness of these strategies to support them as a first-line approach to providing PS

Provider Referral

- “Classic” STD approach—the syphilis model for PS
- Benefits:
 - More partners notified of their exposure;
 - Partner notification verifiable;
 - More likely partner will receive accurate information about risk and referrals to services
 - Protects index patient’s confidentiality

Patient Referral

- Often perceived as better aligned with HIV programs' emphasis on putting the client 1st
- Benefits:
 - Helps client develop disclosure skills
 - Less resource intensive for PS programs
 - Partner may be more comfortable with a person he/she knows

Patient Referral

- Costs of the approach:
 - Fewer partners notified
 - Index patient loses anonymity
 - Index patient may not be able to answer partner's questions, or may answer them incorrectly

PS Elements

**Identify PS candidates
(index patients)**

**Contact index patients,
Interview, counsel
and refer**

**Notify partners of
their exposure**

**Provide
appropriate
services to
partners**

Identifying Candidates

- **Goal = Find candidates for partner services**
 - Use *all* the resources available to find candidates:
 - Partner services programs should use surveillance and disease reporting systems to assist with identifying persons who are potential candidates for partner services.
 - Strongly consider using individual-level data,
 - Put appropriate security and confidentiality procedures in place.

Prioritizing Candidates

- Highest Priority:
 - Female partners who are/may be pregnant
 - Partners suspected of or known to be engaging in behaviors that increase the risk of transmission to multiple other persons
 - Partners with whom originating patient (OP) has had unprotected anal or vaginal sex
 - Partners of OP known to have an HIV viral load >50,000 HIV RNA copies/ml
 - Partners of OP who is newly *infected*
 - Partners of OP who is diagnosed with an STD

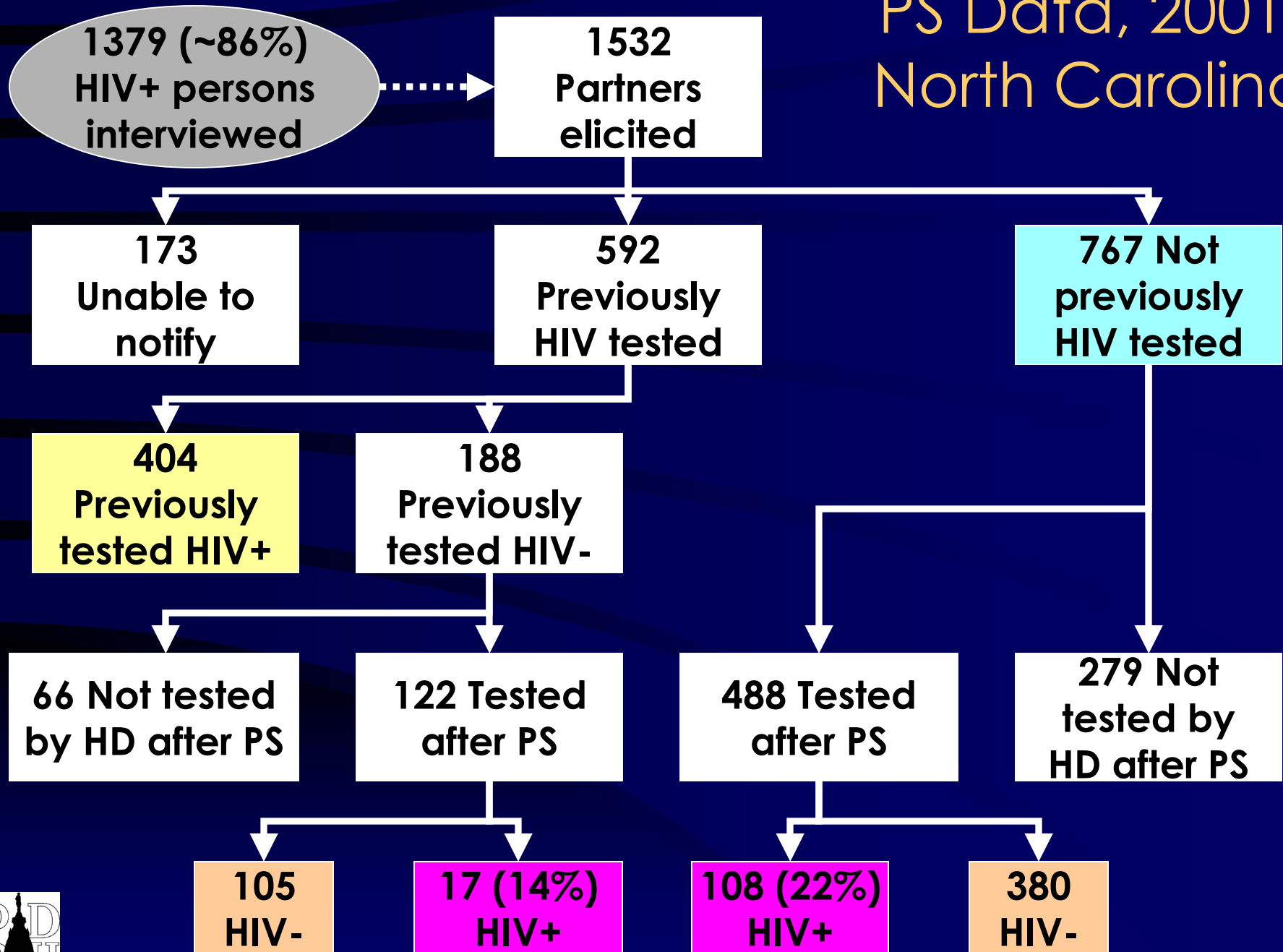
Program Effectiveness

- ~250,000 (25%) of HIV infections are undiagnosed
- Routine Counseling and Testing
 - <1% HIV Prevalence
- Social Networks¹
 - 6% HIV Prevalence
- Partner Services



1. CDC, *Social Networks Testing*, 2006

PS Data, 2001, North Carolina



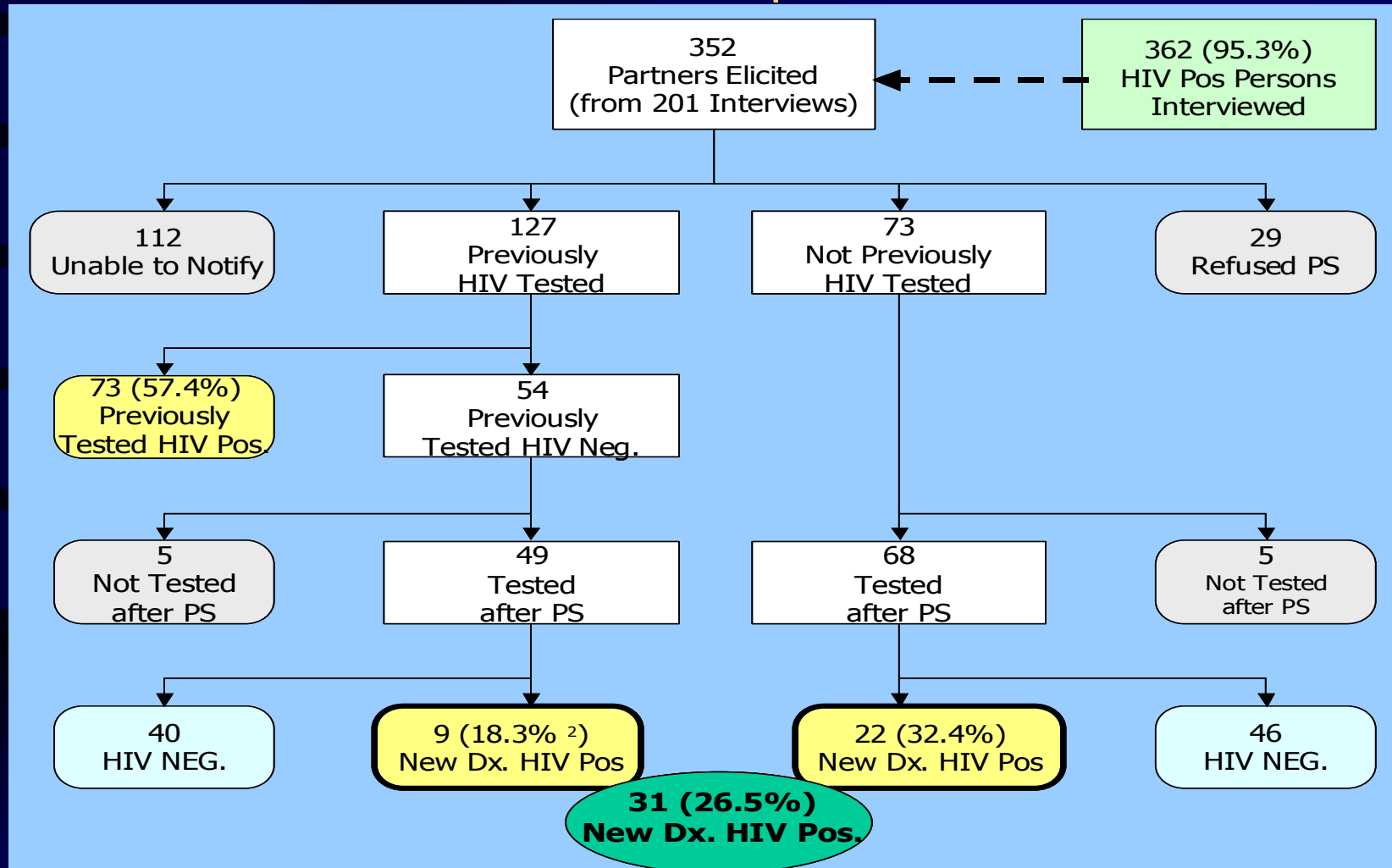
Program Effectiveness – NC Study

- Overall Positivity – 20.5%
 - Previously HIV-negative
 - $17/122 = 14\%$
 - Not previously tested
 - $108/488 = 22\%$



HIV Partner Services

PDPH/STD Control Snapshot 1/08 – 6/09



Note

- Previous HIV Positive data is combined self report and confirmed diagnosis

Program Effectiveness – Philadelphia

- Overall Positivity – 26.5%
 - Previously HIV-negative
 - $9/49 = 18.3\%$
 - Not previously tested
 - $108/488 = 32.4\%$



Philadelphia Program

- Clients referred to STD Control
 - The assigned DIS follows up on referrals received from:
 - City-wide District Health Centers and AACO funded screening sites
 - Philadelphia Prison Systems
 - Insurance companies
 - Provider referrals
 - Out of Jurisdiction Areas (OOJ)

Increasing the Acceptability of Partner Services

- The DIS is introduced as a part of the care team
- The DIS introduces the idea of PS to the client
- The care provider does not bias the patient about partner services

Acknowledgments

- AACO
- Division of Disease Control, Epidemiology Unit
- STD Control DIS Staff
- Providers, Clinicians, and line staff across all departments

Special Thanks

A special thanks goes to the following Centers for Disease Control staff for their generous contributions to this presentation:

- Rheta Barnes, MSN, MPH
- Cindy Getty
- Matthew Hogben
- Abigail Viall, M.A.

Step 3: Weight Factors

Assign a weight (level of importance) to each factor.

<p style="text-align: center;">FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</p> <p style="text-align: center;"><i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i></p>		
FACTOR	DEFINITION	DISCUSSION
HIV/AIDS Surveillance		This factor shows the extent of the HIV/AIDS epidemic among the target population.
AIDS incidence	The number of AIDS cases diagnosed in a defined population in a specified period, often a year	<p>Because of a comprehensive national AIDS surveillance system, AIDS incidence data are among the most reliable and complete population-based epidemiologic data available. AIDS incidence data may help CPGs understand the extent to which AIDS has affected a given population relative to another.</p> <p>In considering AIDS incidence data, however, CPGs should be aware that recent declines in AIDS incidence are attributable in large part to antiretroviral therapies. Currently, differences in AIDS incidence among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or in access to or use of health care.</p>
AIDS prevalence	The number of people living with AIDS in a defined population on a specified date	AIDS prevalence data show the number of people living with advanced HIV disease. While AIDS incidence data show the total number of AIDS diagnoses in a specified period in time, prevalence data show how many people are living with AIDS, regardless of when they were diagnosed.

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

FACTOR	DEFINITION	DISCUSSION
AIDS mortality	The number of deaths among people with AIDS in a specified period, often a year	<p>Like AIDS incidence and AIDS prevalence data, AIDS mortality data can be useful in understanding the extent to which the epidemic has affected a given population relative to another.</p> <p>Recent declines in AIDS deaths are attributable in large part to antiretroviral therapies. Differences in AIDS deaths among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or differences in access to or use of health care.</p>
HIV incidence (diagnosed)	The number of HIV cases diagnosed in a defined population in a specified period, often a year	<p>The number of HIV infections diagnosed among people who received HIV tests during a specified period of time, usually a year. The data do not show the total number of HIV infections because not everyone is tested. Nor do the data show when HIV infections occurred, for people may be tested years after infection.</p> <p>To distinguish between HIV incidence among people with and without AIDS, we refer to diagnosed HIV (including AIDS) incidence and diagnosed HIV (not AIDS) incidence. In general, diagnosed HIV (not AIDS) incidence represents people infected with HIV more recently than people represented by AIDS incidence data.</p>
HIV prevalence (diagnosed, including AIDS)	The number of people living with diagnosed HIV (including people with AIDS) in a defined population on a specified date	<p>This factor shows the total number of people diagnosed with HIV or AIDS, minus those who have died, at a given point in time. Diagnosed HIV prevalence includes only people who have been tested, diagnosed, and reported; people who were tested anonymously are not included.</p> <p>Almost all areas now have HIV reporting; however, two years of HIV reporting data are considered the minimum for projecting trends. Diagnosed HIV (not AIDS) prevalence represents those people living with HIV infection but not AIDS.</p>

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS <i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i>		
FACTOR	DEFINITION	DISCUSSION
Documentation of HIV-Risk Behaviors		This factor provides data about behaviors that may lead to HIV transmission/acquisition.
Key indicators of HIV-risk behaviors	Data sets that document that HIV-risk behaviors are occurring within the target population	<p>Although it's impossible to know how often target populations engage in HIV-risk behaviors, CPGs may use a variety of data to estimate occurrences.</p> <p>Sexually transmitted diseases (STDs): Gonorrhea, syphilis, and chlamydia are reportable STDs in most project areas. Because STD rates are reliable indicators of high-risk behavior (unprotected sex), groups with high rates of STDs are potentially at increased risk for HIV infection. Additionally, some STDs increase the risk of transmission in individuals who are exposed to HIV. The extent to which STD rates correlate with HIV risk will depend on the HIV prevalence (diagnosed) within the sexual network of persons practicing unsafe sex and on the local dynamics of STD transmission.</p> <p>Note: STD data alone do not indicate a risk for HIV infection. For example, if HIV prevalence (diagnosed) is extremely low, even high STD rates do not indicate a high risk. If HIV prevalence (diagnosed) is extremely high, even low STD rates do not indicate a low risk for HIV infection.</p> <p>Youth Risk Behavioral Surveillance System (YRBSS): This study measures health-risk behaviors among adolescents in school through representative biennial national, state, and local surveys. Out-of-school youth may have higher levels of HIV risk behaviors.</p>

FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS

Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.

FACTOR	DEFINITION	DISCUSSION
<p>Other indicators of risk behaviors</p>	<p>Other data sets that may signal HIV risk behaviors occurring within the target population</p>	<p>Adolescent sexual activity: Teenage pregnancy is sometimes a marker for early initiation of unprotected sex, and an indication of high-risk behaviors. Take care in interpreting these data because teenage pregnancy may be intentional.</p> <p>Other behavioral data: Depending on local data collection and research systems, CPGs may be able to access local population studies of behaviors associated with HIV transmission, such as anal intercourse or needle sharing, and studies of the determinants of high-risk behaviors.</p> <p>CPGs should work with epidemiologists, behavioral scientists, etc., to determine whether other studies that collect behavioral data exist (especially any funded by federal — e.g., NIMH, NIDA, CDC — or state agencies).</p>
<p>Riskiness of population behaviors</p>	<p>The nature and relative risk of behaviors that occur in the target population</p>	<p>This factor considers the relative risk of behaviors among target populations. The risk for HIV transmission and acquisition associated with the highest-risk behaviors is well understood. The three most risky behaviors for transmitting HIV are, in descending order of risk, the use of HIV-infected injection equipment, unprotected receptive anal sex with an infected partner, and unprotected vaginal sex with an infected male partner.</p>
<p>Multiple high-risk behaviors</p>	<p>The extent to which multiple high-risk behaviors occur within the target population</p>	<p>This factor considers the occurrence of more than one high-risk behavior within a given population. For example, men who have unsafe sex with men and inject drugs are engaging in multiple high-risk behaviors.</p>

<p style="text-align: center;">FACTORS FOR SETTING PRIORITIES FOR TARGET POPULATIONS</p> <p style="text-align: center;"><i>Note: Before selecting any factor, it is important for CPGs to consider the strengths and limitations of the data.</i></p>		
FACTOR	DEFINITION	DISCUSSION
Sociodemographic Characteristics		This factor, which can be measured in several different ways, examines complex issues that may affect the provision of HIV prevention interventions.
Size of target population	The estimated size of the target population in the geographic area where the program will be implemented.	Estimating target population size has been difficult for many project areas. CDC recommends using a World Health Organization methodology available at: http://www.who.int/docstore/hiv/Core/Chapter_9.10.html
Difficulty of meeting population needs	The complexity of needs and whether the population has been reached by current programs, whether service providers have capacity, etc.	<p>CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization data (services mapping, services access and utilization, etc.) to determine risk in a population.</p> <p>Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p>
Barriers to reaching the population	The extent to which barriers to providing HIV prevention programs exist in a high-risk population.	<p>CPGs may consider the following sociodemographic characteristics when looking for indicators of barriers — cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors, and beliefs will also provide information about barriers.</p> <p>Review all available data and information sets. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p>