Philadelphia EMA Integrated HIV Prevention and Care Plan

Prepared for: Philadelphia Ryan White Part A Planning Council and HIV Prevention Planning Group

OFFICE OF HIV PLANNING | 2017-2021

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Introduction

The following document is the sum of the work of the Philadelphia Eligible Metropolitan Area (EMA) Ryan White Part A Planning Council (RWPC), the Philadelphia HIV Prevention Planning Group (HPG), the Philadelphia Department of Public Health's AIDS Activities Coordinating Office (PDPH's AACO), and the Office of HIV Planning (OHP)[1]. This plan includes and draws upon epidemiologic data, community input, focus groups, surveys, geographic analysis, and historical and social context. While firmly rooted in the federal guidance for integrated care and prevention plans, it expands upon many elements in order to provide a more complete assessment of the HIV system in the nine-county Philadelphia region. In accordance with the guidance, AACO and OHP staff actively participate in the Pennsylvania statewide HIV planning process, while a representative from the Pennsylvania Department of Health participates in the Philadelphia EMA planning process. In addition, OHP staff have attended New Jersey HIV Planning Group meetings, and representatives from the New Jersey HIV Planning Group and the New Jersey Department of Public Health sit on the Philadelphia EMA RWPC. Furthermore, this plan provides for ongoing coordination and future collaboration with both the Pennsylvania Department of Health and the New Jersey Department of Public Health. This document also includes multiple needs assessment activities, which meets and exceeds the guidance's requirements of CDC-funded recipients.

[1] Editor's note: Throughout this document "PDPH" will refer to the AIDS Activities Coordinating Office, except where "AACO" is used to distinguish between specific AACO activities as recipient of the Ryan White Part A grant for the EMA and activities of other divisions and departments of PDPH. "Recipient" is also used to refer to AACO when discussing Ryan White Part A program activities and monitoring.

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Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

The following section is based on tables and figures from the Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning, Philadelphia Eligible Metropolitan Area (2015).[2] When possible, the information from the original profile has been updated for this plan. Both the original profile and the following section combine data from numerous sources, and they have been developed in accordance with the 2014 Integrated Guidelines for Developing Epidemiologic Profiles.[3] The complete epidemiologic profile describes the general population of the EMA, risk indicators, characteristics of the local HIV epidemic, unmet need and service utilization. The epidemiologic overview below includes selected highlights from the full profile, augmented by further information and context from the Philadelphia Department of Public Health (PDPH).

[2] Office of HIV Planning. (2015). Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning, Philadelphia Eligible Metropolitan Area. Retrieved from http://www.hivphilly.org/Documents/EpiProfile/2015Epi.pdf.

[3] Centers for Disease Control and Prevention and Health Resources and Services Administration. (2014). Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and Ryan White HIV/AIDS Programs Planning. Atlanta, Georgia: Centers for Disease Control and Prevention.

a. Geographical Region of the EMA

The Health Resources and Services Administration (HRSA) defines the Philadelphia Eligible Metropolitan Area (EMA) as Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties in Pennsylvania, and Burlington, Camden, Gloucester, and Salem Counties in New Jersey.

The Philadelphia Eligible Metropolitan Area

b. Socio-demographic Characteristics

The Philadelphia area spans two states and encompasses urban, suburban, and rural areas. Demographic makeup varies greatly by area, from 86% non-Hispanic White in Bucks County to the majority-minority City of Philadelphia. Chester County is the highest-income county in Pennsylvania and one of the wealthiest counties in the United States, while Philadelphia has the highest rate of deep poverty of any major city in the country. These demographic variations within the region also translate to variations in at-risk populations and people living with HIV/AIDS throughout the area.

In 2015, the nine-county Philadelphia metropolitan area had 5,410,714 residents.[4] Of these, Philadelphia had 1,567,442 residents. In the suburban Pennsylvania counties, Bucks had 627,367 residents, Chester had 515,939 residents, Delaware had 563,894 residents, and Montgomery had

[4] U.S. Census Bureau. (2015). PEPANNRES Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015 [Data]. *2015 Population Estimates.* Retrieved from http://factfinder.census.gov/.

819,264 residents, totaling 2,526,464 suburban Pennsylvania residents. Among the Southern New Jersey counties, Burlington had 450,226 residents, Camden had 510,923 residents, Gloucester had 291,479 residents, and Salem had 64,180 residents, totaling 1,316,808 Southern New Jersey residents.

Race and Ethnicity

Racial and ethnic composition varies widely across the Philadelphia area. In 2014, 64% of the EMA's population was non-Hispanic White, 20% was non-Hispanic Black, 5% was non-Hispanic Asian, and 9% was Hispanic (all races).[5] Yet, in Philadelphia, only 36% of the general population was White, while 42% was Black, 7% was Asian, and 13% was Hispanic. Camden County was 58% White, 18% Black, 5% Asian, and 15% Hispanic. Bucks County was 86% White, 6% Black, 4% Asian, and 7% Hispanic. Even within these counties, racial and ethnic distribution was uneven. In each county, there are areas in which residents are predominantly of a single racial/ethnic group. This is particularly stark in Philadelphia, where the sheer population makes these patterns more evident. In addition, according to a 2015 analysis, Philadelphia is the fourth-most segregated city in the United States.[6] This is illustrated through the Philadelphia county map on the following page.

Poverty and Income

As with many metropolitan areas, income varied throughout the Philadelphia EMA. By county, the highest median household income was found in Chester County ($86,093 in 2014), while median household income in Coatesville (a city within Chester County) was only $35,601.[7] This is even lower than Philadelphia's median household income of $37,460. In Camden County, the median household income was $61,842, but in the City of Camden, median household income was only $26,201. Median individual income by gender varied from county to county within the EMA, although the wage gap was largest in the county with the highest income (Chester) and smallest in the county with the lowest income (Philadelphia).

Less than 6% of people in Burlington County lived below the poverty level, while over 26% of Philadelphia lived in poverty. In every county, poverty is particularly concentrated in specific areas, although it is the most widespread in Philadelphia. The map on the next page illustrates where White, Black, Asian, and Hispanic residents in poverty live throughout the city. As seen below, Hispanics in poverty are concentrated in lower Northeast Philadelphia, while Blacks in poverty are concentrated in North, West, and Southwest Philadelphia. Whites and Asians in poverty are slightly more distributed: poor Whites are found in South, near West, upper Northeast, and lower Northwest Philadelphia, while poor Asians are concentrated in pockets in South Philadelphia, upper North Philadelphia, and the Northeast.

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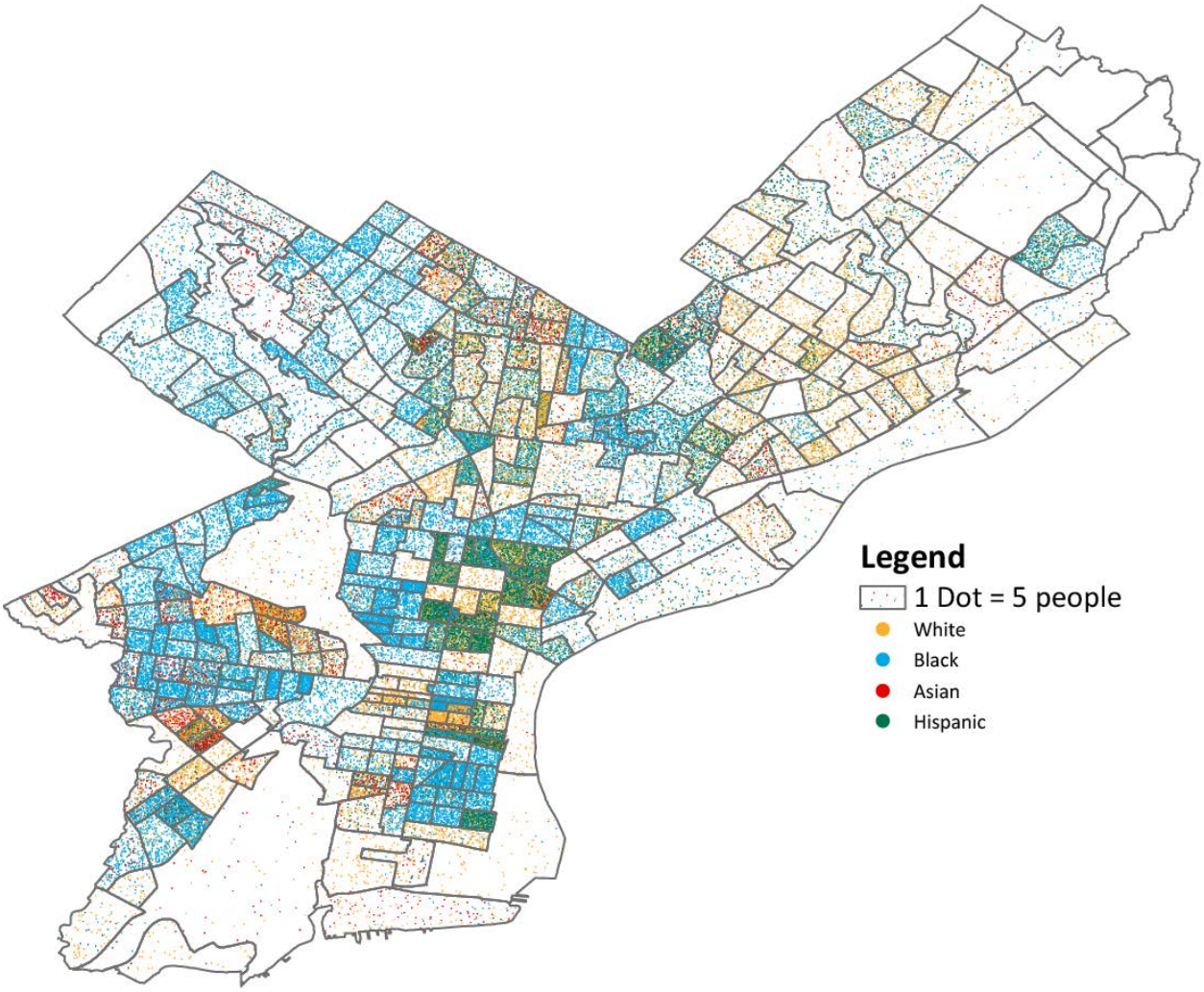
[5] U.S. Census Bureau. (2014). DP05 Demographic and Housing Estimates [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

[6] Silver, Nate. (2015). The Most Diverse Cities Are Often The Most Segregated. Retrieved from http://fivethirtyeight.com/features/the-most-diverse-cities-are-often-the-most-segregated/.

[7] U.S. Census Bureau. (2014). S1901 Income in the Past 12 Months (in 2014 Inflation-Adjusted Dollars) [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

People in Philadelphia Living At or Below *Poverty*, by Race/Ethnicity (2014)



Author: Mari Ross-Russell, Office of HIV Planning

Maps describing the racial/ethnic distribution of people in poverty are available for each of the nine counties online. While these maps provide context on all people below poverty, it is notable that 12.5% of Philadelphia lives in deep poverty (defined as less than half of the federal poverty level). This is the highest deep poverty rate of the ten largest cities in the United States. The City of Camden had an even higher deep poverty rate in 2014, with 20.4% of residents living in deep poverty.

Education

In every county and both states of the EMA, poverty rates decreased for both men and women as educational attainment increased. In 2014, the poverty rate for men within the EMA with at least a bachelor's degree was 3.4%, and 4.2% for women.[8] By contrast, the poverty rate among men who have not completed high school (or a GED program) was 24.4%; for women, this rate was 31.3%. In the City of Philadelphia, women without a high school education had a poverty rate of 41.9%, while men without a

[8] U.S. Census Bureau. (2014). B17003 Poverty Status in the Past 12 Months of Individuals by Sex by Educational Attainment [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

high school education had a poverty rate of 33.2%. As seen below, education level is also linked to unemployment.

Employment

In Philadelphia, 14.9% of residents in the labor force were unemployed in 2014.[9] Unemployment rates varied significantly throughout the nine-county area; for example, the unemployment rate in Chester County was only 6.3%. As with poverty, unemployment rates also varied within counties: while Camden County residents in the workforce experienced 11.4% unemployment, 22% of Camden City's workforce was unemployed.

Unemployment also varied by race/ethnicity: 10.6% of Whites in Philadelphia's labor force were unemployed, while 19.9% of Blacks and 19.9% of Hispanics (any race) were unemployed. In nearly every county in the nine-county area, Blacks and Hispanics experienced a higher rate of unemployment than Whites – with the exception of Gloucester County, where unemployment among Hispanics was slightly lower than unemployment among Whites.

As seen with the poverty rate by education level, the rate of unemployment went down as the level of education increased. Philadelphians aged 25 – 64 who had less than a high school education saw an unemployment rate of 23.2%, while Philadelphians with at least a bachelor's degree had a 5.1% unemployment rate. Again, this was true of every county in the nine-county Philadelphia EMA.

Insurance

New Jersey fully expanded Medicaid in 2014. Pennsylvania had limited Medicaid expansion in 2014 under a program called Healthy PA but fully expanded Medicaid in 2015. The most recent insurance coverage estimates from the American Community Survey are 1-year estimates for 2014, so these will not completely capture the impact of Medicaid expansion in New Jersey in 2014, nor the full expansion in Pennsylvania that did not occur until 2015.

In 2014, 12.6% of Philadelphians were uninsured.[10] Uninsured rates in the suburban Pennsylvania counties ranged from 5.1% in Montgomery County to 7.9% in Delaware County. In the New Jersey counties, uninsured rates ranged from 6.1% in Burlington and Gloucester Counties to 11.1% in Camden County.

By contrast, in 2010, 14.9% of Philadelphia was uninsured. In the suburban Pennsylvania Counties, uninsured rates went from 6.7% in Bucks County to 9.2% in Delaware County. Uninsured rates in the four New Jersey Counties ranged from 7.4% in Burlington County to 12.4% in Camden County. In fact, the percentage of people who were insured increased across all counties in the EMA between 2010 and 2014.

For all counties, uninsured rates were significantly higher among people who were unemployed. In all but one county, the uninsured rate among people who were unemployed was at least three times as

[9] U.S. Census Bureau. (2014). S2301 Employment Status [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.
[10] U.S. Census Bureau. (2014). S2701 Health Insurance Coverage Status [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

high as the uninsured rate in the general population. (In Gloucester County, people who were unemployed experienced 2.83 times the uninsured rate of the general population.)

In all counties, men were more likely to be uninsured than women. In all counties but Salem County, the uninsured rate was higher among 19 to 25 year olds than the general population. In every county where data was available, the uninsured rate among Hispanics was much higher than among non-Hispanic Whites, ranging from 2.2 times as high in Gloucester and Philadelphia Counties to 8.2 times as high in Chester County.

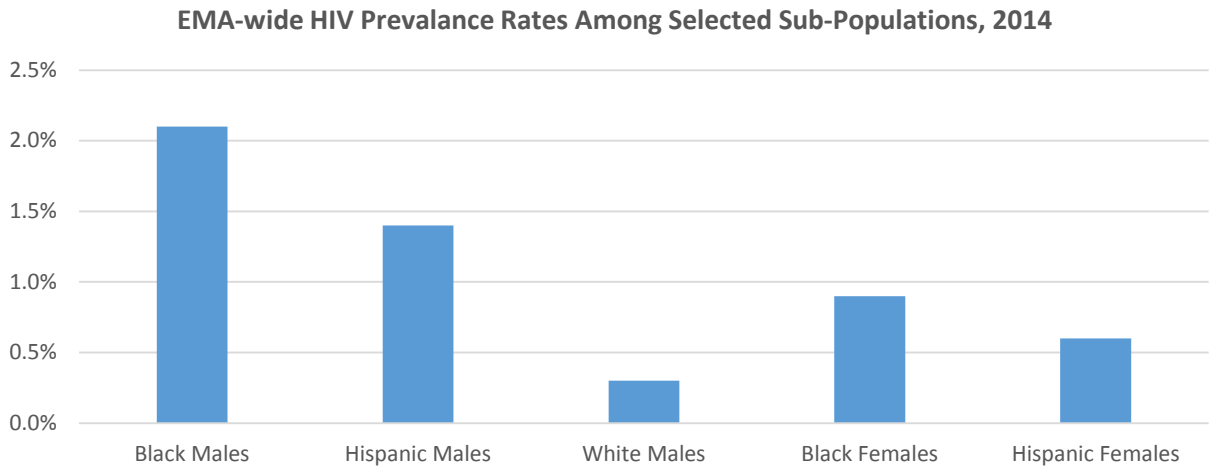
c. HIV/AIDS

As of 2014, an estimated 27,121 people were living with HIV/AIDS in the nine-county Philadelphia EMA. Of these, 11,843 (44%) were living with HIV (non-AIDS), while another 15,278 (56%) were living with AIDS. Between 2012 and 2014, there were 3,292 new HIV/AIDS diagnoses, of which 2,120 were diagnosed with HIV, and 1,172 were diagnosed with AIDS. The total number of people living with HIV/AIDS in the region has been growing over time, as new diagnoses are outpacing deaths among people with HIV/AIDS.

Newly Diagnosed and Prevalent HIV and AIDS Cases, Philadelphia EMA

	2012		2013		2014	
	New Diagnoses	Prevalence	New Diagnoses	Prevalence	New Diagnoses	Prevalence
HIV not AIDS	712	11,244	729	11,508	679	11,843
AIDS	470	15,739	393	15,456	309	15,278

With 1.3% of residents living with HIV, the City of Philadelphia has a generalized epidemic, defined as a prevalence rate of 1% or higher. Prevalence for the entire nine-county EMA is about 0.3%. This prevalence rate varies by population, as displayed on the following page. When reviewing HIV prevalence by race/ethnicity and gender, Black men have the highest rates, followed by Hispanic men, Black women, and Hispanic women.



As with other characteristics within the nine-county Philadelphia EMA, HIV/AIDS varies within the area. For planning purposes, the nine counties in the Philadelphia EMA are broken out into three smaller regions: the City of Philadelphia, the four suburban Pennsylvania Counties (including Bucks, Chester, Delaware, and Montgomery), and the four New Jersey Counties (Burlington, Camden, Gloucester, and Salem). As seen previously, these smaller regions vary greatly by demographics and other characteristics.

The next table displays characteristics of people who were newly diagnosed with HIV from 2012 – 2014. Race/ethnicity, gender, age, and mode of transmission vary by region. In Philadelphia, a higher percentage of new diagnoses were among youth, females, non-Hispanic Blacks, and men who have sex with men than in the rest of the EMA. In the suburban PA counties, a higher percentage of new cases were among non-Hispanic Whites, men, and people 50 and older. In the New Jersey counties, a higher percentage was seen among non-Hispanic Whites, Hispanics, women, and people over 30.

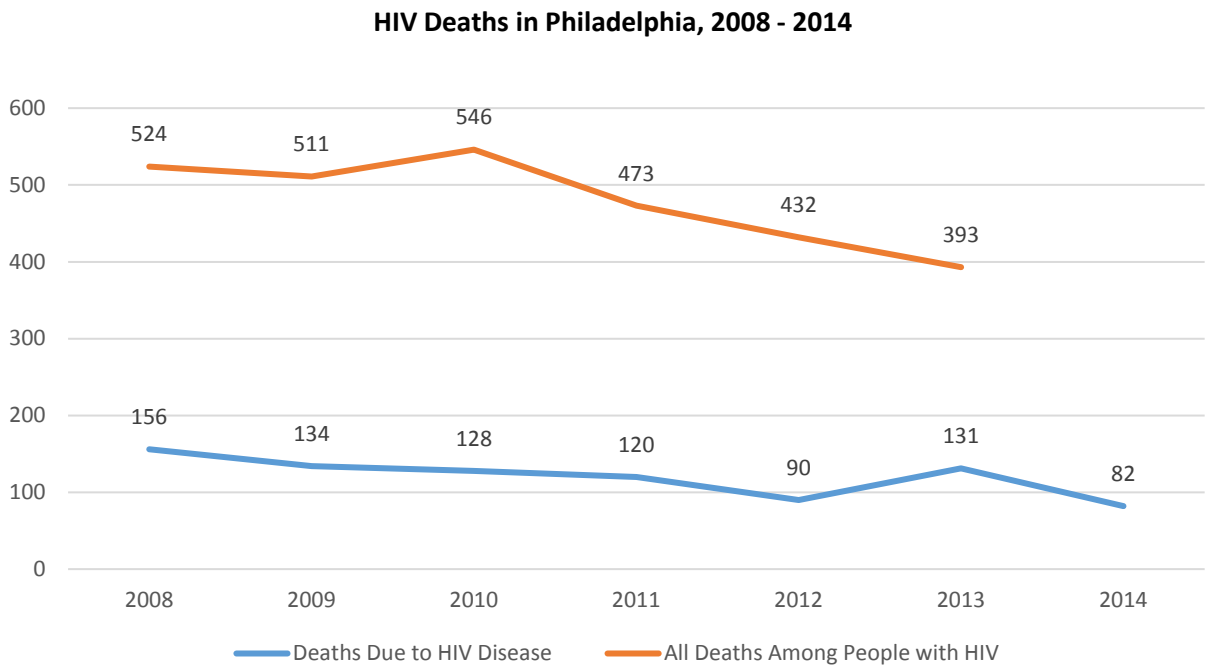
This information is useful for identifying emerging regional trends within the nine-county area. Specific populations will be discussed later in this section.

Newly Diagnosed HIV (Non-AIDS) for 2012-2014, Philadelphia EMA					
	EMA Total N=2,120	**EMA %**	**Phila N=1,433 %**	**PA N=391 %**	**NJ N=224 %**
Race/Ethnicity					
White, non-Hispanic	409	19.3	13.0	38.9	23.6
Black, non-Hispanic	1,335	63.0	70.1	45.3	52.0
Hispanic	307	14.5	14.1	10.0	22.3
Asian/Pacific Islander	30	1.4	1.6	1.8	0.0
American Indian/Alaskan Native	9	0.4	0.6	0.3	0.0
Multi-Race	24	1.1	0.6	3.8	0.0
Unknown	6	0.3	0.0	0.0	2.0
Gender					
Male	1,641	76.2	70.9	79.0	70.9
Female	479	23.8	21.7	21.0	29.1
Age					
<13 years	12	0.6	0.1	1.3	1.7
13 - 19 years	126	5.9	6.8	4.9	3.4
20-24 years	442	20.8	22.7	17.9	15.5
25-29 years	365	17.2	18.1	15.6	15.2
30-39 years	435	20.5	19.7	20.5	24.7
40-49 years	370	17.5	16.7	17.9	20.6
50+ years	370	17.5	15.9	22.0	18.9
Mode of Transmission					
Men who have sex with men (MSM)	1,048	49.4	52.1	49.9	35.8
Injection drug users (IDU)	140	6.6	6.8	5.1	7.8
MSM/IDU	24	1.1	1.2	1.3	0.7
Heterosexuals	786	37.1	37.5	33.5	39.9
Other/hemophilia/blood transfusion	0	0.0	0.0	0.0	0.0
Perinatal exposures	15	0.7	0.3	1.3	1.7
Risk not reported or identified	107	5.0	2.1	9.0	14.2

Deaths

Within the Philadelphia Eligible Metropolitan Area, deaths among people with HIV/AIDS have been on the decline. This is true for both deaths by any cause among people with HIV and deaths attributed to HIV-related illness. The line graphs below show the decline in deaths for Philadelphia only because data for HIV-related deaths are limited in the EMA in recent years due to small numbers of deaths in many of the counties.

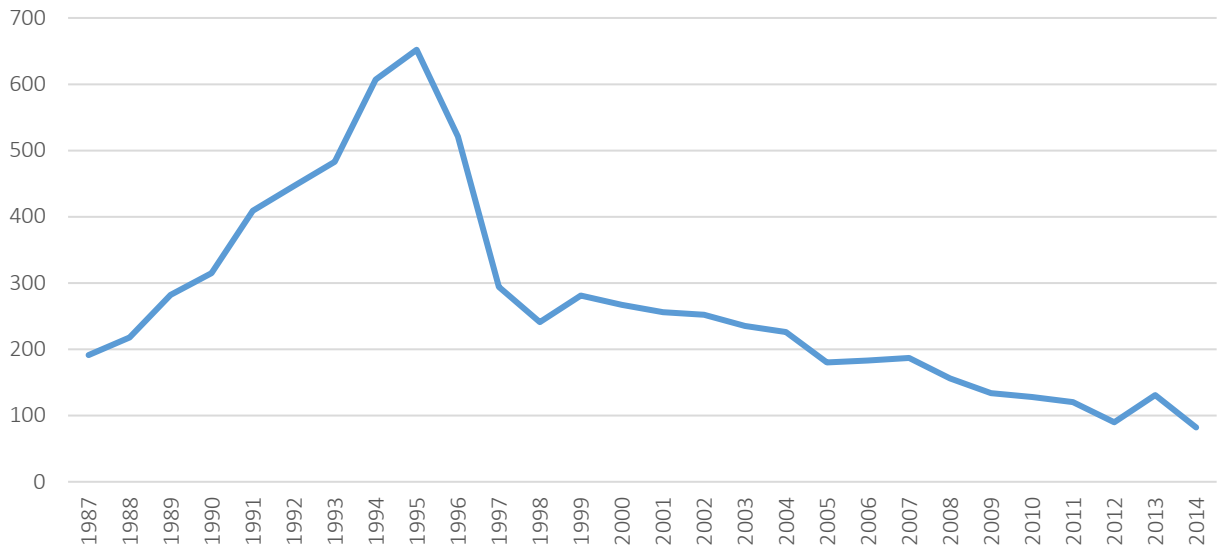
As seen in the first graph, all deaths among people with HIV/AIDS and deaths due to HIV disease in Philadelphia have declined from 2008 to 2013. The second graph shows deaths due to HIV disease from 1987 – 2014.[11] [12] Deaths attributed to HIV disease in Philadelphia peaked in 1995, when there were 652 deaths. There were 82 deaths attributed to HIV-related illness in 2014.



[11] Centers for Disease Control and Prevention, National Center for Health Statistics (2015). Underlying Cause of Death 1999-2014 on CDC WONDER Online Database [Data]. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from http://wonder.cdc.gov/ucd-icd10.html.

[12] Centers for Disease Control and Prevention, National Center for Health Statistics (2015). Compressed Mortality File 1979-1998. CDC WONDER Online Database, compiled from Compressed Mortality File CMF 1968-1988, Series 20, No. 2A, 2000 and CMF 1989-1998, Series 20, No. 2E, 2003 [Data]. Retrieved from http://wonder.cdc.gov/cmf-icd9.html.

Philadelphia Deaths Attributed to HIV Disease, 1987 - 2014



Emerging Populations: New HIV Cases versus Prevalence

The epidemic in the nine-county Philadelphia EMA is complex and has changed over time. There are a significant number of long-term survivors who have been living with HIV for 10, 15, 20+ years, and the populations that are acquiring HIV have shifted over time. Consequently, the people who are currently living with HIV/AIDS within the nine-county area are demographically very different from the people who are just being diagnosed with HIV/AIDS. Nearly a quarter (23%) of PLWH in the EMA likely were exposed to HIV through injection drug use, but less than 7% of new diagnoses were among people who inject drugs from 2012 – 2014. This decrease in new cases among people who inject drugs is commonly attributed to Philadelphia's syringe exchange program. Meanwhile, people aged 13 - 24 make up only 4% of total people living with HIV/AIDS in the EMA, but represented 26.7% of new HIV/AIDS diagnoses from 2012 – 2014. This demonstrates an emerging population for new HIV infections. Still, 61% of PLWH in the EMA are 45 and older, indicating that there is a significant aging population among people who are already HIV-positive. These differences indicate that different strategies may be needed for people who are linking to HIV care for the first time and those who the system is attempting to retain in care.

Special Populations

The target populations provided in the National HIV/AIDS Strategy are helpful in identifying those people most at risk of acquiring HIV or being loosely engaged in HIV care.[13] However, the Philadelphia EMA's diversity means that the target populations represent the majority of the EMA's general population. For example, combined population estimates for Black women and men, Latino men and women, and youth 13 – 24 total over 2 million EMA residents. Within the City of Philadelphia, Black women and men make up 42% of the population, and Latino men and women make up 13% of the population. These two target populations alone comprise 55% of the city's 1.56 million inhabitants.

[13] The White House, Office of National AIDS Policy (2015). *National HIV/AIDS Strategy for the United States: Updated to 2020*. Retrieved from https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.

Therefore, while each National HIV/AIDS Strategy population is addressed through Philadelphia EMA goals (with the exception of people in the Southern United States), some of the populations have been stratified.

Gay, Bisexual, and Other Men Who Have Sex with Men of All Races and Ethnicities

PDPH estimates that 5% of men in Philadelphia are gay, bisexual, or other men who have sex with men (MSM). Yet, MSM make up over one-third (36%) of people living with HIV/AIDS within the Philadelphia EMA. In 2014, one-third of new AIDS cases were among MSM, and over half of new HIV (non-AIDS) cases were among MSM in Philadelphia. This indicates that MSM are emerging as a significant at-risk population. Philadelphia surveillance data from 2014 suggests that 33.1% of the entire Black MSM population is living with HIV/AIDS and aware of their status. Meanwhile, incidence has increased among MSM aged 24 and under: this subpopulation accounted for nearly one-third (32.3%) of all newly diagnosed HIV (non-AIDS) for the EMA in 2014. EMA data on HIV diagnoses indicates that the majority of these infections are among Black MSM, since 60.7% of new MSM HIV (non-AIDS) diagnoses between 2012 and 2014 were among Black MSM. In Philadelphia's National HIV Behavioral Surveillance (NHBS) project, 27.5% of MSM tested positive for HIV. PDPH estimates that 13.2% of HIV-positive MSM are not aware of their status, which is higher than the citywide estimate of 10.4% undiagnosed HIV infections.

Furthermore, there was a 19% increase in the number of new HIV diagnoses in MSM in Philadelphia between 2006 and 2012, but a 55% increase in the estimated number of infections among MSM over that time. This suggests that there is a growing population of MSM who are unaware of their HIV status.

Black Women and Men

Black women and men make up 20% of the EMA-wide population but 58% of people living with HIV/AIDS in the Philadelphia EMA. In every part of the EMA, the percentage of new HIV infections among Blacks is significantly higher than the percentage of Blacks in the general population. In 2014, 67% of all new diagnoses in Philadelphia were among Blacks; of these, 45% were attributed to heterosexual contact, and 49% were attributed to male-to-male sexual contact. Only three percent were attributed to injection drug use.

Latino Men and Women

Latino men and women make up 9% of the EMA-wide population but 14% of people living with HIV/AIDS within the EMA. In Philadelphia, 14.5% of new diagnoses were among Latinos in 2014. Of these new diagnoses, 47% were attributed to male-to-male sexual contact, 41% were attributed to heterosexual contact, and 12% were attributed to injection drug use.

People Who Inject Drugs

While injection drug use was a leading exposure category early in the HIV/AIDS epidemic, new infections through injection drug use have declined considerably. Nearly one-quarter (23%) of people living with HIV/AIDS in the Philadelphia EMA were exposed to HIV through injection drug use, but only about 5% of new HIV diagnoses in 2014 occurred among people who inject drugs. According to Philadelphia's National HIV Behavioral Surveillance (NHBS) project, over two-thirds of all people who inject drugs in Philadelphia access syringe supplies through the locally-funded syringe exchange program. This program is widely attributed as the cause of declining HIV infections among people who inject drugs. In addition

to syringe exchange, this program provides harm reduction services like on-site HIV counseling and testing and referral to medical care. Furthermore, the NHBS project demonstrated that people who accessed the syringe exchange program had much higher rates of HIV testing than the general population of people who inject drugs (over 90%).

Youth Aged 13 – 24

Youth aged 15 – 24 make up about 15% of people living in the nine-county EMA.[14] Yet, a disproportionate number of new HIV diagnoses have been among youth in recent years. From 2012 – 2014, 29.5% of new diagnoses in Philadelphia were among youth aged 13 – 24. This figure was 22.8% in the PA counties and 18.9% in the New Jersey counties. Estimated new infections in 2013 were even higher for this group: people aged 13 – 24 accounted for 44% of these estimated new infections.

Transgender Women

Data on transgender women in the general population is very limited. In 2016, the Williams Institute estimated that 0.6% (about 1.4 million) of adults in the United States were transgender, based on survey data.[15] In 2015, the Census Bureau more conservatively identified 89,667 transgender individuals who were alive in 2010, based on official name and sex changes in Social Security Administration records.[16] Assuming that the more inclusive William Institute estimate similarly applies to the Philadelphia EMA, we can crudely estimate that there may be 32,464 people who are transgender in the EMA.

There is information available about transgender women living with HIV/AIDS in Philadelphia, although transgender data is not available for the surrounding counties. Surveillance data on transgender persons is not uniformly collected by testing or medical providers. In addition, some transgender people may not identify as transgender or may be gender non-conforming. Philadelphia HIV surveillance data did not have the capacity to collect current gender until 2009 (only sex at birth was captured prior to this). This has resulted in incomplete reporting of transgender persons living with HIV in Philadelphia. Improving this data is a high priority for the PDPH. The 2014 HIV Care Continuum (see Section B) was based on 140 transgender persons living with HIV in Philadelphia. Of these, 127 identified as trans women, 6 as trans men and, 7 identified another way. Of transgender persons living with HIV in Philadelphia, 72% were Black, 17% were Hispanic, and 6% were White. Nearly three-quarters were over the age of 30. For transgender persons living with HIV, most reported sexual risk as their mode of transmission (80%), with another 9% reporting injection drug use, and another 11% reporting both sexual and injection drug use as their risk.

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[14] U.S. Census Bureau (2015). S0101 Age and Sex [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/. The differences in age group between the section header and this sentence is not an error, but reflective of data reporting differences.

[15] Flores, A.R., Herman, J.L., Gates, G.J., Brown, T.N.T. (2016). *How many adults identify as transgender in the United States?* The Williams Institute. Retrieved from http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf

[16] Harris, Benjamin Cerf (2015). *Likely Transgender Individuals in U.S. Federal Administrative Records and the 2010 Census*. U.S. Census Bureau. Retrieved from http://www.census.gov/srd/carra/15_03_Likely_Transgender_Individuals_in_ARs_and_2010Census.pdf.

Pregnant Women

Prenatal care is a particular challenge in Philadelphia, where an average of 31% of mothers do not receive adequate prenatal care. According to PDPH data, 3% of HIV-positive women of childbearing age in the EMA become pregnant and deliver a baby each year. After extensive analysis, PDPH found that 25% of HIV-positive women who gave birth between 2005 and 2013 received their HIV diagnosis during pregnancy. Of these women, only 39% received adequate prenatal care during pregnancy, and 52% had achieved viral suppression at the time of delivery. This indicates an even lower receipt of appropriate prenatal care than seen in the general population (69%).

d. Indicators of HIV Risk

Mental Health

According to the 2010 – 2012 National Survey on Drug Use and Health (NSDUH), 4.91% of Philadelphians had a serious mental illness in the year before the survey, while 18.46% had any mental illness diagnosis during that time.[17] These figures were 3.47% and 16.88% in Southeastern Pennsylvania, and 3.4% and 16.66% in Southern New Jersey.[18] Furthermore, the NSDUH estimated that 7.95% of Philadelphians, 6.95% of Southeastern Pennsylvanians, and 6.46% of Southern New Jerseyans had a major depressive incident in the previous year.

Among people with HIV/AIDS, mental illness diagnoses were more common than in the general population. The 2009 – 2010 Medical Monitoring Project in Philadelphia found that 49% of people with HIV/AIDS had a mental health diagnosis. This indicates that approximately 13,289 people with HIV/AIDS in the Philadelphia EMA may have some form of mental illness.

Substance Use

The 2010 – 2012 National Survey on Drug Use and Health estimated that 28.44% of Philadelphians binge drank in the month before the survey, as compared with 25.75% of Southeastern Pennsylvanians and 22.87% of people in Southern New Jersey.

In Philadelphia, the 2010 - 2012 NSDUH estimated that 13.13% of residents used an illicit substance in the month before the survey, and that 4.2% of Philadelphians used an illicit substance other than marijuana in the previous month. In the surrounding PA counties, 7.81% of residents were estimated to have used any substance in the month before the survey, while 2.83% of residents were estimated to have used an illicit substance other than marijuana. In Southern New Jersey (a NSDUH region that includes the four EMA counties as well as three other counties), 8.82% of residents were estimated to have used an illicit drug in the past month, while 3.52% of residents were estimated to have used an illicit drug other than marijuana. The NSDUH estimated that 4.99% of Philadelphians, 4.7% of Southern

[17] United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (2010 – 2012). Pennsylvania: 2010 – 2012 National Survey on Drug Use and Health substate estimates. Retrieved from http://www.samhsa.gov/data/sites/default/files/substate2k12-StateTabs/NSDUHsubstateStateTabsPA2012.htm.

[18] United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (2010 – 2012). New Jersey: 2010 – 2012 National Survey on Drug Use and Health substate estimates. Retrieved from http://www.samhsa.gov/data/sites/default/files/substate2k12-StateTabs/NSDUHsubstateStateTabsNJ2012.htm.

New Jerseyans, and 3.77% of Southeastern Pennsylvanians used pain relievers non-medically in the past year.

According to the 2012 Treatment Episode Data Set - Admissions (TEDS-A), 93% of people in the Philadelphia area who were in rehabilitation programs for injecting drugs were White.[19] Among all Whites in rehabilitation programs, heroin was the most common primary substance, followed by alcohol. Among Blacks and Hispanics, the most common primary substance was marijuana, followed by alcohol. The National Survey on Drug Use and Health estimated that 3.75% of people in Philadelphia needed but did not receive treatment for illicit drug use in the year before the survey, as compared with 2.14% of people in Southeastern Pennsylvania and 2.26% of people in Southern New Jersey.

The January 1, 2016 Morbidity and Mortality Weekly Report cited reports that there had been a sharp increase in seizures of fentanyl in Philadelphia, which has previously been associated with increased overdose deaths.[20] In 2014, the state of Pennsylvania ranked #8 for overdose deaths in the United States, with 2,426 overdose deaths, a 12.9% increase over the previous year. New Jersey experienced a 3.4% decline to 1,253 deaths. Overdose death rates by county in the EMA ranged from 10.9 per 100,000 in Chester County to 29.7 per 100,000 in Gloucester County in 2013.[21]

Pennsylvania law changed to allow emergency responders to carry naloxone for the purposes of overdose reversal in November 2014. From that time until September 1, 2015, Delaware County police reversed 84 overdoses, 29% of Pennsylvania police's 289 overdose reversals.[22] In the first six months of 2015, Philadelphia Fire and Emergency Medical Services (EMS) administered naloxone 1,258 times.[23] Camden County police also carry naloxone, and completed their 300th overdose reversal in September 2015. However, it is impossible to know how many of these overdoses would have resulted in death.

Some types of substance use appear to be more prevalent among the EMA's PLWH than the general population. Data from the 2013 Medical Monitoring Project in Philadelphia showed that 14.2% of people with HIV/AIDS who were accessing care binge drank, as compared with the 28.44% of all Philadelphians estimated to binge drink. However, 24.2% of MMP participants used illicit substances in the previous twelve months, while 13.13% of Philadelphians were estimated to have used an illicit substance in the

[19] United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality (2012). Treatment Episode Data Set -- Admissions (TEDS-A). Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]. Retrieved from http://doi.org/10.3886/ICPSR35037.v1

[20] R.A. Rudd, N. Aleshire, J.E. Zibbell, & R.M. Gladden (2016). Increases in Drug and Opioid Overdose Deaths – United States, 2000 -2014. *Morbidity and Mortality Weekly Report, 64*(50 – 51), 1378 – 1382. Retrieved from http://www.cdc.gov/mmwr/pdf/wk/mm6450.pdf.

[21] Centers for Disease Control and Prevention, National Center for Health Statistics (2015). Underlying Cause of Death 1999-2014 on CDC WONDER Online Database [Data]. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from http://wonder.cdc.gov/ucd-icd10.html.

[22] Sapatkin, Don (2015, September 02). Pennsylvania police reversed 289 overdoses, state says. *Philadelphia Inquirer.* Retrieved from http://articles.philly.com/2015-09-02/news/66112402_1_drug-overdoses-naloxone-narcan.

[23] Delaware Valley Intelligence Center (2015). Philadelphia Narcan Administration by ZIP Code 01 January through 30 June 2015. Retrieved from https://info.publicintelligence.net/DVIC-Narcan-2015.pdf.

month before the NSDUH. In addition, 10.7% of people with HIV/AIDS reported currently using substances during their PDPH's Client Services Unit intake.

Sexual Behaviors

Among adults in eight of the nine counties in the Philadelphia EMA (excluding Salem County), 121 of 4,193 Behavioral Risk Factor Surveillance Survey respondents in 2010 reported engaging in "risky behavior" in the year before the survey.[24] Risky behavior was defined as any of the following: intravenous drug use, sexually transmitted disease treatment, exchange of sex for money or drugs, or anal sex without a condom in the previous year. These behaviors were reported most frequently among people aged 25 – 34.

For the entire state of New Jersey, 29.1% of high school students surveyed in 2013 reported having sex in the past three months, and 41.4% of sexually active students did not use a condom at their last encounter.[25] Of all students, 12.2% reported having had at least 4 partners during their lives. In Philadelphia, 37.3% of high school students surveyed reported having sex within the last three months, and 42.2% of these students reported not using a condom at their last encounter. Of all students, 21.8% reported having had at least four partners during their lives.

Teen Pregnancies

In 2014, there were 6,659 births to teen mothers in Pennsylvania and 2,223 births to teen mothers in New Jersey.[26] Across all counties within the nine-county Philadelphia EMA, births to teen mothers decreased from 2008 to 2012. There were an estimated 2,736 births to 15 – 19-year-old mothers in the Philadelphia EMA in 2014 (excluding Salem County), a considerable decline from the estimated 4,362 births to teen mothers in these eight counties of the EMA in 2008.

Prenatal Care

Within Philadelphia, an average of 30.9% of pregnant mothers of received inadequate[27] prenatal care from 2011 – 2013.[28] This figure was 37% among Black mothers and 34.8% among Hispanic mothers. When broken out by age, 45% of mothers under the age of 20 received inadequate prenatal care. For the entire state of Pennsylvania, 18.4% of all mothers received inadequate prenatal care, compared with 30.1% among mothers under the age of 20, 30.2% among Black mothers, and 27.4% among Hispanic mothers. The most recent data available on prenatal care for the state of New Jersey is from 2008 – 2010. Statewide, an average of 14.9% of all mothers received inadequate prenatal care, as compared with 33.1% of mothers under the age of 20, 26.3% of Black mothers, and 20.4% of Hispanic mothers. In

[24] Centers for Disease Control and Prevention (2010). Behavioral Risk Factor Surveillance System Survey Data [Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/brfss/annual_data/annual_2010.htm.

[25] Centers for Disease Control and Prevention (2013). 1991-2013 High School Youth Risk Behavior Survey Data [Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://nccd.cdc.gov/youthonline/.

[26] U.S. Census Bureau (2014). B13002 Women 15 to 50 Years Who Had a Birth in the Past 12 Months by Marital Status and Age [Data]. *2010-2014 American Community Survey 1-Year Estimates*. Retrieved from http://factfinder.census.gov/.

[27] Inadequate care was defined as a mother receiving less than half of recommended prenatal visits.

[28] National Center for Health Statistics (2015). Final natality data [Data]. Retrieved from http://www.marchofdimes.org/peristats.

Camden County, an average of 19.7% of all mothers from 2008 to 2010 received inadequate prenatal care. This figure was 31.3% for mothers under the age of 20, 26.3% for Black mothers, and 25.5% for Hispanic mothers.

Sexually Transmitted Infections

In Philadelphia, recent data on sexually transmitted infections indicate that they are once again declining following a period of increase. From 2010 to 2013, cases of syphilis (all stages) were on the rise; however, they saw a slight decline to 892 cases in 2014.[29] Within 2014 syphilis cases, 48% were among people known to be HIV-positive. Cases of gonorrhea were on the rise from 2010 to 2012, peaking at 7,293 cases; however, gonorrhea has also been on the decline, and 2014 saw only 5,961 cases. Incidence of gonorrhea among people with HIV/AIDS was 2.3% in 2014.[30] This trend has also been seen in chlamydia: cases of chlamydia increased from 2010 to 2012, when they peaked at 20,803, but have since fallen to 18,935 in 2014.[31] In addition, incidence of chlamydia among people with HIV/AIDS was also 2.3% in 2014.

In the suburban Pennsylvania counties, cases of chlamydia and gonorrhea rose from 2010 to 2013, and fell slightly in 2014.[32] The number of cases of primary and secondary syphilis by county are too small to analyze trends, but at the state level, annual primary and secondary syphilis cases have risen from 369 to 531 from 2010 to 2014.

Trends in sexually transmitted infections vary among the New Jersey counties. For gonorrhea, all counties but Salem County experienced more cases in 2014 than in 2010.[33] In 2014, there were more cases of chlamydia in Burlington and Gloucester Counties than in 2010, while there were fewer cases in Camden County, and slightly fewer cases in Salem County. There were also more cases of primary and secondary syphilis in the New Jersey counties in 2014 than 2013, although the total for the four counties was still only 51.

Incarceration

According to a Pew Charitable Trust report as of 2010, Philadelphia had the highest rate of incarceration of any of the ten major cities in the United States.[34] The prison population in Philadelphia rose from 1999 through 2008, and began to decline in 2009. The Pew report partially attributed this decline to a

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[29] Philadelphia Department of Public Health, STD Control (2015). Reported Cases of Syphilis (All Stages) [Data]. Retrieved from https://hip.phila.gov/Portals/_default/HIP/DataReports/Syphilis/Syphilis_ReportedSyphCaseCountsGenderAge_1990_2014.pdf.

[30] Philadelphia Department of Public Health, STD Control (2015). Reported Cases of Gonorrhea [Data]. Retrieved from https://hip.phila.gov/Portals/_default/HIP/DataReports/Gonorrhea/Gonorrhea_ReportedGCCaseCountsGenderAndAge_1990_2014.pdf

[31] Philadelphia Department of Public Health, STD Control (2015). Reported Cases of Chlamydia [Data]. Retrieved from https://hip.phila.gov/Portals/_default/HIP/DataReports/Chlamydia/Chlamydia_ReportedCTCaseCountsGenderAndAge_1990_2014.pdf.pdf

[32] Pennsylvania Department of Health, Bureau of Communicable Diseases (2016). Sexually Transmitted Disease [Data]. Retrieved from https://www.phaim.health.pa.gov/EDD/Default.aspx.

[33] New Jersey Department of Health, Division of HIV, STD, and TB Services (2016). 2014 Comprehensive STD by County [Data]. Retrieved from http://www.nj.gov/health/std/stdstats/stdstats2014/composite_totals.pdf.

[34] The Pew Charitable Trust, Philadelphia Research Initiative. (2016). *Philadelphia's Crowded, Costly Jails: The Search for Safe Solutions* (pp. 2-5). Retrieved from http://www.pewtrusts.org/~/media/assets/2010/05/17/philadelphias_crowded_costly_jails_rev.pdf

decrease in arrests and partially to a new state policy that moved many inmates from the Philadelphia Prison System to the state system. In addition, the City of Philadelphia decriminalized the possession of small amounts of marijuana in October 2014. When comparing year-long arrest data (removing 2014, since the policy changed partway through the year), this led to an 81.2% decrease in marijuana possession arrests from 2013 to 2015.[35]

Recent data on incarcerated populations is limited, however, and often only available at the state level. As of 2013, there were 84,538 incarcerated persons in Pennsylvania, with a prison incarceration rate of 391 per 100,000 and a jail incarceration rate of 277 per 100,000.[36] In New Jersey, 40,073 persons were incarcerated, with a prison incarceration rate of 252 per 100,000 and a jail incarceration rate of 202 per 100,000. There was a daily average of 8,350 inmates in the Philadelphia jail system in 2014.[37] In addition, a local study found that 3.5% of men within the Philadelphia Prison System were HIV-positive, and this rate was even higher among women. A PDPH estimate indicated that about 2,739 people living with HIV were released back into the EMA from county, state, and federal prisons annually. In the first six months of 2015, 10.1% of medical case management intakes reported incarceration within the previous twelve months.

Housing

Rent (and rent as a proportion of income) varies across the Philadelphia EMA. In 2014, median income for Philadelphia renters was $26,624, while median rent was $915 per month.[38] This places median rent at 41% of median gross household income for renters in Philadelphia, which is higher than the national figure of 33%. By county within the EMA, this figure ranges from 31% - 40%. However, housing as a percentage of median income is even more expensive in the cities of Chester and Camden than in Philadelphia. The median rent in Chester city was $810 in 2014, while median renter household income was $21,423. The median rent in Camden city was $872, and the median household income for renters was $18,702. This places median rent to median renter household income at 45% and 56%, respectively. These figures demonstrate that there are variations in access to affordable housing throughout the EMA, but housing is particularly unaffordable in cities.

From 2014 to 2015, homelessness increased by 0.6% in Pennsylvania and decreased by 13.5% in New Jersey.[39] By contrast, homelessness decreased by 2.0% nationally. Unsheltered homelessness increased in both states, rising 4.2% in New Jersey and a notable 38.4% in Pennsylvania. The national rate decreased by 1.2%.

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[35] Pennsylvania State Police, Pennsylvania Uniform Crime Reporting System (2016). 18F – Drug Possession – Marijuana [Data]. Retrieved from http://ucr.psp.state.pa.us/UCR/Reporting/Query/Summary/QuerySumArrestUI.asp.

[36] U.S. Bureau of Justice Statistics (2016). State Imprisonment Rate [Data]. Retrieved from http://www.sentencingproject.org/the-facts/.

[37] Pennsylvania Commission on Crime and Delinquency (2016). Average Daily County Jail Population per 100,000 County Population 2013 [Data]. Retrieved from http://pacrimestats.info/trend_reports.aspx?p=\2013\Prisons_and_Jails\County_Jail_Population.

[38] U.S. Census Bureau (2015). S2503 Financial Characteristics [Data]. *2010-2014 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/.

[39] National Alliance to End Homelessness (2016). *The State of Homelessness in America 2016* (pp. 6 – 17). Retrieved from http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf.

In Philadelphia, the Office of Homeless Services has a Continuum of Care Board that addresses homelessness in a number of populations, including people with HIV/AIDS. Their Point in Time Count (conducted on January 29, 2014) identified 5,738 homeless persons in Philadelphia.[40] Of these, 104 were people known to be living with HIV/AIDS; 82 of these homeless PLWH were sheltered on the night of the count.

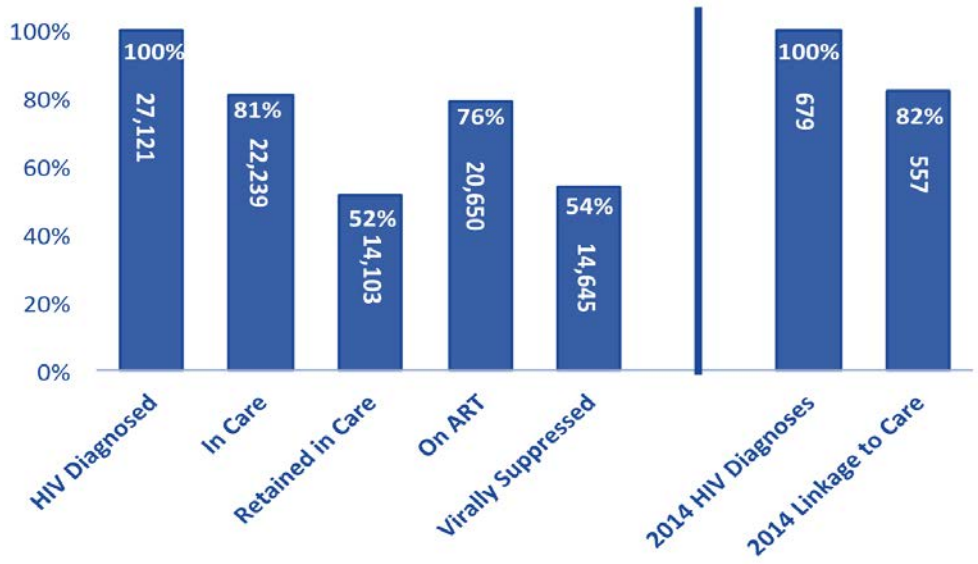
[40] City of Philadelphia, Office of Supportive Housing (2015). Philadelphia Continuum of Care 2014 Point in Time Summary [Data]. Retrieved from http://www.phila.gov/osh/PDF/Philadelphia_CoC_2014_Point_inTimeCount.pdf.

B. HIV Care Continuum

The EMA has used a diagnosed-based HIV Care Continuum for planning and evaluation purposes for over 5 years. The Philadelphia EMA Ryan White Part A Planning Council (RWPC) and the Philadelphia HIV Prevention Planning Group (HPG) use these data to make planning decisions.

a. HIV Care Continuum

Philadelphia HIV Care Continuum, 2014



HIV Care Continuum Definitions

HIV-Diagnosed is defined as the number of people living with HIV/AIDS (PLWH) in the EMA who have been diagnosed with HIV regardless of AIDS status. The data source for this stage is EMA wide HIV/AIDS surveillance data for PLWH using the person's current address as of December 31, 2014. The denominator for this indicator is HIV-diagnosed individuals.

In Care is defined as the number of PLWH in the EMA who had evidence of at least one CD4 count and/or one viral load and/or received antiretroviral therapy in 2014. The data source for this indicator is the EMA-wide estimate for Unmet Need, which has been described as the need for HIV primary medical care among individuals who know their HIV status but are not receiving such care. The denominator for this indicator is HIV-diagnosed individuals.

Retained in Care is the number of PLWH who received regular medical care in 2014. Regular medical care is defined as receipt of two or more CD4 counts and/or viral loads during 2014 with at least 90 days between the results. The data source for this indicator is City of Philadelphia HIV surveillance laboratory data. The denominator for this indicator is HIV-diagnosed individuals.

Prescribed Antiretroviral Therapy is the number of PLWH who have documentation of a prescription for antiretroviral therapy in their medical records in a calendar year. This data source is local data from the Medical Monitoring Project (MMP), which tracks the percentage of PLWH in the EMA who are prescribed ART. MMP is a national probability sample of HIV-infected persons receiving care in the U.S. in order to describe HIV care and support services being received and the quality of care received. The most recent local data for the City of Philadelphia for 2013 indicates that 79% of PLWH are on ART. This represented 97% of PLWH who were in care in the MMP sample. The denominator for this indicator is HIV-diagnosed individuals.

Virally Suppressed is the number of PLWH whose most recent viral load in 2014 was below 200 copies/mL. The data source is City of Philadelphia HIV surveillance laboratory data. All persons without a viral load were classified as unsuppressed. The denominator for this indicator is HIV-diagnosed individuals.

Linkage to Care is the number of PLWH in the EMA who have had a CD4 and/or a viral load test within three months after their diagnosis. The data source of this stage is City of Philadelphia HIV surveillance data. The denominator for this indicator is the number of newly diagnosed cases of HIV infection (regardless of AIDS status) in 2014 within the EMA.

The graph on the previous page illustrates the Philadelphia HIV Care Continuum, which relies on the number of individuals diagnosed with HIV as its denominator for all points along the continuum. See the table below to compare the EMA's continuum to national averages and the National HIV/AIDS Strategy objectives for 2020[41]. Philadelphia's outcomes along the continuum are better than national estimates. However, significant improvements are needed to reach the NHAS 2020 objectives. PDPH has efforts underway and future activities planned to increase the number of PLWH who know their status, who are engaged in care, and who are virally suppressed. PDPH analysis suggests that improving linkage to care could have the greatest impact on reducing the number of PLWH who are not engaged in HIV care (Unmet Need) in the future. Of the persons with Unmet Need in 2013, 42.2% had never linked to care after their initial HIV diagnosis; 36.7% had been linked to care in the past but had been lost to care for the 2 years prior to 2013; and 21.1% had evidence of care in either 2011 or 2012, indicating they were receiving sporadic care.

Engagement in Care Comparison

	EMA Continuum 2014	National Estimates 2012[42]	NHAS Goals by 2020
Diagnosed	90%	86%	90%
Linkage to Care	82%	80%	85%
Retained in Care	52%	54%	90%
Virally Suppressed	54%	42%	80%

[41] For more information on the National HIV/AIDS Strategy Updated for 2020 see the fact sheet at: https://www.whitehouse.gov/the-press-office/2015/07/30/fact-sheet-national-hivaids-strategy-updated-2020

[42] The data for the national estimates are all 2012 data, except for the Linkage to Care which is for people diagnosed in 2013 who were linked to care within a month of diagnosis. http://www.cdc.gov/hiv/pdf/Continuum_Surveillance.pdf

Further discussion of the Continuum includes disparities by subpopulations, as well as, PDPH activities to improve outcomes along the Continuum. More information on programmatic objectives, strategies, and activities can be found in Section II A.

b. Disparities Along the Continuum

HIV Diagnosis

Significant disparities exist in HIV (not AIDS) incidence in the EMA for men, racial minorities, youth and young adults, and MSM. Minority populations make up the majority of the cases (80.4%) more recently infected with HIV in the EMA and 87.0% of the cases in the City of Philadelphia. Among persons recently diagnosed with HIV (not AIDS), a greater proportion of cases among women, youth ages 13-24, MSM, and heterosexuals occur among minorities.

Men account for more than three-fourths of HIV cases. HIV cases among women in the EMA are stable. Less than one-quarter of newly diagnosed HIV cases occurred among women from 2012 to 2014.

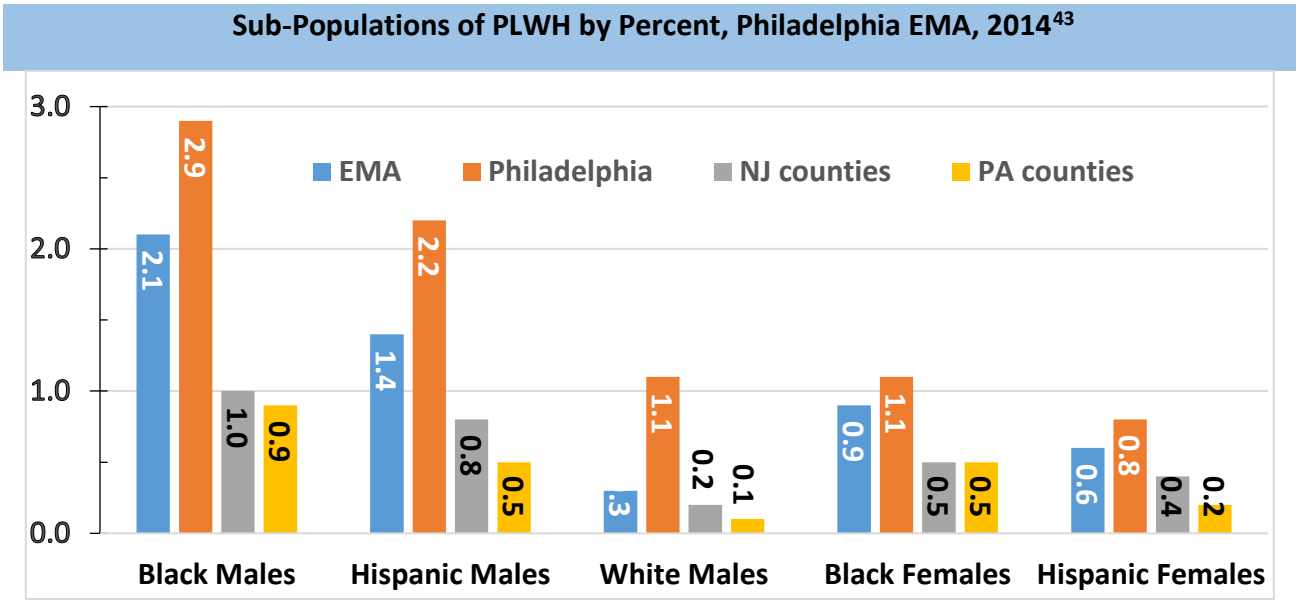
A growing number of newly diagnosed HIV (not AIDS) cases are among youth. Most of the cases of newly diagnosed HIV (not AIDS) are among persons age 20 – 39. However, a growing number of HIV cases are occurring in the 13 – 24-year-old age group (26.7%).

The low HIV incidence among people who inject drugs (PWID) is likely the result of the availability of syringe exchange in the City of Philadelphia. Less than 7% of new HIV infections occurred in PWID from 2012 to 2014.

HIV diagnoses have been relatively stable between 2012 and 2014. Sub-populations most affected are: Latinos (7.9% increase), those 50 and over (27.4% increase), and MSM (14.2% increase). Meanwhile, significant declines occurred among females (21.6% decrease), Whites (8.7% decrease), Blacks (7.5% decrease), PWID (31.1% decrease) and heterosexuals (8.2% decrease). Diagnoses were stable in all other groups.

Concurrent Diagnosis of HIV/AIDS

Trend data on concurrent HIV/AIDS diagnosis (persons diagnosed with AIDS within 3 months of their HIV diagnosis) indicates that both the number and proportion of persons with concurrent HIV/AIDS have decreased over the last several years: 30.1% in 2011, 29.7% in 2012, 26.6% in 2013, and 24.8% in 2014. The decline in concurrent HIV/AIDS is likely driven by increases in routine opt-out HIV testing, specifically in Philadelphia. Women, Whites, and those infected through heterosexual transmission are more likely to be diagnosed with concurrent HIV/AIDS. The risk of concurrent HIV/AIDS significantly increases in persons over the age of 30, and worsens even more among persons over the age of 40. Significant geographic differences occur in the diagnosis of concurrent HIV/AIDS, PLWH in the Pennsylvania counties are more likely than those in Philadelphia or the New Jersey counties to be concurrently diagnosed.



Living with HIV/AIDS

HIV/AIDS prevalence rates are notably higher in Philadelphia compared to the four Pennsylvania and four New Jersey counties for the same period. Rates are greatest among Black men, followed by Hispanic men, Black women, Hispanic women, White men, and White women. About 0.5% of all residents of the EMA are living with HIV/AIDS and aware of their status. However, the prevalence in the City of Philadelphia, which represents more than three-fourths of the EMA's epidemic, is 1.3% and as high as 2.9% in Black males, which meets the definition of a generalized epidemic. In the surrounding Pennsylvania and New Jersey counties, HIV is confined mainly to individuals who engage in high-risk behaviors, such as MSM, PWID, or sex workers.

In Care

Unmet Need for HIV primary care remains stable in the EMA at 19%.[44] After several years of consistent declines, the level of Unmet Need has plateaued for PLWH, PLWA, and the combined population. The estimate demonstrates that the declines are the result of systematic, concentrated efforts to identify, inform, refer, link, and retain in care PLWH through implementation of the EMA's EIIHA strategy; increased focus on retention in care through monitoring and quality management of RW provider services for PLWH; and innovative uses of surveillance and client outcome data to track progress on identifying, informing, referring, linking and retaining in care persons who test positive for HIV.

[43] White women are purposefully excluded from this graph because the percentage of White women in the EMA living with HIV/AIDS is so low. To include the percentage would make the graph less readable/useful to the reader.
[44] Unmet Need has been described as the need for HIV primary medical care among individuals who know their HIV status but are not receiving such care. This is different than measuring "retention in care", which is measured here as receipt of two or more CD4 counts and/or viral loads during 2014 with at least 90 days between the results.

Estimates for Engagement in Care for MSM of Color

	% Estimate	Number
HIV-infected	100%	7,033
HIV-diagnosed (as of December 31, 2014)	87%	6,105
Linked to HIV care	70%	4,915
Retained in HIV care	45%	3,144
On ART	55%	3,839
Suppressed viral load (<=200 copies/mL)	48%	3,364

Source: PDPH, 2015

Retained in Care

City of Philadelphia HIV surveillance data was used to examine disparities in Retention in Care. Males have lower rates of retention (48.8%) compared to females (57.0%) and transgender individuals (62%). Whites have lower rates of retention (46.1%) compared to Blacks (52.7%) and Latinos (51.8%) regardless of transmission risk. MSM (49.6%) and PWID (48.3%) have lower rates of retention compared to PLWH infected through heterosexual transmission (55.2%). PLWH ≥65 years of age have lower rates of retention (45.8%) compared to all other age groups (51.9%).

It is important to look at the Continuum as a whole, especially when looking at retention in care. An individual with a history of viral suppression may only go to the doctor once a year, and therefore not meet measurements for "retention in care". Local data from Philadelphia indicates that 19.2% of PLWH who were virally suppressed in 2014 did not meet the retention in care measure. A study by Yehia et. al. (2015) found that 10.0% of patients in a cohort of 17,140 patients from 11 U.S. HIV clinics were not retained in HIV care but had a suppressed viral load. [45] Additionally, based on this study, a greater proportion of patients would be classified as having met need, given they were retained in HIV care, despite the fact that they did not achieve viral suppression.

On ART

Youth aged 18 – 24 are less likely to be prescribed ART (81.7%) compared to persons 25 – 49 years of age (98.9%) and persons over 50 years of age (100%). No other disparities by sex, race/ethnicity, or mode of transmission have been identified.

Viral Suppression

The Philadelphia HIV surveillance data was used to examine disparities in viral suppression. There were no significant disparities in viral suppression based sex at birth and race/ethnicity. PWID and MSM/IDU have lower rates of viral suppression (48.3% and 47.9%, respectively) compared to MSM (54.7%) and persons infected through heterosexual contact (56.3%). Persons <35 years of age are less likely to be virally suppressed (49.1%) compared to persons ≥35 years of age (54.6%). Transgender individuals have

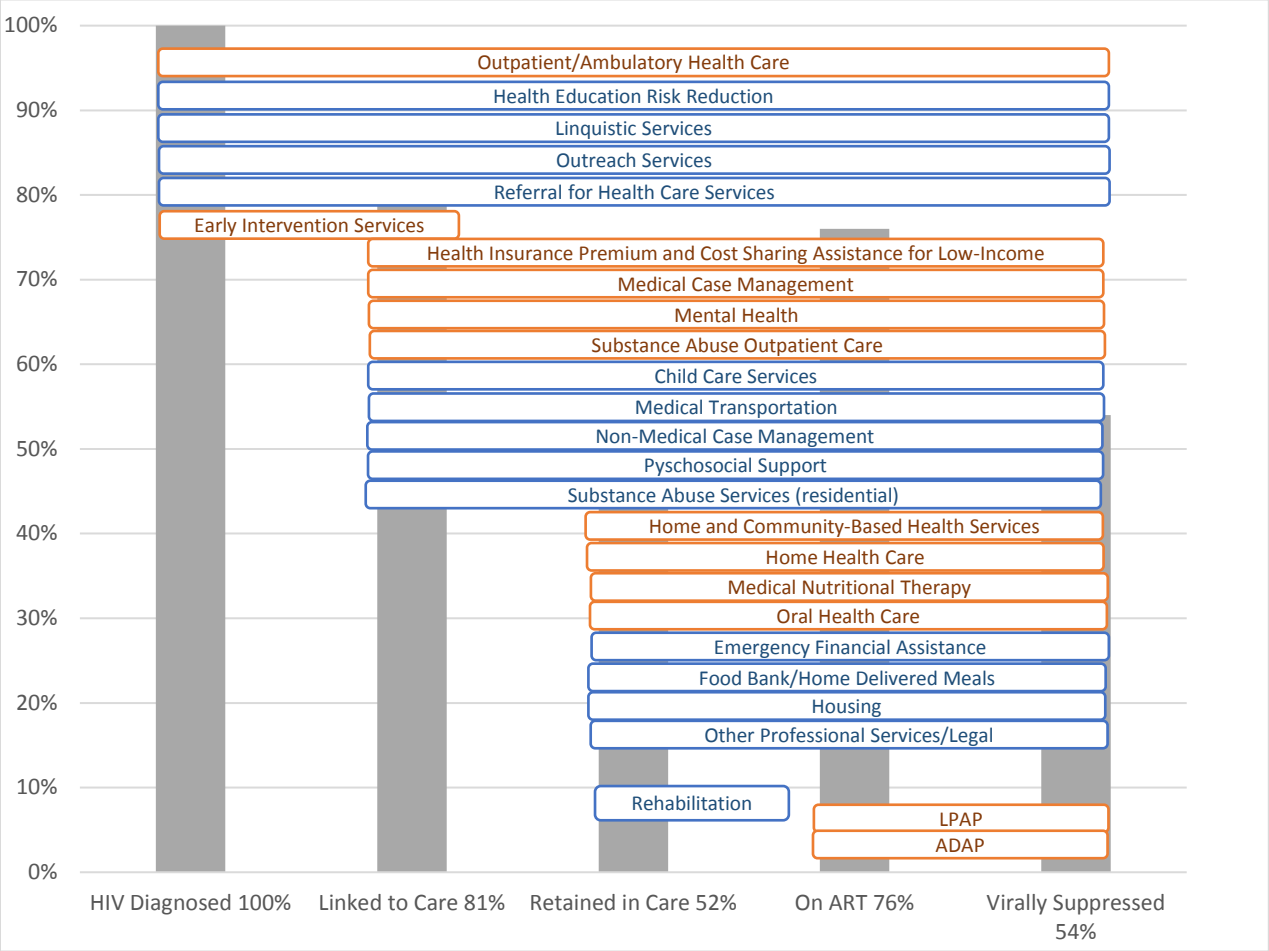
[45] Yehia, B.R. et al. (April 2015). Impact of age on retention in care and viral suppression. *Journal of Acquired Immunodeficiency*. 68(4), 413-419.

higher rates of viral suppression than the overall PLWH population (62%). There were no disparities found by race/ethnicity or within individual risk groups of MSM, PWID, or heterosexual transmission.

c. Continuum Use in Planning

In planning for 2016, the RWPC carefully analyzed the relationship between the local Continuum and eligible Ryan White service categories. PDPH staff, PLWH, community members, providers of Ryan White and other services, and OHP staff collaborated to develop a description of the extent to which each service category improved an individual's engagement in each stage of the Continuum. This RW service Continuum was a weighted factor of 30% in RWPC's priority setting tool. The factor quantified the impact of service categories along the Continuum, so that the more stages that a single service supported, the higher its final score. This iteration of the Continuum is used to better inform where and how to implement specific Ryan White services and MAI funding to address identified disparities. PDPH provides RWPC with performance outcomes along the Continuum for services to ensure the Part A program effectively addresses gaps in engagement.

Planning Council Determined Ryan White Services Along the Continuum



C. Financial and Human Resources Inventory

This section contains an inventory of the identifiable financial and service delivery resources available in the Philadelphia EMA. CDC-funded high impact prevention services, HRSA-funded core medical and support services, city funded services, and services available through other funded sources both private and public have been provided in table format. A table has been included that describes funding sources and services for Section I: C.a.i, ii and iv as outlined in the guidance. Another table can be found in Appendix A which includes funded service providers both public and private addressing guidance Section I: C.a.iii.

Section I: C. b is addressed in a table (found in Appendix A) that provides an overview of the HIV workforce capacity in the jurisdiction based on the overall occupational outlook as defined by the United States Department of Labor, Bureau of Labor Statistics for the eight county area of Bucks, Chester, Delaware, Montgomery, Philadelphia, Burlington, Camden, and Gloucester. Data for Salem County, New Jersey was not available, because it was included in a separate Metropolitan Statistical Area (MSA). *Designated Health Professional Shortage Area Statistics* as reported by the Bureau of Health Workforce, Health Resources and Services Administration are also included. Both New Jersey and Pennsylvania are designated health professional shortage areas.

a. Funding Sources and Services, Actual for 2015 and Anticipated for 2016

	Funding Source	Part A	Part B	Part C	Part D	Part F	CDC	SAMHSA
2015	Dollar Amount	23,515,526	27,385,953	5,243,110	2,333,743	278,693	7,527,547	1,657,117
	%	14.3%	16.7	3.2%	1.4%	0.2%	4.6%	1.0%
2016	Dollar Amount	25,428,282	27,385,953	5,148,591	2,257,406	261,620	8,943,170	
	%	15.1%	16.3%	3.1%	1.3%	0.2%	5.3%	
Core Services	Outpatient/Ambulatory Medical Care	✓	✓	✓	✓			
	AIDS Drug Assistance Program		✓					
	AIDS Pharmaceutical Assist.	✓						
	Oral Health Care	✓	✓	✓	✓	✓		
	Early Intervention Services						✓	
	Health Insurance Premium/ Cost-Sharing Assistance		✓					
	Home Health Care		✓					
	Home & Community-based Health Services		✓					
	Hospice Services		✓					
	Mental Health Services	✓	✓	✓	✓			✓
	Medical Nutrition Therapy	✓	✓	✓				
	Medical Case Management	✓	✓		✓			
	Substance Abuse Services – Outpatient	✓	✓	✓	✓			✓
Supportive Services	Non-medical Case Management							
	Child Care Services							
	Emergency Financial Assistance	✓	✓					
	Food Bank/Home-delivered Meals	✓	✓					
	Health Education/Risk Reduction		✓				✓	
	Housing Services	✓						
	Legal Services	✓	✓					
	Linguistic Services		✓					
	Medical Transportation Services	✓	✓					
	Outreach Services		✓	✓	✓		✓	
	Psychosocial Support Services		✓					
	Referral for Health Care/ Supportive Services	✓						
	Rehabilitation Services							
	Respite Care		✓					
	Substance Abuse Services – Residential							
	Treatment Adherence Counseling							
	Psychosocial Support Services							
	HIV Testing						✓	

Funding Sources and Services, Actual for 2015 and Anticipated for 2016 Continued

	Funding Source	HOPWA	Other HUD	State	Local	3rd Party Reimbursements and Rebates	Total All Funding
2015	Dollar Amount	7,951,436	2,435,519	7,160,256	1,988,161	76,814,351	164,291,412
	%	4.8%	1.5%	4.4%	1.2%	46.8%	100%
2016	Dollar Amount	9,104,000	2,435,519	7,160,256	1,988,161	77,815,563	167,928,521
	%	5.4%	1.5%	4.3%	1.2%	46.3%	100%
Core Services	Outpatient/Ambulatory Medical Care			✓	✓	✓	
	AIDS Drug Assistance Program					✓	
	AIDS Pharmaceutical Assist.						
	Oral Health Care				✓	✓	
	Early Intervention Services				✓		
	Health Insurance Premium/ Cost-Sharing Assistance						
	Home Health Care				✓		
	Home & Community-based Health Services						
	Hospice Services					✓	
	Mental Health Services					✓	
	Medical Nutrition Therapy					✓	
	Medical Case Management				✓	✓	
	Substance Abuse Services – Outpatient					✓	
Supportive Services	Non-medical Case Management						
	Child Care Services						
	Emergency Financial Assistance	✓					
	Food Bank/Home-delivered Meals				✓		
	Health Education/Risk Reduction			✓			
	Housing Services	✓	✓	✓			
	Legal Services				✓		
	Linguistic Services						
	Medical Transportation Services						
	Outreach Services			✓			
	Psychosocial Support Services						
	Referral for Health Care/ Supportive Services						
	Rehabilitation Services						
	Respite Care						
	Substance Abuse Services – Residential				✓		
	Treatment Adherence Counseling						
	Psychosocial Support Services						
	HIV Testing			✓	✓		

HIV Care Continuum Steps/Services Impacted

Stages of the HIV Care Continuum	Goal	Service Category (One or more may apply)
I. Diagnosed	Increase the percentage of clients who are aware of their status	***O/A Medical Care,*** Referral for Healthcare/ Support Services
II. Linked to Care	Increase the percentage of clients linked to care	***O/A Medical Care, Medical Case Management Substance Abuse-Outpatient,*** Housing Services, Medical Transportation
III. Retained in Care	Increase the percentage of clients retained in medical care	***O/A Medical Care, Medical Case Management, Oral Health Care, Mental Health Services, Substance Abuse-Outpatient, Medical Nutrition Therapy,*** Housing Services, Medical Transportation, Referral for HC/Support Services, Food Bank/HD Meals, Emergency Financial Assistance, Legal Services
IV. Prescribed ART	Increase the percentage of clients with access to prescribed HIV/AIDS medications consistent with HHS Treatment Guidelines	
V. Virally Suppressed	Increase the percentage of clients with a viral load of <200 copies/mL	

b. Work Force Capacity

The work force capacity table found in Appendix A is an overview of the area's workforce. Federal data was used to estimate the HIV workforce because specific data regarding the local HIV service workforce are not available. [46] Many public and private health systems serve the region's PLWH and those individuals most at risk.

According to federal labor statistics, key workforce shortages for the EMA include:

- Community health workers
- Counselors
- Dentists (specialists)
- Dieticians
- Epidemiologists
- Health educators
- Healthcare support workers
- Internists (general)
- Obstetricians and gynecologists
- Pediatricians
- Psychiatric aides and technicians
- Social scientists
- Social workers

To further illustrate workforce capacity issues, data from the Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services is provided on the next page. This analysis looks at the shortages of medical professionals in various geographic areas. Health Professional Shortage Area (HPSA) designations have been used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. "There are three categories of HPSA designation based on the health discipline that is experiencing a shortage: 1) primary medical; 2) dental; and 3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that, in order to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For primary medical care, the population to provider ratio must be at least 3,500 to 1 (3,000 to 1 if there are unusually high needs in the community)."[47]

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[46] The data is from the United States Department of Labor, Bureau of Labor Statistics, Occupation Outlook Handbook, May 2014. The areas contained in this table represent Metropolitan Divisions 15804 (Burlington, Camden, and Gloucester counties) and 37964 (Bucks, Chester, Delaware, Montgomery, and Philadelphia counties). Retrieved from http://www.bls.gov/oes/current/oes_37964.htm

[47] Bureau of Clinician Recruitment and Service, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, HRSA Data Warehouse: Designated Health Professional Shortage Areas Statistics, as of December 31, 2015. Retrieved from: file:///W:/2016%20Integrated%20Prevention%20&%20Care%20guidance/articles%20and%20other%20materials/Designated%20HPSA%20Statistics.pdf

The Health Professional Shortage Area for Pennsylvania and New Jersey, as of December 31, 2015

Location	Total Primary Care HPSA Designations [48]	Percent of Need Met [49]	Practitioners Needed to Remove HPSA Designation [50]
New Jersey	30	54.90%	13
Pennsylvania	159	63.70%	88
	Dental Care	**Percent of Need Met**	**Practitioners Needed to Remove HPSA Designation**
New Jersey	35	25.96%	23
Pennsylvania	164	38.98%	310
	Mental Health Care	**Percent of Need Met**	**Practitioners Needed to Remove HPSA Designation**
New Jersey	33	71.51%	4
Pennsylvania	122	60.84%	44

The city of Philadelphia has an adequate number of primary care providers, but these providers are not evenly distributed throughout the city. A study commissioned by PDPH found six neighborhoods had high population to provider ratios.[51] As measured by adults per primary care provider, the highest access neighborhoods have ten times more access than the lowest access neighborhoods. The population-to-provider ratios ranged from 250:1 to over 2600:1. Most of the lowest access

[48] The number of additional primary care physicians, dental care and mental health care providers needed to achieve a population-to-primary care physician ratio below the thresholds necessary for designation in all designated primary care HPSAs that would result in their removal from designation. The formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by nurse practitioners and physician assistants in an area. The figure reported for Practitioners Needed to Remove Designations for facility HPSAs includes correctional facilities. It excludes facilities not located in a HPSA that are designated based on providing services to the population of a geographic or population HPSA. It also excludes facilities automatically designated based on statute, including health center program grantees, Federally Qualified Health Center Look Alikes, Indian Health Service facilities, and rural health clinics that meet NHSC site requirements.

[49] The Percent of Need Met is computed by dividing the number of primary care physicians, dental care and mental health care providers available to serve the population of the area, group, or facility by the number of dentists that would be necessary to reduce the population to provider ratio below the threshold for designation so that it would eliminate the designation as a dental HPSA. Federal regulations stipulate that, in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds a certain threshold. For dental geographic designations, the ratio must be at least 5,000 to 1. For dental population designations or geographic designations in areas with unusually high needs, the threshold is 4,000 to 1. For correctional facilities, the threshold is 1,500:1 and takes into account the average length of stay, and whether or not intake examinations are routinely performed.

[50] The Percent of Need Met is computed by dividing the number of primary care physicians, dental care and mental health care providers available to serve the population of the area, group, or facility by the number of providers that would be necessary to reduce the population to provider ratio below the threshold for designation so that it would eliminate the designation as a dental HPSA. Federal regulations stipulate that, in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds a certain threshold. For dental geographic designations, the ratio must be at least 5,000 to 1. For dental population designations or geographic designations in areas with unusually high needs, the threshold is 4,000 to 1. For correctional facilities, the threshold is 1,500:1 and takes into account the average length of stay, and whether or not intake examinations are routinely performed.

[51] Brown, E., Grande, D.T., Barber, C.M., Polsky, D.E., Seymour, J.W. (May 2015). *Location Matters: Differences in Primary Care Supply by Neighborhood in Philadelphia*. Retrieved from http://ldi.upenn.edu/sites/default/files/location-matters-full-report060715.original.pdf

neighborhoods were also ones with concentrated poverty and a high percentage of minority populations. These same factors are associated with neighborhoods with increased HIV risk[52].

c. Coordination of HIV Prevention, Care and Treatment Services and Funding Sources

All Ryan White Part A funding is coordinated through PDPH's AIDS Activities Coordinating Office (AACO). Philadelphia EMA Ryan White Part A Planning Council (RWPC) plans activities in coordination with all other known public funding for HIV/AIDS and, to the extent possible, private grant programs that are implemented in partnership with Ryan White settings. Coordination of all these resources ensures that Ryan White funds are the payer of last resort, maximizes the number and accessibility of services available, and reduces duplication. Part A funding is somewhat more flexible than other public sources and is strategically allocated to necessary services and activities. This is due in large part to limitations on other resources which results in the inability to fully meet the need, e.g. funding restrictions or geographic constraints, or for which there is no other payer.

The EMA maintains a comprehensive HIV testing program that leverages city, state, federal, and private resources in a coordinated system that integrates routine testing in healthcare settings and supports targeted testing in community-based settings. As the recipient for CDC HIV funding in Philadelphia, PDPH is able to implement full coordination among HIV surveillance, prevention, and care services as well as engage a broad range of partners in the Continuum, including the New Jersey and Pennsylvania Departments of Health, the Philadelphia Prison System, emergency shelters, and other PDPH divisions, including Ambulatory Health Services, Division of Disease Control, STD Control. PDPH coordinates efforts with a large number of private sector entities, including community health care providers, hospitals/emergency departments, Federally Qualified Health Centers, maternal home visiting programs, HIV/AIDS services organizations, and several HIV service demonstrations projects.

d. Efforts to Identify and Secure Needed Services

Housing

EMA resources are unable to meet current housing needs of PLWH. The waiting list for HOPWA housing was approximately 350 people in January 2016. As of this plan, there were about sixty people on that waiting list for the HOPWA program in the New Jersey counties. Philadelphia's Division of Housing and Community Development estimates that it would need approximately $3.85 - 4 million in additional funding per year, as well as increased capacity, to end its HOPWA waiting list. The waiting list for the Housing Choice Voucher Program (formerly known as Section 8) has not been open in Philadelphia since 2010, and the waiting list will not reopen until the majority of those applications are served.[53] The current wait list has 100,000 people. The wait is estimated to be ten years.[54]

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[52] The findings of a geographic analysis of social determinants of HIV risk was completed in 2011 by OHP. The results of this analysis found that neighborhoods with the highest rates of PLWH were also neighborhoods with low socio-economic status, high concentrations of Black residents, high death rates, high birth risk, low neighborhood stability, and high crime rates of multiple types. The full analysis can be downloaded: http://hivphilly.org/Documents/2011GeoReport.pdf

[53] Philadelphia Housing Authority (2015). *Housing Choice Voucher Waiting List Update*. Retrieved from http://www.pha.phila.gov/pha-news/pha-news/2015/hcv-waiting-list-application-update.aspx.

[54] *Long wait, high demand for PHA housing*. Philadelphia Tribune. May 16, 2016. Retrieved from: http://www.phillytrib.com/metros/long-wait-high-demand-for-pha-housing/article_d7cde3e7-afde-5026-ba57-aab2b80304f4.html

In an effort to mitigate some of the unmet housing need of PLWH, the RWPC is assessing the feasibility of using Ryan White Part A funds to provide for short term transitional housing. Priority would be given to individuals experiencing homelessness. The RWPC will also explore the feasibility and impact of a Housing First program. The RWPC allocated Part A funds to rental vouchers (for Philadelphia only) in the 2017-2018 fiscal year, should the EMA receive a significant increase in Part A funds.

Health Insurance Cost-Sharing

The RWPC has identified health insurance cost-sharing as a possible barrier for privately insured PLWH. Pennsylvania is one of a few states not to cover health insurance premiums and cost-sharing assistance for Ryan White-eligible PLWH. At this time, Pennsylvania's ADAP program does not provide cost-sharing assistance for HIV-related healthcare and laboratory tests, only for prescription drugs. The RWPC allocated Part A resources for fiscal year 2017-2018 to fund a pilot program to provide cost-sharing assistance for privately insured PLWH in Philadelphia. At the time of this plan, the RWPC was working with PDPH to develop the reimbursement/payment mechanisms and eligibility requirements for the program. As of July 1, 2016, New Jersey funded organizations in the EMA to support co-pays and cost-sharing dependent on a detailed policy indicating a knowledge of insurance plans and a detailed tracking system to monitor true out of pocket costs (TROOP). The New Jersey Department of HIV, STD, and Tuberculosis Services (DHSTS) supports only Silver marketplace plans with a 70% actuarial value.

D. Assessing Needs, Gaps, and Barriers

The following needs assessment demonstrates that rising HIV prevalence significantly increases demand on available resources and highlights disproportionate impact on vulnerable populations. Multiple primary and secondary data sources were used to assess jurisdictional needs, including quantitative and qualitative research conducted by Office of HIV Planning (OHP) and PDPH. These data provide compelling evidence that, despite the availability of high quality outpatient ambulatory medical care and other medical and psycho-social services, health disparities persist for PLWH and other vulnerable communities. Although HIV incidence is stable or decreasing for most populations, the MSM and youth populations experience disproportionate risk of acquiring HIV. The HIV prevention system, which includes routine and targeted testing, PrEP, nPEP, condom distribution, partner services, and linkage navigation services, is targeted to address the disparities experienced by these populations.

This discussion will summarize the service needs and barriers in both the HIV prevention and care system in the EMA. The processes and data used to identify service needs, gaps, and barriers will be followed by a description of those identified needs, gaps and barriers.

a. Needs Assessment Process

Community input into the planning process is assured through multiple means. Memberships of the Part A Ryan White Planning Council (RWPC), the Philadelphia HIV Prevention Planning Group (HPG), and their respective committees reflect the demographics of the local HIV/AIDS epidemic. Community participation is welcomed by both the RWPC and HPG; all meetings are open to the public. Members and guests receive transportation reimbursement and refreshments at meetings. Language interpretation services are provided whenever requested within reasonable timeframes. Members and participants regularly receive training and data necessary to make planning decisions from OHP and PDPH staff and other local experts. Annually, both planning bodies actively recruit members to meet any gaps in representation. The Positive Committee represents the needs of PLWH through formal planning processes and needs assessment activities.

The Office of HIV Planning (OHP) supports the planning bodies in their assessment of service needs, gaps and barriers by providing data collected from other sources, as well as conducting original research on current needs in care and prevention services. Major needs assessment activities conducted by OHP since 2012 include the 2012 Ryan White consumer survey, focus groups with young MSM and heterosexuals of low socio-economic status, an online survey of medical case managers about consumer need for local pharmaceutical assistance, and surveys of both PLWH and providers about transportation access for PLWH. Information collected in these activities informs all planning processes, including development of this integrated plan, and service priorities and regional allocations of Ryan White funding.

OHP Needs Assessment Activities

Ryan White consumers were surveyed on their access to services, gaps, and barriers to care in the 2012 consumer survey. This survey was also conducted in 2007 and 2002. OHP worked with the EMA's Ryan White providers to ensure that a random sample of 25% of their clients received the survey through the

U.S. mail. Survey questions included basic demographics, health outcomes, barriers to services, and consumer priority for services. OHP received and analyzed 700 responses from the 3,500 survey distributed. The majority of the respondents were long-term survivors who were retained in care and had a suppressed viral load. These data tend to reflect the needs of consumers who are accessing services. Consumer survey data give the EMA information on service needs at the retained in care, on ART, and virally suppressed stages in the Continuum. Results from the survey informed RWPC and HPG efforts along the Care Continuum and also informed the Ryan White Part A service priorities and regional allocations. The survey asks consumers if there were services they needed but did not receive and why they didn't receive those services. These responses help RWPC and PDPH mitigate service gaps and barriers. Another consumer survey is scheduled for 2016/2017. OHP will work to update the survey to reflect the NHAS goals and indicators, as well as to collect data to evaluate the impact of ACA on the EMA's PLWH.

As a part of stakeholder engagement, OHP conducted focus groups in 2014 with MSM aged 18-30 and heterosexuals of low socio-economic status aged 25-65.[55,56] The discussions focused on the participants' experiences with primary and HIV specialty healthcare and HIV testing. Future focus groups with other populations are planned for 2017/2018. OHP shared the analysis with the HPG, RWPC, HIV service providers, federal partners, and community members through formal and informal means.

OHP has used geography to analyze social determinants of health for over a decade. In 2011, OHP requested Public Health Management Corporation conduct a multinomial logistic regression analysis of the relationships between HIV risk and 15 indicators of severe need in Philadelphia census tracts.[57] In 2015, OHP completed maps of over 60 social determinants for each of the EMA's counties.[58] These maps are used by RWPC and HPG to explore how social determinants like income, education, race/ethnicity, racial segregation, and disease and crime prevalence affect HIV risk and access to HIV care.

In fall 2015, PDPH requested that OHP conduct an online survey of medical case managers to better understand why and how the Local Pharmaceutical Assistance Program (LPAP) was used in the EMA. Case managers were asked about the situations in which clients rely on the program and barriers to accessing medications through other payers. These data informed the RW Part A grant application and the RW regional allocations for the service in FY2016/2017.

OHP conducted another online survey of RW medical case managers about PLWH access to transportation in 2016. The short survey asked how the provider organizations assisted clients attending medical appointments and what barriers providers and consumers experienced in accessing RW and Medicaid medical transportation. A similar survey was conducted with the members of the Positive

[55] The focus group analysis, *Experiences with HIV testing and Health Care in Philadelphia: Young men who have sex with men,* is available for download: http://www.hivphilly.org/Reports/YMSM.pdf

[56] The focus group analysis, *Experiences with HIV testing and Health Care in Philadelphia: High Risk Heterosexuals*, is available for download: http://hivphilly.org/Reports/HRH.pdf

[57] The 2011 Geographic Risk Analysis is available at http://www.hivphilly.org/Documents/2011GeoReport.pdf

[58] Data availability varies by county so not every county has data on every factor. The 2015 social determinant maps for each of the EMA's counties are available for download: http://www.hivphilly.org/documents.html

Committee in 2015. Those results informed the survey for case managers and discussions within the Needs Assessment, Positive, and Comprehensive Planning Committees of the RWPC.

PDPH and National Data Sources

Client Services Unit data measure client needs at PDPH Ryan White medical case management intake. Presenting needs will be high and generally unmet, because most of the clients calling are not currently retained in HIV care, even if they were so previously. These data give the EMA information on service needs at the HIV diagnosed and linked to care stages in the Continuum. These data are used to determine RW service priorities and regional allocations.

Medical Monitoring Project is a nationally representative, population-based surveillance system to assess clinical outcomes, behaviors, and the quality of HIV care. Data on 191 persons interviewed for MMP from Philadelphia for 2013 produced information about met and unmet needs for HIV care and care-related services. These data give the EMA information on service needs at the linked to care, retained in care, and on ART stages in the Continuum. These data are used to determine RW service priorities and regional allocations and inform RWPC about the service needs for PLWH who may not be RW clients.

National HIV Behavioral Surveillance (NHBS) is conducted in rotating, annual cycles, in three different populations at increased risk for HIV: men who have sex with men (MSM), people who inject drugs (PWID), and heterosexuals at increased risk for HIV infection. NHBS collects data in 22 project areas with high prevalence of HIV, of which Philadelphia is one. These data inform RWPC and HPG on risk behaviors, testing patterns, general demographics, HIV prevalence, and substance use of local at-risk populations.

b. Identified Service Needs of PLWH and Those at Most Risk

Poverty is a significant factor driving the needs of people at risk for and living with HIV (PLWH) in the EMA. Poverty reduces access to healthcare. Living in poverty limits individuals' abilities to make healthy choices and adhere to treatment. Even "nominal costs" or co-payments of a few dollars can prevent a person living in poverty from accessing care and medications. Most of the EMA's Ryan White clients are living in or near poverty and are insured by public insurance (like Medicare or Medicaid) or are uninsured. The EMA's coordinated and comprehensive HIV service continuum cannot meet all the needs of all PLWH and those at-risk. Service gaps exist because of lack of adequate funding, limited human resources, competing political priorities, and other factors. PDPH, OHP, and the community planning bodies (RWPC and HPG) work together to identify and address all service needs, gaps, and barriers with the resources available.

PDPH and RWPC regularly assess changes to needs and service gaps due to the implementation of the ACA. The expansion of Medicaid eligibility within the EMA was sporadic and inconsistent due to political changes in Pennsylvania. As of 2015, both Pennsylvania and New Jersey have expanded eligibility to all adults under 138% FPL. Considering the prevalence of poverty within the local population and particularly in PLWH, the EMA expects to see a decrease in the number of uninsured PLWH over the next five years. PDPH, HPG, and RWPC will work to ensure that all the resources available target the current and emerging needs in the era of ACA, and that RW funds remain the payer of last resort.

High Quality HIV and Primary Care

The EMA ensures access to high quality HIV medical care for all eligible PLWH through a coordinated system of diverse RW-funded providers. Despite the availability of high quality outpatient ambulatory medical care and other core and support services, many PLWH face disproportionate risks and effects of social determinants, particularly racial/ethnic minorities, men, and persons 20-49 years of age. In 2014, an estimated 27,121 people were living with HIV/AIDS in the Philadelphia EMA; 11,843 people were living with HIV not AIDS and another 15,278 people were living with AIDS. Over the past three years, 2,120 new cases of HIV and 1,172 new AIDS cases were reported. In 2014, over 14,000 unduplicated clients with HIV/AIDS received outpatient ambulatory medical care through the Ryan White Program, representing over half of the total number of people living with HIV/AIDS in the EMA.

Unmet Need for HIV primary care remains stable in the EMA. After several years of consistent declines, the level of Unmet Need has plateaued for PLWH, PLWA, and the combined population. According to the Unmet Need estimate for 2016 (current methodology), there were 5,197 PLWH (19%) who had not received the specified HIV primary care (2 viral loads in 12 months). PDPH determined that the declines are the result of systematic, concentrated efforts to identify, inform, refer, link, and retain in care persons who test positive for HIV through implementation of the EMA's EIIHA strategy; increased focus on retention in care through monitoring and quality management of RW services for PLWH; and innovative uses of surveillance and client outcome data to track progress on identifying, informing, referring, linking and retaining in care persons who test positive for HIV. Unmet need is more prevalent in some subpopulations like Blacks, Hispanics, and those between 20-29 and 30-39, compared to other racial/ethnic groups and age groups. See Section I. B. for more discussion on engagement in HIV care along the Care Continuum.

According to county health rankings compiled by the Robert Wood Johnson foundation, the EMA contains the most and least healthy counties in Pennsylvania – Chester (1) and Philadelphia (67). The three remaining counties' rankings demonstrate the differences between social and economic conditions among neighboring counties: Montgomery (3), Bucks (6), and Delaware (35). Out of the 21 counties in New Jersey, the EMA's four counties' rankings ranged: Burlington (9), Gloucester (16), Salem (16) and Camden (19).[59] The EMA's three counties with the lowest rankings are also the three counties with the largest HIV epidemics and greatest numbers of new HIV cases. [60]

In the EMA, the communities most affected by HIV are often also the poorest. Poverty creates barriers to care and gaps in services for many of the EMA's PLWH and those at-risk. While the Affordable Care Act (ACA) expanded access to health insurance and primary care for many people, health insurance is not healthcare. Many previously uninsured people do not have experience navigating service systems and may not understand their benefits or the services available to them. These newly-insured individuals need assistance from navigators and medical case managers to fully benefit from expanded access to clinical services.

[59] Robert Wood Johnson Foundation. *County Health Rankings*. Retrieved May 2016 from http://www.countyhealthrankings.org
[60] Office of HIV Planning. (2015). Integrated Epidemiological Profile for HIV/AIDS Prevention and Care Planning, Philadelphia Eligible Metropolitan Area. Retrieved from http://www.hivphilly.org/EpiProfile/2015Epi.pdf

Medical Case Management

Medical case management services help PLWH access supportive and medical services that enable them to stay in care and adhere to treatment. Local data confirm that persons who receive MCM are 1.7 times more likely to be retained in care each year than persons who did not receive MCM. The EMA makes every effort to ensure system capacity to provide medical case management services to all eligible PLWH. RWPC prioritizes medical case management (MCM) as service priority #1; understanding that the MCM system is the fundamental mechanism in the EMA that assists clients in removing barriers to accessing and retaining outpatient/ambulatory medical care and other core and supportive services. In 2014, the RW system provided medical case management to 6,363 clients.

In the EMA, PLWH access RW medical case management through the central intake at PDPH Client Services Unit. Social workers assess clients' medical and psychosocial needs (address any urgent needs) while linking the client to a medical case manager at a provider of their choice. At times, there is a waiting list for MCM services in Philadelphia due to clients requesting MCM services from a provider that is at capacity. CSU staff services to clients until that transition can be made or the client chooses to go to an available MCM provider.

Considering the pervasive nature of poverty and other complicating factors in the lives of PLWH, demand and need for medical case management are high. The EMA MMP sample showed 7.5% of PLWH were not receiving medical case management. Three percent of the 2012 consumer survey respondents reported needing medical case management services.

Transportation

PLWH's transportation barriers vary by geographic location within the EMA. In rural and some suburban areas, access to transit is limited or non-existent. Travel by public transit is time consuming and difficult for individuals with limited mobility. Medicaid transportation is available for Medicaid-eligible clients but consumers report barriers accessing it. Common challenges associated with Medicaid transportation are the need to call to schedule a ride or transit day pass at least 10 days in advance, being picked up late or not at all, and receiving transit day passes after the appointment time. Medicare-covered individuals have reported that even with the discounted transit fares, they don't always have the dollar necessary for fare. RW transportation services are available to PLWH who do not have access to Medicaid or other transportation services through tokens, transit passes and van service.

Transportation was reported as a need by 24% of PLWH who called into Central Intake in 2015. Transportation needs were more common for women of child-bearing age (29%) and PLWH who were recently incarcerated (33%). Participants in the OHP focus groups shared that time to travel to appointments can be a barrier to attending appointments because taking public transit across the city or into the suburbs can take an hour or two. In an informal survey of PLWH participating in the Positive Committee (N=23), 45% reported missing medical appointments due to not having transportation. Of those who reported problems with transportation to medical appointments, 50% reported money-related problems, 38% reported that Medicaid rides were late, and 12% had challenges scheduling rides.

OHP conducted an online survey of RW medical case managers and social workers about their client's transportation needs and barriers (N=50). Thirty-four percent of the case managers reported that their

clients' transportation needs were not being met. Problems with the contracted Medicaid provider were mentioned by the majority of case managers. These problems included: long waits, late pick up, difficult process, transit day passes arriving in the mail after appointments, and needing to schedule transportation at least 10 days prior to appointment. Other barriers noted by case managers included not having enough tokens on site to provide to clients who need them, policies barring giving tokens to clients for non-medical appointments, clients not having money to pay for transportation fares, and clients not having access to transit in their neighborhoods. Case managers expressed frustration with the processes and the limited resources available to help them meet their clients' transportation needs.

Dental Care

Dental care was noted as an unmet need by the respondents to the 2012 consumer survey. Of the respondents, 26% reported not having dental insurance. Forty percent of respondents did not receive dental care in the previous 12 months. Dental care was a need of 8.5% of PLWH calling into Central Intake in 2015.

Questions about access to dental care come up frequently at the Positive Committee meetings. PLWH report not knowing that they can receive free RW dental care services at local dental schools, as well as free or low cost care at public health clinics. Another barrier to access is long waits for appointments at these dental clinics. The wait for appointments for the dental school clinics can be several months long due to high demand and periods of time when students are not available (summer and other breaks). Providers and patients experience the same barriers to transportation to dental appointments as the ones noted above. Many PLWH access dental services for urgent matters due to lack of understanding of services available and lack of knowledge about oral health and living with HIV. Transitioning these patients to comprehensive preventative dental care is often difficult due to short staffing of dental offices, and a lack of dental case managers dedicated to this, as well as general lack of health literacy around oral health.

Approximately half of the EMA's RW clients receive Medicaid benefits, which cover basic preventative and emergency care, with some limitations. Dental providers report that Medicaid coverage of specialty care services is often approved when provided at educational institutions, but may not be in other provider types. The gaps in access are a combination of lack of understanding by both providers and consumers of available services within the EMA and a lack of insurance coverage for needed services.

Mental Health

The EMA estimates 13,289 PLWH in the EMA have mental illness, the majority with depression/anxiety (79.1%), 11.7% with bipolar disorder, and 9.2% with psychosis. Individuals with both mental illness and HIV represent a significant and vulnerable population. Between 2008 and 2010, 730 PLWH in the MMP sample were interviewed, of which 358 (49.0%) indicated having received a mental illness diagnosis. Patients with a mental illness diagnosis were more likely to be female, have Medicaid or Medicare as their insurance, and either actively use or have a history of alcohol abuse and injection drug use. Retention was similar between patients with and without a mental health diagnosis, with approximately 90% of patients satisfying retention criteria in either group. Adjusting for demographic and clinical factors, there was no significant difference in retention or use of ART, but mentally ill patients were

significantly less likely to achieve viral suppression than patients who were not mentally ill. Rates of viral suppression were lower for persons with depression/anxiety and psychosis but not bipolar disorder[61].

Blank et al. (2014) found that HIV prevalence (within samples from Baltimore and Philadelphia) was 4 times higher in a sample of people receiving mental health services than in the general population. There was a positive association between psychiatric severity and HIV infection.[62] In the 2012 consumer survey, 10% of respondents reported needing, but not receiving mental health counseling and other services in the last 12 months, and 42% reported a met need for mental health services. According to RW Central Intake, 45.2% of PLWH report a mental health disorder diagnosis at time of intake. During the first half of 2015, 27% of PLWH reported need for mental health services at intake.

Substance Use

Substance use is a significant public health challenge in the EMA. Rates of substance use are high in the EMA in the general population but are much more common in PLWH. EMA Behavioral Risk Factor Surveillance System data indicates 9.9% of the population used illicit drugs in 2012. [63] Alcohol, marijuana, cocaine, and heroin constituted 85.6% of primary drugs of choice reported at treatment admissions in 2014. [64] All drug use is of concern when planning HIV prevention and treatment services. Drug use affects an individuals' ability to negotiate condom use, leads to sexual risk behaviors, and may include sharing injection equipment. PLWH who use drugs are also less likely to adhere to treatment and to maintain viral suppression, which increases their chances of exposing their sexual and drug using partners to HIV.

Use and dependence on heroin and other opiates is an emerging concern in the EMA. Over the last few years there have been increases in the amount of heroin and other opiates seized by law enforcement, as well as increases in heroin and opiates-related overdose deaths and substance dependency treatment admissions. In Philadelphia, between 2013 and 2014, treatment admissions for primary drug use of heroin increased 1.6 percentage points, an increase of 3.2 percentage points from 2010. [65]

Drug overdose deaths are increasing in the EMA, particularly among Whites and people 25-44. Half of all drug overdose deaths in the EMA involve heroin. In Philadelphia, drug overdose deaths have increased 33% between 2013 and 2014. [66] There were 1,257 overdose deaths in the EMA in 2014: 655 in Philadelphia, 425 in the Pennsylvania suburban counties, and 177 in the New Jersey suburban

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[61] Yehia, B.R., Stephens-Shield, A.J., Momplaisar, F., Taylor, L., Gross, R., Dube, B., Glanz, K. Brady, K. (August 2015). Health outcomes of HIV-infected people with mental illness. *AIDS and Behavior*,1491-1500.

[62] Blank, M.B., Himelhoch, S.S., Balaj, A.B., Metzger, D.S., Dixon, L.B., Rose, C. E., Oraka, E., Davis-Vogel, A., Thompson, W.W., Heffelfinger, J.D. A multisite study of the prevalence of HIV with rapid testing in mental health settings. *American Journal of Public Health*, 104(12): 2377-2384.

[63] Centers for Disease Control and Prevention (2014). Behavioral Risk Factor Surveillance System Survey Data [Data]. Retrieved from http://www.cdc.gov/brfss/annual_data/annual_2012.html

[64] Substance Abuse and Mental Health Services Administration. (2014). Treatment Admissions Data Set [Data]. Retrieved from http://wwwdasis.samhsa.gov/webt/tedsweb/tab_year.choose_year_web_table?t_state=PA

[65] National Drug Early Warning System Sentinel Community Site Profile 2015: Philadelphia. August 2015. http://ndews.umd.edu/sites/ndews.umd.edu/files/SCS%20Philadelphia%202015%20Final%20Web.pdf

[66] Delaware Valley Intelligence Center (2015). Philadelphia Narcan Administration by Zip Code 01 January through 30 June 2015. Retrieved from https://info.publicintelligence.net/DEA-PhiladelphiaOverdoses-2013-2014.pdf

counties.[67,68] Increases in overdose deaths in the EMA and nationwide are being driven by an increase in the number of heroin users; high purity batches of heroin, which cause users to accidentally overdose; an increase in new heroin initiates, many of whom are young and inexperienced; users of prescription opioids initiating use of heroin which varies in purity, dosage amounts and adulterants; and the use of highly toxic fentanyl and other adulterants.[66]

According to the analysis of the National Survey of Drug Use and Health, four out of five recent heroin initiates (79.5%) previously used nonmedical pain relievers (NMPR) whereas only 1% of recent NMPR initiates had prior use of heroin. Not all individuals who use prescription pain relievers will use heroin; only about 4% will, and not all heroin users inject heroin. [69] According to 2013 TEDS data, approximately 70% of individuals in the EMA who were admitted into treatment for heroin dependence reported injecting heroin. About 19% of all individuals admitted to drug treatment in the EMA reported injecting any drugs.

Philadelphia has had a successful syringe exchange program for over 20 years. The syringe access program includes substance use dependency treatment, medical care, social support, and referrals to other services. PDPH estimates the PWID population (2010) of Philadelphia to be 37,378, with an HIV case rate of 48.2 per 100,000. It is unclear how many PWID share injection equipment and how many have increased risk from sexual behaviors like unprotected anal and vaginal sex. A recent analysis of program data from this syringe access program found that, over the period of 1999 to 2014, new registrants for the syringe exchange program have gotten more diverse, more geographically concentrated, and younger over time. Notably, the proportion of Latino new registrants increased from 6.2% in 1999 to 25.4% in 2014. The proportion of people under 40 years of age increased from 11.3% to 58.7% in the same timeframe. [70]

The EMA is concerned about the availability of syringe access in the suburban counties, outside of Camden and Philadelphia Counties. In Pennsylvania, the distribution of syringes is technically illegal, but several municipalities allow syringe access programs because of public health concerns. The EMA will monitor access to substance use dependency treatment services, due to the high demand for treatment for heroin and opioid dependence and limited available slots for the poor and uninsured. The EMA will continue to monitor the data available regarding drug use and PWID; and target HIV prevention, testing, and care services to the communities and subpopulations most in need.

PLWH and Substance Use

PDPH estimates that 10,414 PLWH in the EMA are substance users. Philadelphia MMP data for 2013

[67] Stirling, S. (2015, June 12) N.J. heroin-related deaths rise for 4th straight year, up 155% since 2010. Retrieved from http://www.nj.com/news/index.ssf/2015/06/nj_heroin-related_deaths_rise_for_4th_straight_yea.html
[68] Drug Enforcement Agency. (November 2015) Analysis of Drug-related Overdose Deaths in Pennsylvania, 2014. Retrieved from http://www.dea.gov/divisions/phi/2015/phi111715_attach.pdf
[69] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (August 2013). Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. Retrieved from http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm
[70] Maurer, L.A., Bass, S.B., Ye, D., Benitez, J., Mazzella, S., Krafty, R. (2016). Trend Analysis of Users of a Syringe Exchange Program in Philadelphia, Pennsylvania: 1999-2014. *AIDS Behavior*. P 1-11. http://link.springer.com/article/10.1007%2Fs10461-016-1393-y

indicates that 14.2% of PLWH binge drink and 24.2% used illicit drugs in the last 12 months. Malta et al. (2010) published a meta-analysis of studies assessing adherence to ART and a qualitative systematic review of factors associated with better ART outcomes in HIV infected drug users. [71] Active drug use was associated with worse ART adherence. Better ART outcomes were observed in former drug users, those with less severe psychiatric conditions, those receiving opioid substitution therapy and/or psychosocial support. The high rates of substance use among the HIV infected population require the development and implementation of specialized services, which add cost and complexity to HIV care. Integration between mental health, substance use dependency treatment, and HIV/AIDS prevention and care services is necessary to meet the needs of those living with HIV/AIDS and those at high risk.

Housing Insecurity and Homelessness

Homelessness creates barriers to access, adherence, and continuity of care. Inability to store or access medications, lack of routine medical care, poor nutrition, and the stress of being unstably housed affects the course of HIV disease. PDPH estimates that there are 2,700 PLWH who are insecurely housed on an annual basis in the EMA. A 2011 match of the surveillance registry and a sample of 592 homeless persons found that 41 individuals or 6.9% of homeless persons were living with HIV or AIDS. The EMA's 2012 consumer survey found that, of the 684 respondents, 3.9% reported living in a shelter or on the street. Analysis of demographic data of persons in the EMA who received any Ryan White services in 2014 indicates that 10.1% of persons with known housing statuses were non-permanently housed.

In Philadelphia, the Office of Homeless Services has a Continuum of Care Board that addresses homelessness in a number of populations, including people with HIV/AIDS. Their Point in Time Count (conducted on January 29, 2014) identified 5,738 homeless persons in Philadelphia.[72] Of these, 104 were people known to be living with HIV; 82 of these homeless PLWH were sheltered on the night of the count. The Continuum of Care Board's housing inventory cites a need for 3,909 year-round permanent supportive housing beds.[73] It is important to note that the Point in Time Count only includes homeless people in the city and not in the surrounding areas. In addition, this is according to the strict United States Department of Housing and Urban Development's Final Rule Defining Homelessness and does not include those clients who are unstably housed.[74]

Consistently, PLWH mention Housing as an unmet need. Half of the PLWH report housing assistance as a need at Ryan White Central Intake. Women of child bearing age (59%) and PLWH who were recently

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[71] Malta M., Magnanini M.M., Strathdee S.A., Bastos F.I. (2010). Adherence to Antiretroviral Therapy among HIV-infected Drug Users: A Meta-Analysis. *AIDS Behavior*, 14(4):731-47.

[72] City of Philadelphia, Office of Supportive Housing (2015). Philadelphia Continuum of Care 2014 Point in Time Summary [Data]. Retrieved from http://www.phila.gov/osh/PDF/Philadelphia_CoC_2014_Point_inTimeCount.pdf.

[73] City of Philadelphia, Office of Supportive Housing (2015). Philadelphia Continuum of Care 2014 Housing Inventory Chart. Retrieved from http://www.phila.gov/osh/PDF/Philadelphia_CoC_2014_Housing_Inventory.pdf.

[74] (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution;
(2) Individuals and families who will imminently lose their primary nighttime residence;
(3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or
(4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

incarcerated (53%) are even more likely to report housing needs. Twenty-seven percent of the 2012 Consumer Survey respondents reported needing housing services.

EMA resources are unable to meet current housing needs of PLWH in the EMA. As of January 2016 there were approximately 695 households supported with Housing Opportunities for People with AIDS (HOPWA) funds in Philadelphia and Delaware County, PA. The waiting list for HOPWA housing was approximately 350 people. In New Jersey suburbs, the Department of Planning & Development Division of Housing Services administers a HOPWA housing voucher program assisting 90 clients in 2016. As of this plan, there were about 60 people on that waiting list.

Permanent housing programs are limited in Philadelphia. The waiting list for the Housing Choice Voucher Program (formerly known as Section 8) has not been open in Philadelphia since 2010, and the waiting list will not reopen until the majority of those applications are served.[75] The current wait is estimated to be ten years, and there are over 100,000 people on the wait list.

Risk Behaviors Associated with Insecure Housing

People experiencing homelessness and housing insecurity are more likely to engage in sexual and drug using risk behaviors than housed individuals. Kidder et al. (2008) found that people experiencing homelessness were far more likely to have ever or recently engaged in substance use and HIV transmission risk behaviors.[76] Even after controlling for predicted confounding factors, housing status remained a significant predictor of the number of sex partners in the past 12 months, sex exchange (both lifetime and in last 12 months), unprotected sex with unknown status partners and all drug and alcohol use variables. A study on social instability and HIV risk in low income urban women found that homelessness was the only indicator consistently associated with multiple sex partners, sex exchange, and recent STI diagnosis in controlled models.[77] Men in the OHP focus groups who had been homeless said that while in active addiction they did not care about their health or STI or HIV prevention and would do what was necessary to secure drugs and/or survive.

Sex Education

The state of Pennsylvania does not require comprehensive sexuality education in its schools, only HIV prevention with a focus on abstinence. Individual school boards make decisions on sexual education within their districts, including whether to teach it at all. This is true in Philadelphia as well as the rest of the state. By contrast, New Jersey requires that school districts provide comprehensive health education, including a “Human Relationships and Sexuality” curriculum.

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[75] Philadelphia Housing Authority (2015). *Housing Choice Voucher Waiting List Update*. Retrieved from http://www.pha.phila.gov/pha-news/pha-news/2015/hcv-waiting-list-application-update.aspx.

[76] Kidder, D. P., Wolitski, R. J., Pals, S. L., Campsmith, M. L. (2008). Housing status and HIV risk behaviors among homeless and housed persons with HIV. *Journal of Acquired Immune Deficiency Syndrome*, 00(0), 1-5.

[77] German, D., Latkin, C.A. (2012). Social stability and HIV risk behavior: Evaluating the role of accumulated vulnerability. *AIDS Behavior*, 16(1), 168-178.

The CDC's School Health Profiles describe mandatory health-related curricula in secondary schools by state and urban area.[78] The 2014 survey included questions about whether each of sixteen HIV, STD, and pregnancy prevention topics were taught as a part of a required health course. The topics included basic information such as how to obtain condoms, the importance of limiting the number of sexual partners, and how HIV and other STDs are transmitted. Only 11.4% of Pennsylvania schools, 19.2% of Philadelphia schools, and 24.7% of New Jersey schools required all sixteen topics.

Secondary education provides the broadest opportunity to engage the general population of the EMA. This inconsistency in school health and sexuality education results in an uneven platform for dissemination of information about HIV/AIDS, risk behaviors, and healthy relationships.

Gaps in Service as Reported by Consumers

	2015 Client Services Unit – Need at Intake (N=1011)	2013 MMP (N= 191)	2012 Consumer Survey Respondent Identified Need (N=700)
Service	**%**	**%**	**%**
Dental	7	29	14
Benefits Assistance	37	8	2
Case Management	>90	7	3
Medications	24	2	3
Mental Health	29	2	11
Support groups/Peer Support	10	5	1
Transportation	24	5	5
Food	26	5	7
Housing	50	8	27
Substance Abuse Treatment	8	1	4
Medical Care	29	-	9
HIV Education/Risk Reduction	17	0.5	-
Treatment Adherence	19	2	-
Home Health Care	-	2	-

[78] Z. Demissie, N.D. Brener, T. McManus, S.L. Shanklin, J. Hawkins, L. Kann (2015). School Health Profiles 2014, Characteristics of Health Programs Among Secondary Schools. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/healthyyouth/data/profiles/pdf/2014/2014_profiles_report.pdf.

c. Identified Barriers to HIV Prevention and Care Services

Barriers to HIV prevention, screening, and care services are myriad and vary from interpersonal and individual psychosocial factors to systemic social factors like poverty and HIV stigma. The EMA utilizes every available resource and mechanism to mitigate and eliminate these barriers, yet many persist. Individuals at high risk for HIV and PLWH face many competing pressures and needs that complicate and compromise their abilities to practice risk reduction behaviors, access prevention services, get an HIV test, attend medical appointments, and adhere to treatment regimens. For these reasons, the EMA ensures access to medical care and a wide variety of support services through a coordinated and comprehensive system of services funded through local, state, private, and federal grants.

The following lists offer brief descriptions of the most important barriers and challenges to the EMA achieving the NHAS goals.

Social and Structural Barriers[79]

- Poverty, especially entrenched deep poverty
- Racism, often in conjunction with and/or because of poverty, is one of the drivers of health disparities among Black and Latino populations in the EMA. This racism may be perceived racism, structural racism, or interpersonal racism. Racism also manifests in racial segregation, which impacts individuals' and communities' abilities to access services and resources.
- Gender inequality limits women's ability to negotiate condom use and practice other harm reduction strategies. Many women with HIV and at greater risk for HIV are survivors of interpersonal violence and adult and childhood sexual trauma. These traumatic experiences may interfere with their abilities to engage in healthcare and practice healthy behaviors.
- LGBTQ stigma and discrimination pervade society, even with the legal advances of the last decade. Fear of stigma and discrimination based on one's sexual orientation or gender presentation can be a powerful barrier to accessing healthcare. This stigma is institutionalized in many regards, especially considering Pennsylvania does not have a legal protection against employment, housing, or other discrimination for LGBTQ individuals.
- HIV stigma prevents people from accessing HIV testing and prevention services and from engaging in appropriate health care. HIV stigma manifests in interpersonal, familiar, medical and other public settings.

[79] The social and structural barriers listed in this section are powerful and intersecting forces in HIV risk and health disparities. This section has been kept brief in order to aid readability. It is assumed the reader has a basic understanding of how social determinants influence HIV risk and health. For more information about social determinants of HIV risk refer to:
Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV in 11 states, the District of Columbia and Puerto Rico, 2013. HIV Surveillance Supplemental Report 2015;20(No. 5): http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillancereport-vol20-no5.pdf Published November 2015.
Dean, H. and Fenton, K. Addressing the social determinants of health in the prevention and control of HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis. Public Health Reports. 2010. 125(Suppl 4): 1–5. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882967/
Office of HIV Planning. Where we live matters: Social determinants of HIV risk. 2013 http://www.slideshare.net/HIVPhilly/where-we-live-matters-january-2013-update-57848626
Maps of many of the social determinants for the 9 counties of the EMA can be found on the Office of HIV Planning website on the Documents page: http://hivphilly.org/documents.html

- Mass incarceration affects community and individual-level risk for HIV on multiple levels that include limiting the number of adult males within a community, concentrating HIV within the incarcerated and recently incarcerated populations, practicing risk behaviors while incarcerated due to policies banning or limiting access to condoms and other harm reduction tools, and policies and laws denying individuals employment and other opportunities due to criminal history.
- Lack of affordable housing within the City of Philadelphia is a pervasive problem for the whole community, not just those living with HIV. There is also a lack of federal, state, and local resources to combat the problem. The pervasive nature of poverty makes this lack of housing resources even more acute to the most vulnerable communities.
- Lack of perceived risk of HIV can be found in various subpopulations, including minority heterosexual communities. Lack of perceived risk often leads to lax condom use, other sexual risk behaviors, and not seeking HIV screening.
- Medical mistrust is common among Black, Latino and other minority communities. Medical mistrust leads to individuals not seeking primary care and prevention services, as well as not adhering to treatment regimens.
- Lack of community knowledge about pre-exposure prophylaxis (PrEP) and other HIV prevention services impedes the full implementation of this necessary biomedical intervention.

Legislative and Policy Barriers

- Sexuality education varies in the EMA's public school systems, and often focuses on abstinence and contraception with little to no information relevant to students who do not identify as heterosexual or are gender non-conforming. In both New Jersey and Pennsylvania, sexually transmitted infections and HIV/AIDS education is required, but the methods and curriculum are decided by the local school board and individual schools. Sexuality education is required in New Jersey but not Pennsylvania.
- Syringe access barriers exist in the EMA because of state laws and federal funding restrictions on the purchase of syringes. In New Jersey and Pennsylvania, syringe distribution for the purpose of use of illicit drugs is illegal. Within the EMA, there are only two syringe exchange programs, a multi-site program in Philadelphia (city-funded) and Camden city. Syringes can be purchased in pharmacies without a prescription (at the discretion of the pharmacist) throughout the EMA.
- Federal funding restrictions limit the EMA's ability to provide PrEP to appropriate high-risk individuals. Ryan White funds and CDC HIV prevention funds cannot pay for medications for PrEP use or the accompanying laboratory tests. Pharmaceutical patient assistance programs do not provide funds for laboratory tests required for PrEP management. This limits the EMA's ability to ensure PrEP access to the most at-risk population. Patients wanting to start PrEP often have burdensome paperwork, waiting, and "red tape" to deal with before insurance will cover medications. If the EMA could provide starter packs of medications to individuals, more people could start PrEP immediately.
- Different laws about HIV laboratory reporting requirements hinder PDPH's ability to properly plan for the whole EMA, compare outcomes geographically, and to target programs and

resources appropriately. There are also significant reporting delays, which prevent planning in real time.

- Pennsylvania's "super protected data" policies, which cover mental health status, HIV status, and drug and alcohol treatment, hinder coordination within the state's various programs.
- Pennsylvania law considers it a felony for a person living with HIV to engage in sex work, even when using condoms and/or the activity cannot transmit HIV. New Jersey law criminalizes "an act of sexual penetration without the informed consent of the other person" by anyone who knows they are HIV positive. These laws impact the decisions PLWH make around disclosure and sexual behaviors. Neither state laws consider whether the intent was malicious or if transmission occurred or was likely to occur.
- Law enforcement may consider an individual carrying condoms as a sign of prostitution. This discourages sex workers from using condoms.

Health Department Barriers

- PDPH experiences challenges in coordinating between several health departments. These challenges range from differences in the type of surveillance data collected and timing of release of those data to differences in priorities, laws, and policies between jurisdictions. The differences in the types of data collected limit the ability of PDPH to develop EMA-wide Care Continuums and to compare the outcomes across the regions.

Program Barriers

- Due to PA and NJ confidentiality laws and differences in reporting requirements and methods, real time coordination of services on the client and provider levels are hindered. Written releases are required for any HIV-related information to be shared between providers.
- Lack of adequate funding to provide affordable short-term and permanent housing for PLWH and those at high risk for HIV. Federal, state, and local funds cannot meet the demand.
- Some medical providers are uninformed about PrEP, which leads to reluctance to prescribe PrEP to their patients. Many medical practices do not know how to bill for PrEP-related services and advocate for patients who want to initiate PrEP. Local AETC has been offering tailored training about PrEP implementation to clinics and medical providers, which has increased provider acceptability and implementation of PrEP. More work and funding are needed to fully implement PrEP throughout the EMA.
- Medical providers' reluctance to offer routine HIV testing to their patients is a barrier to full implementation of routine testing. Providers' reluctance stems from lack of perceived risk for patients, reluctance to discuss sexuality and risk behaviors, perception that HIV testing will be time consuming, and lack of knowledge about third-party billing.

Service Provider Barriers

- Lack of participation of insurers and state Medicaid offices in planning prevents a full understanding of how the public and private insurance programs provide for the needs of PLWH and those at risk. Coordination and integration of services would improve with participation from these payers.

Client Barriers

- Most of the EMA's PLWH and individuals most at risk for HIV are living in or near poverty. Poverty affects every aspect of an individual's life and well-being, including limiting access to healthcare and prevention services.
- Lack of reliable transportation is a common problem for people throughout the EMA. Transit does not run in many suburban and rural parts of the EMA. Those who live near transit lines may not have the money to pay fares. The PA Medicaid transportation provider is unreliable. Travel times to appointments via transit or Medicaid transportation can take hours, which limits individuals' abilities to keep appointments.
- Many PLWH and those at risk lack access to needed behavioral and mental health services due to lack of insurance coverage for needed treatment, workforce capacity issues, shortage of inpatient and outpatient treatment slots, and lack of integration of these services in primary care.
- Non-English proficiency is a barrier for various cultural and ethnic communities within our diverse EMA. Even if language interpretation and translation are available at service providers, many people are unaware of these or do not feel comfortable seeking healthcare and other services outside of their own communities. Printed health education materials are often only distributed in English.
- Many of the individuals at greatest risk for HIV experience stigma, discrimination and violence due to their gender, race, sexual orientation, and/or socio-economic status. Populations most vulnerable to the compounding impact of these intersectional identities are young men of color who have sex with men, Black men and women living in poverty, Latinas and Latinos, and Trans women of color. The trauma experienced by these individuals and communities must be addressed in order to provide comprehensive healthcare. These experiences of trauma impact the individual's ability to trust providers, access health care, and protect themselves from HIV and other health risks.
- Many PLWH and those at high risk are living with chronic and complex health concerns like diabetes, asthma, heart disease, viral hepatitis, mental health diagnoses, and substance use dependency. These co-morbidities require holistic and comprehensive care. Co-morbidities can also complicate HIV treatment through physiology and an individual's behaviors and health literacy about their various conditions.
- Housing instability and homelessness affect many PLWH and those at risk. Without adequate housing, it is difficult to maintain HIV treatment and continue healthy behaviors. Those who are insecurely housed may engage in risky sexual behaviors to secure housing. Affordable housing is scarce in the EMA, and the public housing programs are unable to meet demand.
- Low health literacy affects individuals' abilities to understand and adhere to treatment regimens.
- Fear of law enforcement and or other federal, state or local authorities prevents some individuals from seeking healthcare and other services; for example, undocumented immigrants, sex workers, drug users, and individuals with a history of incarceration.

E: Data Access, Sources, and Systems

a. Data Sources and Systems

The data used in this plan, the integrated epidemiologic profile, and HIV planning draw on a wide variety of sources. Regular review of data is fully integrated into the planning process. For example, the annual RWPC allocations process draws on the most recent epidemiologic data, service cost data, local consumer survey data, and more. The integrated epidemiologic profile compiles much, but not all, of this data. This plan, including the epidemiologic overview, draws on that information and adds further contextual information when appropriate. The primary data sources included in local HIV planning needs assessments, as well as this plan, are below.

PDPH and National Data Sources

- United States Census Bureau
    - American Community Survey: Information regarding general population, race, ethnicity, poverty, insurance status, education, and employment
    - Research on Americans who are likely transgender
- Bureau of Justice Statistics: Information on state imprisonment rates and HIV/AIDS mortality
- Pennsylvania Uniform Crime Reporting System: Drug-related arrest data
- Centers for Disease Control and Prevention
    - Youth Risk Behavior Survey: Survey data on risk behaviors of high school students, including drug and alcohol use and sexual behaviors
    - Behavioral Risk Factor Surveillance System: Survey data on risk behaviors of adults, including drug and alcohol use and sexual behaviors
    - Wide-Ranging Online Data for Epidemiologic Research (WONDER): Deaths attributed to HIV disease
- Health Resources and Services Administration
    - Health Professional Shortage Areas: Data regarding employment and shortages of health professionals; used heavily in the Resource Inventory
- Substance Abuse and Mental Health Services Administration
    - National Survey on Drug Use and Health: Data on serious mental illness and drug use
    - Treatment Episode Data Set – Admissions: Data on drug of choice and method of administration by demographic for people admitted to rehabilitation programs
- Philadelphia Housing Authority: Information about housing, homeless, and HIV, including point-in-time counts and general estimates
- Medical Monitoring Project: Local data on the medical care and needs of people living with HIV
- National HIV Behavioral Surveillance: Local HIV behavioral risk data for men who have sex with men, people who inject drugs, and high-risk heterosexuals
- Local and state health departments
    - HIV surveillance: New diagnoses, prevalence, and demographic data
    - STD surveillance
    - PDPH/AACO Client Services Unit: Requests at client intake, barriers to service, client demographics

- HIV prevention
- Vital statistics
- CAREWare: Client-level data
- Unduplicated client-level service utilization data
- Ryan White Services Report data
- Incidence estimates (where available)
- Quality management reports
- HRSA/HAB and PDPH/AACO performance measures

These data sources are augmented by published peer-reviewed research and comprehensive reports from various organizations, including the National Alliance to End Homelessness and The Pew Charitable Trust.

OHP Research

OHP assesses access to services, gaps, and barriers through a consumer survey every five years. The survey relies on Ryan White providers to randomly sample 25% of their clients, and asks questions about demographics, health status, barriers to care, and service priorities. In 2012, 3,500 surveys were distributed, and there were 700 responses. The next consumer survey will be conducted in 2016/2017.

In 2014, OHP held focus groups about general access to healthcare with young men who have sex with men and heterosexuals of low socioeconomic status. These focus groups provided new contextual information about individual experiences with the healthcare system that impact target populations' access to and interactions with healthcare and HIV testing.

In addition, OHP regularly uses geographic analysis to illustrate social determinants of health, inform planning decisions, and augment other data sources. OHP also conducts small-scale exploratory surveys as necessary in order to identify needs for further investigation.

b. Policy Facilitators and Challenges

One of Philadelphia's greatest assets in HIV data availability is the coordination of HIV funding under PDPH's AIDS Activities Coordinating Office (AACO). As a RW Part A recipient, RW Part B regional sub-recipient, and a directly-funded CDC HIV prevention recipient, PDPH's AACO has access to a comprehensive compendium of information about people who use HIV-related services in the region. This enables a thorough view of people living with or at risk for HIV who are a part of PDPH's HIV service system.

In order to augment this information, the Planning Council and HPG use many different data sources. While this provides a broad basis for HIV planning that includes several social determinants of health, it also necessitates using sources with different methods, variables, classifications, reporting, and coverage areas.

When using outside data sources, the geographical area is often ambiguous. The Philadelphia Metropolitan Statistical Area (MSA) is defined in several ways, and may include 11 counties in 4 states, 9 counties in 2 states (as seen in the EMA), 5 counties in 1 state, or another variation, depending on the source. The definition used in any given report is not always clear. There are also situations where a

county within the EMA is excluded by a data source. For example, Behavioral Risk Factor Surveillance Survey data is available for the 5-county Philadelphia MSA and a 3-county Camden MSA, but the latter excludes Salem County. In other cases, additional counties are included, as seen in the 7-county Southern New Jersey region in the National Survey on Drug Use and Health. The lack of uniform aggregate data standards across federal data sources, particularly as they pertain to geographic area, creates a challenge to planning for the EMA.

In addition, the Philadelphia EMA falls under two state health departments and one city health department. Each health department has a different structure, collects different data, and reports on different variables. This is the case for both HIV data and other categories of data. Furthermore, each releases data on a different schedule, which often involves a lengthy reporting delay.

The most significant policy challenge in developing the HIV Care Continuum in particular is the lack of comparable data from Pennsylvania and New Jersey. The City of Philadelphia has full electronic reporting of CD4 and viral load data. However, Pennsylvania only requires reporting for CD4 counts below 200 and detectable viral loads. In Pennsylvania, CD4 counts over 200 and undetectable viral load reports are not reported. Meanwhile, New Jersey requires reporting for all viral loads as well as CD4 counts below 200, and it only recently implemented electronic lab reporting. Consequently, a comprehensive HIV Care Continuum for the entire EMA is not currently possible.

Finally, one of the biggest barriers to effective data-informed service planning is maintaining compliance with Pennsylvania's strict HIV confidentiality laws. Surveillance-driven interventions have been demonstrated as effective strategies in many jurisdictions, but the Philadelphia EMA must use workarounds to implement these types of interventions. However, PDPH has identified many strategies to implement surveillance-assisted programs while complying with confidentiality laws; this can be seen in START Care, CoRECT, and HIV surveillance-assisted Partner Services referrals.

c. Unavailable Data

There is limited information available on the general population of certain risk groups. For example, detailed data on factors like income and insurance is not available by sexual orientation, which makes it difficult to analyze differences between men who have sex with men and the general population. This is even more difficult for persons who are transgender, since data related to gender identity is rarely collected, and certainly not on a population level. The lack of availability of population estimates and demographics for those populations creates a major difficulty in planning services. Likewise, risk behaviors (such as illicit drug use) are often underreported. This impacts planning for prevention service delivery, but also affects available information on mode of HIV transmission. Additionally, there is limited information on PrEP uptake, particularly for privately-insured patients; data on patients on PrEP in the region would be useful in prevention service planning.

Section II: Integrated HIV Prevention and Care Plan

A: Goals and Objectives

The Philadelphia Integrated HIV Prevention and Care Plan is the result of the collaborative effort of the Philadelphia Ryan White Part A Planning Council, the Philadelphia HIV Prevention Planning Group, and the Philadelphia Department of Public Health, AIDS Activities Coordinating Office to engage service delivery providers, people living with HIV, persons at higher risk for HIV infection, and other community stakeholders. The EMA has demonstrated a sustained commitment to HIV service system integration, funding coordination, quality management, and planning since the community first responded to the needs of people with AIDS more than three decades ago.

In keeping with the National HIV/AIDS Strategy (NHAS), the EMA's continuum of care has been built around various strategies for ensuring access to high quality and comprehensive HIV screening, prevention and care services that mitigate social, structural, economic, and personal barriers. The following goals and objectives were developed in keeping with the NHAS goals and objectives, and with the understanding of the local epidemic and social and structural barriers existent within the EMA.

The plan uses the NHAS target populations, as well as locally identified target populations. The NHAS populations include:

- Gay and bisexual men and other men who have sex with men of all races and ethnicities (MSM)
- Black women and men
- Latino men and women
- Transgender women
- People who inject drugs
- Youth ages 13-24

Activities that address and or support components of the care continuum have been shown in bold within the various activities throughout this section.

Goal 1: Reduce new HIV infections

Objective 1.1: Increase the proportion of people who know their HIV status

Strategy 1.1.1: Promote adoption of opt-out routine HIV screening in a variety of healthcare settings

Timeline	Responsible Parties	Activities	Target Population	Data Indicators
By the end of 2021	PDPH and partners	Provide training on third-party billing and integrating routine HIV screening into patient flow	Clinical providers Health care facilities	TA units delivered
By the end of 2021	Clinical providers Health care facilities	**Implement site appropriate routine HIV screening policies**	People aged 13 to 65	# of HIV tests in healthcare settings # of new HIV diagnoses in healthcare settings

Strategy 1.1.2: Offer targeted HIV screening and education particularly among gay and bisexual men and other men who have sex with men (MSM), transgender persons, high risk heterosexuals, and people who inject drugs (PWID)

Timeline	Responsible Parties	Activities	Target Population	Data Indicators
Through the end of 2021	Community-based providers PDPH-funded providers CDC-funded providers	**Community outreach and provision of the best testing technology for the site, including 4th generation testing where feasible**	NHAS populations EIIHA populations People who are experiencing homelessness	# of community-based tests HIV positivity rate # of new HIV diagnoses
Through the end of 2021	PDPH Community-based providers	Ongoing geographic and performance analysis of test sites to improve targeting	NHAS populations EIIHA populations People who are experiencing homelessness	HIV positivity rate # of community testing sites
Through the end of 2021	Philadelphia County Prison Health Services PDPH	**Offer opt-out HIV screening at intake**	Persons incarcerated in Philadelphia County jails	# of HIV tests in jails # of positive tests

Strategy 1.1.3: Offer timely screening and linkage to care to sexual and drug using partners of PLWH

Timeline	Responsible Parties	Activities	Target Population	Data Indicators
Through the end of 2021	HIV clinical providers HIV testing providers Health care facilities	**Refer all diagnosed PLWH to partner services**	Diagnosed PLWH	# of referrals to partner services
Through the end of 2021	PDPH	**Use surveillance data to trigger partner services**	Diagnosed PLWH	# of referrals to partner services
Through the end of 2021	DIS – PA Department of Health (PADOH), NJ Department of Public Health (NJDPH), PDPH	**Provide HIV and STI screening to identified partners of PLWH**	Sexual and drug using partners of PLWH	# of partners of PLWH tested # of partners of PLWH identified

Objective 1.2: Reduce the number of new HIV infections

Strategy 1.2.1: Ensure condom access and promote condom use

Timeline	Responsible Parties	Activities	Target Population	Data Indicators
Through the end of 2021	PDPH PADOH NJDPH	Continue widespread access to condoms through public schools, community-based providers and mail order	MSM High risk heterosexuals Youth aged 13-24 Trans women	# of condoms distributed # of condom distribution sites
By end of 2021	PDPH	Utilize social media to (re)normalize condom use through Do You Philly website targeting young MSM of color, free mail order condom distribution program, and adolescent website, Take Control Philly	Young MSM, sexually active youth, adolescent users of social media, general public	Social media metrics as available Number of condoms distributed through mail order requests
By end of 2021	PDPH	Develop social marketing campaign to promote use of condoms	Young MSM	Metrics of use of condoms collected through surveys TBD.

By the end of 2021	PDPH	Implement a new performance measure related to condom use in both care and prevention systems	Diagnosed PLWH and people accessing targeted testing services	Condom use at last sexual encounter

Strategy 1.2.2: Ensure the provision of PrEP and nPEP to at-risk populations

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PDPH PDPH-funded providers NJDPH PADOH	Coordinate EMA-wide provision of PrEP and nPEP	High risk HIV-individuals PWID Trans women Black women Latinas MSM Youths 13-24	NHBS survey data # of people accessing publicly-funded PrEP, and nPEP
By the end of 2021	PDPH	Develop and implement a plan to inform the public about the availability of PrEP and nPEP	High risk HIV-individuals PWID Trans women Black women Latinas MSM Youths aged 13-24	NHBS survey data

Strategy 1.2.3 Ensure equitable access to syringe access services, substance use treatment and related harm reduction services

Timeline	Responsible Parties	Activities	Target Population	Data Indicators
By the end of 2021	RWPC HPG PDPH Substance use service providers	Expand syringe access services throughout the EMA	PWID PLWH with opioid dependency	# of syringe access sites # of syringes exchanged
By the end of 2021	RWPC HPG PDPH Substance use service providers	Expand access to medication-assisted treatment for opioid dependency throughout the EMA	PWID PLWH with opioid dependency	# of treatment referrals
By the end of 2021	RWPC HPG PDPH Substance use service providers	Expand access to and capacity of substance use treatment throughout the EMA	PWID PLWH with opioid dependency	# of treatment referrals # of RW SA units provided

Strategy 1.2.4: Reduce the amount of HIV virus within communities

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH PADOH NJDPH RWPC Medical case management providers	**Ensure equitable access to ARVs**	PLWH	# of ADAP clients Percentage of diagnosed PLWH on ARVs MMP indicator related to ARV Rx
Through the end of 2021	PDPH PADOH NJDPH RWPC Clinical providers	**Support treatment adherence activities**	PLWH	HAB measure – 06 PHL measure - 03

Strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH	Continue the HIV Fetal and Infant Mortality Review process in Philadelphia to improve health outcomes for HIV+ women and HIV-exposed infants	HIV+ pregnant women HIV+ women HIV exposed infants	# of cases reviewed # of recommendations implemented by Community Action Board
Through the end of 2021	Clinical providers PDPH	Promote perinatal medical case management program	HIV+ pregnant women HIV+ women who want to become pregnant	# of women referred to perinatal case management # of perinatal case management clients

Strategy 1.2.6: Identify persons with acute HIV infection and immediately link them to HIV care

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH Hospitals Health care provider organizations	**Promote the implementation of 4th generation HIV testing**	NHAS populations People aged 13 to 65	# of acute infections identified # of 4th generation tests # of 4th generation testing sites
Through the end of 2021	Clinical providers PDPH Medical case management providers Testing sites	**Ensure immediate linkage to HIV care and ARVs**	Newly diagnosed people with acute HIV infection	% of newly diagnosed people with acute HIV infection immediately linked to care

Strategy: 1.2.7: Reduce the percentage of youth, including gay and bisexual men who engage in HIV-risk behaviors

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PADOH PDPH NJDPH School districts within the EMA	Promote comprehensive, culturally-competent sexuality education that includes and addresses the needs of LGBTQ youth	Students in public schools	YRBS School Health Education Profiles
By the end of 2017	PDPH	Create online campaign Do You Philly to encourage condom use, HIV testing, and PrEP uptake in Philadelphia	Young MSM of color	# of condom requests Social media and website analytics
Through the end of 2021	PDPH Philadelphia high schools	Continue condom distribution program and Take Control Philly campaign	Youth aged 13-24	# of condoms distributed # of condom requests

Anticipated challenges and barriers to Goal 1 include:

- Access to PrEP is complicated by high cost, burdensome paperwork, and lack of community and provider knowledge/comfort.
- Sexuality education is not mandated in PA schools. Local school districts decide what curriculum and sexuality content are taught in schools, which leads to inconsistent or non-existent sexuality education in public schools.
- Individual-level barriers complicate immediate linkage and treatment adherence like drug use, poverty, mental health, lack of insurance, homelessness, etc.
- There is a lot competition for young people's attention via social media and online campaigns.
- Access to prenatal care is a challenge to women living in poverty due to a variety of causes like lack of adequate number of providers in some communities and complicating personal factors including drug use, mental illness, and domestic violence.
- Philadelphia Public schools allow STD testing, but not HIV testing, within schools. Including HIV testing would allow for the opportunity of early diagnosis and treatment, as well as referral to appropriate risk reduction interventions.
- Healthcare facilities must change internal administrative practices to adopt routine screening and develop mechanisms to bill third party payers.
- Reaching at-risk populations requires providing culturally competent and culturally appropriate services at non-traditional times and locations.
- Providing health services in prison/jail settings requires partnership and collaboration.
- Prisoners with HIV may be released without notice or adequate linkage to community-based care.
- Partner services requires trust in public health personnel to maintain confidentiality with sensitive personal information.

Resources

To achieve the objectives related to this goal, multiple funding sources will be coordinated to maximize available resources, including CDC (HIV prevention), Ryan White (Parts A, B, C, D and MAI), public and private insurance, and City General Revenue funding. (See Coordination of Services and Funding in Section I. C. a. i.)

Goal 2: Increase access to care and improve health outcomes for people living with HIV

Objective 2.1: Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis

Strategy 2.1.1: Reduce individual and programmatic barriers to care

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH NJDPH PADOH	**Continue development and delivery of evidence-based (and informed) and protocol driven linkage services including navigation services such as CoRECT, DIS Linkage Services and NJ Clinical navigation programs**	Newly-diagnosed PLWH PLWH never linked to care	# of navigation services clients # of successfully linked navigation clients
Through the end of 2021	PDPH PADOH NJDPH RWPC	**Expand access to supportive services that enable timely linkage to care, including transportation and psycho-social support**	PLWH	Related HAB measures for gap in HIV medical care

Strategy 2.1.2: Reduce systemic barriers to timely linkage to care.

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH NJDPH PADOH	**Continue to support a range of co-located HIV testing and clinical services**	NHAS populations	# of co-located testing and clinical sites
By the end of 2021	PDPH and health care providers	**Develop protocols for immediate linkage to care for persons who test in community settings**	NHAS populations	# protocols /MOU developed

Strategy 2.1.3: Promote access to Ryan White services for newly-diagnosed individuals

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH Mid-Atlantic AETC NJ AETC	Disseminate information about RW services for newly-diagnosed individuals	Non-Ryan White clinical providers Hospitals	# of TA units
Through the end of 2021	PDPH RWPC	Continue provision of centralized medical case management intake	PLWH	# clients linked to medical case management

Objective 2.2: Increase the percentage of people with diagnosed HIV infection retained in care

Strategy 2.2.1: Reduce individual barriers to retention in HIV care

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH NJDPH PADOH RWPC RW providers	**Continue co-located clinical and supportive services, including mental health, substance use treatment, and medical case management**	PLWH	# of provider sites with co-located services
Through the end of 2021	RW clinical providers PDPH	Provide ongoing assessment of behavioral health needs of patients in HIV clinical providers and linkages to appropriate services	PLWH	HAB measures – 21 and 23
Through the end of 2021	PDPH	Provide data-to-care activities including CoRECT and ARTAS to find and reengage clients to care who have been lost to care.	PLWH who have fallen out of care	# clients re-linked to care # clients with durable viral suppression

Strategy 2.2.2: Reduce programmatic and provider barriers to retention in HIV care

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PDPH RW providers RWPC Mid-Atlantic AETC NJ AETC	Ensure all RW services are linguistically and culturally competent and LGBTQ affirming	RW clients	CSU grievance data TA units Consumer survey data
By the end of 2021	PDPH RW providers RWPC Mid-Atlantic AETC NJ AETC	Promote adoption of trauma-informed approaches	RW providers	TA units Quality Improvement Plans (QIP)
Through the end of 2021	PDPH Mid-Atlantic AETC NJ AETC	**Support vigorous pursuit of health insurance enrollment of all eligible RW clients**	RW providers	TA units # of enrolled RW eligible clients

Strategy 2.2.3: Reduce systemic barriers to retention in HIV care

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By end of 2017	RWPC PDPH	Develop a plan to address documented barriers to retention in care, including transportation	PLWH	Plan completed
Spring 2017	PDPH RWPC PADOH	Determine the most efficient, cost-effective, and feasible mechanism to provide health insurance cost-sharing assistance	RW clients	Assessment completed

Objective 2.3: Increase the percentage of people with diagnosed HIV infection who are virally suppressed

Strategy 2.3.1: Reduce individual barriers to treatment adherence

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH PADOH NJDPH RWPC Philadelphia Department of Housing and Community Development (DHCD)	**Ensure access to food banks and other food services.**	PLWH NHAS populations	# of RW food bank units CSU intake data about food needs
Through the end of 2021	PDPH	**Provide high quality medical case management which develops and individualized plan to address adherence with clients**	PLWH	HAB measures – 01 and 02 PHL - 03

Strategy 2.3.2: Reduce individual barriers to ART

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH RW providers PADOH NJDPH	**Vigorously pursue health insurance and ADAP enrollment for eligible clients**	PLWH	# of insured RW clients # of SPBP/ADAP clients
Through the end of 2021	PDPH RWPC	**Minimize interruptions to ART adherence through provision of emergency pharmaceutical assistance**	PLWH	# of Rx units dispensed # of emergency pharmaceutical assistance clients

Strategy 2.3.3: Reduce systemic barriers to ART

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH PADOH NJDPH	**Support comprehensive ADAP formulary, including access to Hepatitis C treatment**	PLWH	% of FDA approved treatment regimens on the formulary

Objective 2.4: Increase the percentage of PLWH retained in HIV care who are stably housed

Strategy 2.4.1: Continue to support homelessness prevention activities

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH RWPC	Provide direct emergency financial assistance for rent, mortgage, and utilities	RW clients	# of DEFA units # of DEFA clients

Strategy 2.4.2: Continue and expand access to transitional and long term housing for PLWH

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PDPH RWPC DHCD PADOH NJ Dept of Community Affairs	Increase EMA capacity to house homeless and housing-insecure PLWH	PLWH	# of HOPWA housing slots # of RW-funded transitional housing units
By the end of 2017	PDPH RWPC	Investigate feasibility of RW funded Housing First project	PLWH experiencing homelessness	Completion of feasibility report

Strategy 2.4.3: Provide services that combat economic and individual barriers to housing

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH MCM providers	Ensure medical case managers assess and address housing instability when developing and reviewing care plan	RW client	Quality management data

Anticipated challenges and barriers to Goal 2 include:

- Individuals often have competing needs and complicating factors that must be addressed for successful linkage to care.
- Lack of perceived risk for HIV persists in some communities, which may prevent people from accessing HIV testing services.
- It is difficult to get information about services to the most at-risk individuals and communities because of medical mistrust and lack of engagement in primary care.
- There are many factors associated with an individual reaching viral suppression, including individual biology and co-morbid conditions.
- Costs of medications are ever-changing and can be very expensive. Access to generic drugs is limited due to patent laws. ADAP and other EMA formularies may need to adjust to meet needs and available resources.
- Health insurance enrollment is voluntary. Some individuals will choose not to participate.
- Individuals have competing needs and priorities that may interfere with their ability to attend appointments and access health care services.
- Communities most at risk for HIV are often also communities that have experienced trauma at the community and individual levels, which complicates their ability to trust medical care providers and access services.
- Implementation of trauma-informed services is complex and requires significant resources (financial, human, and otherwise), which might not be available to every provider organization.
- Implementing health insurance cost-sharing assistance is complex and will require significant financial resources.
- The availability of affordable housing is limited in the EMA, especially in Philadelphia.
- Current resources cannot meet the demand for housing for PLWH.
- Maintaining housing can be difficult to PLWH with substance use dependency and severe mental illness.

Resources

To achieve the objectives related to this goal, multiple funding sources will be coordinated to maximize available resources, including CDC (HIV prevention), Ryan White (Parts A, B, C, D and MAI), public and private insurance, and City General Revenue funding. (See Coordination of Services and Funding in Section I, C., a. i.)

Goal 3: Reduce HIV-related disparities and health inequities

Objective 3.1: Reduce HIV related disparities in new diagnoses among high-risk populations

Strategy 3.1.1: Increase access to services that address social determinants of HIV risk

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PDPH Navigation services provider	Provide prevention navigation services to HIV-negative high risk individuals in Philadelphia	HIV-negative MSM of color	# of navigation clients # of linkages to behavioral health and social services
Through the end of 2021	PDPH	Develop and sustain the Philadelphia 1509 Collaborative to implement comprehensive HIV prevention and care services for MSM of color	Collaborative partners	Number of MOUs and collaborative protocols developed
Through the end of 2021	PDPH RW MCM providers RWPC PADOH NJDPH	**Provide culturally competent medical case management services in clinical and community-based settings throughout the EMA.**	PLWH NHAS populations	# of MCM clients # of MCM providers HAB/AACO measures: HAB – 01 and 02 PHL-02
Through the end of 2021	RWPC PDPH HPG	**Monitor access to and availability of substance use treatment and mental health treatment**	PLWH	CSU intake data MMP unmet need data RW program data

Strategy 3.1.2: Increase access to biomedical prevention interventions

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2021	PDPH PADOH NJDPH	Ensure the provision of PrEP and nPEP to at risk populations	NHAS populations	# of providers prescribing PrEP NHBS data
By the end of 2021	PDPH	Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support	MSM of color	# referrals # linkages to PrEP
Through the end of 2021	PDPH	Continue and expand community education activities about PrEP	MSM of color Community leaders High risk heterosexuals Sexual and drug using partners of PLWH PWID Trans women	# of community education events 15-09 data
Through the end of 2021	PDPH Mid-Atlantic AETC NJ AETC	Continue and expand clinical education about PrEP	Primary care providers	# of TA units
Through the end of 2021	PDPH RWPC PADOH NJDPH	**Support a comprehensive and geographically diverse RW care system to ensure access to ARVs and treatment adherence services.**	PLWH	% of RW clients virally suppressed

Strategy 3.1.3: Assess local disparities along the Prevention Continuum

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH	Assess systemic and provider level disparities in the care and prevention continuum	NHAS defined and local identified populations	Reports on disparities at the provider and systemic level
Through the end of 2021	PDPH and provider partners	Develop quality improvement projects to address identified disparities	NHAS defined and local identified populations	QIP

Objective 3.2: Reduce disparities in viral suppression

Strategy 3.2.1: Continue RW-funded activities to link and retain MSM of color, youth aged 13 to 24, transgender women, and other NHAS populations

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH RW clinical providers RW MCM providers RWPC	Ensure quality improvement efforts to address disparities along the Care Continuum in RW clinical and MCM services	MSM of color Youth aged 13 to 24 Trans women NHAS populations	QIP
Through the end of 2021	PDPH RW clinical providers RW MCM providers RWPC	Ensure clinical and support services that address the unique needs and life experiences of disproportionately affected populations	Black MSM Latino MSM Latinas Black women Trans women LGBTQ youth Youth aged 13-24 PWID People experiencing homelessness	Population-specific Care Continuums

Strategy 3.2.2: Encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, PWID, people experiencing homelessness and people with limited English-proficiency and health literacy

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH RW clinical providers RW MCM providers RWPC	Ensure clinical and support services address the unique needs and life experiences of disproportionately affected populations	Black MSM Latino MSM Latinas Black women Trans women LGBTQ youth Youth aged 13-24 PWID People experiencing homelessness	Population-specific Continuums Provider reports on disparities
Through the end of 2021	PDPH Mid-Atlantic AETC	Support training and technical assistance on trauma-informed care	Clinical providers MCM providers	# of TA units

Strategy 3.2.3: Increase access to clinical, pharmaceutical, and other services that address co-morbid conditions, including but not limited to viral hepatitis and STIs

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH PADOH NJDPH Clinical providers	Increase access to hepatitis C treatment	PLWH with hepatitis C	# of ADAP clients who receive HCV treatment NJ and PA Medicaid eligibility for Hepatitis C treatment
By the end of 2021	PDPH RW clinical providers	Increase STI screening at RW funded sites	Sexually-active RW clients	O/AMC HAB measures – 13,15,17 PHL- 02, 04

Anticipated challenges and barriers to Goal 3:

- Mistrust of medical providers within communities at most-risk for HIV
- Hepatitis C treatment is very expensive. Current resources cannot meet the need for all PLWH who are co-infected. Access to treatment through public and private insurers may be limited and contingent on health status and other factors.
- Trauma and discrimination is a common experience for PLWH, which complicates their care engagement and ability to adhere to treatment.
- The most difficult to engage patients have complex social, medical, and economic needs that cannot be met through the RW system.
- PrEP access and uptake are not equitable. Paperwork for patient assistance programs and insurance coverage is often burdensome and delays initiation.
- HIV stigma and lack of perceived risk persist in many communities.

Resources

To achieve the objectives related to this goal, multiple funding sources will be coordinated to maximize available resources, including CDC (HIV prevention), Ryan White (Parts A, B, C, D and MAI), public and private insurance, and City General Revenue funding. (See Coordination of Services and Funding in Section I, C. a. i.)

Goal 4: Achieve a more coordinated response to the HIV epidemic[80]

Objective 4.1: Support collaboration, communication and coordination across all sectors

Strategy 4.1.1: Continue coordination of resources

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH	Continue centralized grant administration of RW Parts, CDC, and other local funds for HIV prevention and care services in the EMA.	NA	NA

Strategy 4.1.2: Continue outreach and education to clinical providers outside the RW system

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	PDPH Mid-Atlantic AETC NJ AETC	Educate and update clinical providers throughout the EMA on the most current evidence-based guidelines and protocols, including but not limited to routine HIV screening and PrEP provision	Clinical providers	TA units

[80] Many of the activities under Goal 4 do not have target populations or data indicators because of the nature of the activity, particularly those related to increasing collaboration and coordination with integrated planning partners and stakeholders. See Section III for detailed discussion about how these activities will be monitored.

Strategy 4.1.3: Continue and expand efforts to make relevant public data accessible, useful and user-centered

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2017	OHP	Develop and implement a HIV services resource inventory database for public use	RW providers PLWH Social workers Clinical providers People seeking HIV prevention services Health navigators	Product launch
Through the end of 2021	OHP	Develop and disseminate materials that are accessible, usable, and audience-centered using both traditional and digital methods to support informed community planning	RWPC HPG Federal partners Local stakeholders PADOH NJDPH County health departments PLWH RW providers HIV prevention providers	NA
Through the end of 2021	OHP PDPH PADOH NJDPH	Improve efforts to provide HPG and RWPC with timely, accurate, and accessible data to inform decision-making	HPG RWPC stakeholders	Planning body survey results

Objective 4.2: Facilitate collaboration, communication and coordination in integrated planning activities

Strategy 4.2.1: Foster relationships between health departments within the EMA

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
By the end of 2017	OHP	Hold a meeting of integrated planning partners to further collaboration, communication, and coordination	PDPH NJDPH PADOH HPG co-chairs RWPC co-chairs NJ HPG co-chairs PA HPG co-chairs	# of meetings # of attendees

Strategy 4.2.2: Increase integration, communication and collaboration amongst the existing planning bodies

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	OHP PDPH	Continue participation in relevant regional meetings and events	NA	NA
Through the end of 2021	OHP PDPH RWPC HPG	Explore opportunities for further integration of the RWPC and Philadelphia HPG	NA	NA

Strategy 4.2.3: Support community and stakeholder participation in integrated planning activities

Timeline	Responsible parties	Activity	Target Populations	Data Indicators
Through the end of 2021	OHP RWPC PDPH HPG	Support the activities of the Positive Committee and other avenues of PLWH participation in integrated planning activities and RW service prioritization and resource allocations.	PLWH	# PLWH who attend Positive Committee meetings RWPC membership data
Through the end of 2021	OHP PDPH RWPC HPG	Develop, implement and disseminate results of needs assessment activities as necessary and required	RWPC HPG PLWH Federal partners County health departments Local stakeholders	NA
Through the end of 2021	OHP PDPH RWPC HPG	Engage stakeholders and community members by using traditional and digital methods, including but not limited to language interpretation and translation	Local stakeholders PLWH RWPC HPG	NA

Anticipated challenges and barriers to Goal 4 include:

- Legal barriers to data sharing between providers, health departments, etc.
- Inconsistencies in lab reporting laws across the EMA hinder data coordination and comparison.
- Stakeholders have different, and sometimes competing, priorities and requirements.
- Some stakeholders needed for truly collaborative and coordinated planning do not have the same urgency to engage in those types of activities, e.g. private insurance companies and other divisions in city and state governments.
- Geographic distance, travel costs and other logistical concerns may hinder in-person meetings.
- Language interpretation and translation services are costly and require several business days to arrange.

Resources

To achieve the objectives related to this goal, multiple funding sources will be coordinated to maximize available resources, including CDC (HIV prevention), Ryan White (Parts A, B, C, D and MAI), public and private insurance, and City General Revenue funding. (See Coordination of Services and Funding in Section I, C., a. i.)

B: Collaborations, Partnerships and Stakeholder Involvement

a. Stakeholder Contributions

The Philadelphia EMA Ryan White Planning Council and the HIV Prevention Planning Group are both comprised of consumers and providers of services, including many PLWH. The members of these planning groups reflect the community that they serve to ensure that the decisions made by the planning bodies are in the best interest of individuals receiving HIV prevention and care services. The planning activities of both groups have benefited from PDPH representatives at committee meetings and the ongoing participation of staff of the Pennsylvania Department of Health, New Jersey Department of Public Health, Mid-Atlantic and New Jersey AIDS Education and Training Centers (AETC), and the regional HRSA office. Community members regularly attend community planning meetings, participate in needs assessment activities, and provide feedback through formal and informal methods.

Comprehensive Planning is one of five Planning Council committees. The Comprehensive Planning Committee makes recommendations on integrated planning and RW service provision based on available data. The committee also sets the Ryan White Part A service priorities in accordance with local epidemiological, needs assessment, and service utilization data. The objectives, strategies, and activities in this plan are a result of the work of this committee and that of the Needs Assessment Committee, in conjunction with other community stakeholders, HPG, OHP, and PDPH.

The Needs Assessment Committee of the RWPC reviews epidemiological data and research, in addition to developing needs assessment activities and tools. The Needs Assessment Committee collaborates with PDPH, medical providers, and consumers to develop surveys about service needs, barriers, linkage and retention to care, and service provision.

The Philadelphia HIV Prevention Group (HPG) is composed of HIV prevention providers, PLWH, community members, and other stakeholders. Over the last year, the HPG provided feedback to the PDPH on PrEP implementation, as well as helped to develop a list of providers prescribing PrEP to patients. The HPG hosted a panel of young men who were currently taking PrEP. The panel provided the HPG members and prevention providers in attendance an opportunity to engage with the young men about their experiences taking the medication, the reactions from their friends and families, and their experiences with paying for PrEP.

The Office of HIV Planning (OHP) provides the administrative and technical support for the HIV Prevention Planning Group and RWPC. OHP responsibilities include: assessing community needs through a variety of methods, including qualitative and quantitative research activities, conducting community outreach and educational activities, writing comprehensive plans, recording and monitoring official processes (including meeting minutes), collaborating with the PDPH AIDS Activities Coordinating Office (AACO) and other community and governmental organizations, and providing logistical and administrative support to the planning bodies. The OHP maintains an active presence at community meetings, which allows information to be shared easily. OHP staff currently participates in the Pennsylvania HIV Planning Group, the EMA's quarterly Outpatient Ambulatory Care Quality

Improvement meetings, the Suburban HIV/AIDS Coalition (SHAC), Philadelphia HIV FIMR, the Philadelphia School District sexual health materials review committee, and the New Jersey HIV Planning Group. OHP staff shares information from these meetings through staff reports at community planning meetings and formal presentations from stakeholders.

b. Gaps in Stakeholder Participation

The EMA's planning process would benefit from the regular participation of representatives from the private insurers within the region and New Jersey and Pennsylvania Medicaid departments. Over time, multiple invitations and inquiries have been made to invite participation from these important stakeholders, but without any long-term change. OHP and PDPH will continue to provide the best available information about public and private insurance coverage to the RWPC and HPG, as well as continue to find ways for these stakeholders to provide valuable input into service planning and delivery.

The RWPC and HPG are reflective of the EMA's epidemic and the communities most at risk. The groups strive to be inclusive and representative of the varied and diverse communities they serve. Recently, the groups have been working to incorporate the participation and feedback from youth and young adults into their work through participation of youth stakeholders in meetings, as well as through means like focus groups and surveys. At the time of this plan, there are plans to increase youth participation in the Positive Committee and HPG through establishing relationships with trusted providers of youth services to help identify and recruit young people to become attendees or members of these groups.

c. Letter of Concurrence

See attachment for Letters of Concurrence to the goals and objectives of this plan from the co-chairs of the Philadelphia Ryan White Planning Council and the Philadelphia HIV Prevention Planning Group in Appendix B: Letters of Concurrence**.**

C: People Living with HIV and Community Engagement

a. Community participation in plan development

Community input is integrated into the planning process. Memberships of the Council, HPG, and their respective committees reflect the demographics of the local HIV/AIDS epidemic, including geographical considerations. All planning activities and meetings are open to the public, inclusive, and evidence-based. Great care is taken to assure that deliberations consider the needs of historically underserved populations, persons who are unaware of their HIV status, and consumers who have been lost to care. Direct input from the community is provided by planning body members, members of the Positive Committee, various needs assessment activities, consumer surveys, and three resource allocations processes for Ryan White Part A services (one for each of the three sub-regions of the EMA: City of Philadelphia, the four Pennsylvania counties, and the four New Jersey counties). Additional input from the community augments these mechanisms, including analysis of OHP Ryan White consumer survey data, utilization reports from consumers of Ryan White services gathered by PDPH's Client Services Unit, and a formal feedback process available to consumers through the region's information and referral and client services hotlines.

b. PLWH and community participation in plan development

Approximately half of the members of RWPC are PLWH. PLWH members and non-members of RWPC participate in the decision-making processes and regularly attend RWPC meetings. RWPC and HPG share the Positive Committee, which has supported the engaged and informed participation of PLWH in all community planning activities for over a decade. The committee meets monthly on relevant topics, including training on epidemiological data, service provision, and how to best participate in planning meetings. The committee also advises OHP on consumer surveys and other needs assessment activities. Members of the committee often bring up emerging needs and other issues for further discussion and investigation by RWPC and HPG.

In 2015 a group of Spanish-speaking PLWH began participating in Positive Committee meetings. Positive Committee meeting minutes are translated in Spanish and distributed at meetings and posted on the OHP website (along with the meeting materials in English). Interpretation services are available for any RWPC and HPG meeting, provided adequate notice is provided. Spanish interpretation services are regularly provided at the Positive Committee.

c. Methods for community engagement

The RWPC, HPG, PDPH and OHP work together to design mechanisms to collect community and consumer needs and challenges. These mechanisms include regular monthly meetings of the community planning bodies with time allotted for public comment and participation. Meeting times and locations are advertised on the OHP website and updated paper meeting calendars are distributed at every meeting. OHP supports community participation through transportation cost reimbursement and refreshments at meetings. OHP has taken other steps to make information about community planning and RW services available to Spanish-speaking and other non-English speaking community members,

including adding Google translate to the OHP website and publishing the Positive Committee's consumer FAQ brochure in Spanish. OHP hired a bilingual receptionist in 2015 to increase access to OHP activities and meetings to Spanish-speaking community members.

d. Community insights and solutions

Community input is the norm in the EMA's planning activities with an active PLWH committee, diverse and reflective RWPC and HPG, and ongoing needs assessment activities. Some recent examples of how community input helped identify health problems and develop solutions are included here; however, this entire planning document is the result of the critical insights provided by the community. In 2015, the topic of transportation as a barrier to HIV medical care was brought to the attention of RWPC during allocations deliberations by Positive Committee members. OHP conducted a survey for providers to assess barriers related to transportation services, including Medicaid transportation as a result (see Section I.D for a more detailed discussion). In 2014, OHP conducted focus groups with YMSM and heterosexuals of low socio-economic status to learn more about their healthcare and HIV testing experiences and preferences. PLWH and those at risk for HIV participated in those focus groups, and their contributions are included in this plan (see Section I D). Issues related to information dissemination and knowledge of RW services among Spanish-speaking PLWH were raised in Positive Committee meetings. OHP and PDPH have worked with these consumers to address their individual and community-level barriers to health information and needed services.

Section III: Monitoring and Improvement

Process for updating planning bodies and stakeholders

Given the diversity of the EMA, coordination between internal and external stakeholders and the PDPH (the recipient), RWPC, and HPG is critical to creating a cohesive strategy for the implementation of the integrated plan. PDPH solicits input from external stakeholders and consumers, which helps to determine priorities and inform the plan's monitoring and improvement activities. RWPC receives regular updates from PDPH staff on program implementation, RW expenditures and underspending, outcome data, and clinical quality management (CQM) activities. PDPH staff attend all RWPC meetings, and OHP staff attend PDPH's regional CQM meetings with subrecipients. RWPC and HPG receive annual updates from the PDPH Medical Director/Epidemiologist, which includes the EMA's Care Continuum. AACO's Client Services Unit Manager reports Central Intake data and RW program data to the RWPC annually, and PDPH's Information Services Manager participates in the RWPC's Comprehensive Planning Committee meetings throughout the year to ensure full use of CQM data in the planning process. The RWPC's Comprehensive Planning Committee receives data from PDPH and reviews the integrated plan, provides feedback, and monitors progress annually.

Progress on plan implementation is reported to a number of stakeholders. These stakeholders include federal, state, and local governments, funding agencies such as HRSA and CDC, the RWPC and HPG, the Philadelphia Health Commissioner's Office, consumers, the Pennsylvania Department of Health, and subrecipients. PDPH reports its CQM activities and progress to HRSA twice a year in writing through the progress report and annual application, and submits reports to the Pennsylvania Department of Health on a regular basis. In addition to site visits and written reports, the recipient participates in the National Quality Center (NQC) Regional Group QM Meetings for RW Part C/D programs.

OHP and PDPH attend community meetings to share updates and provide information on planning and program activities, as well as to solicit feedback from stakeholders. OHP maintains a website with all meeting minutes and materials, planning documents, and presentation slides. OHP also uses social media, a blog, and an email newsletter to inform the community and stakeholders about planning activities and to solicit feedback. Input on CQM activities related to the integrated plan is obtained from subrecipients at regional QM meetings. Consumer feedback is obtained through PDPH's Client Services Unit, the consumer input required as a component of subrecipients' quality improvement projects, the RWPC which has 50% consumer representation, and the Positive Committee. The Positive Committee

supports the role of consumers of HIV services in planning and decision-making activities through regular trainings, special educational presentations, and group discussion. PDPH and OHP staff attend the PA HPG and participate in its committees. Information is shared between the EMA's planning bodies and the PA HPG through OHP staff. OHP staff work with PA HPG support staff to coordinate planning efforts and share data. OHP staff and RWPC members attend the NJ HPG. The HPG's Governmental Co-Chair provides regular updates on PDPH's HIV prevention activities and implementation of programs and an annual update on HIV prevention programs and related PDPH activities. The Integrated Executive Committee meets quarterly to review the activities and goals of the planning bodies and to receive updates from PDPH and OHP on program implementation, strategic planning, and other activities.

Monitoring and evaluation of goals and objectives

Monitoring and evaluation of the implementation of the strategies and objectives of the integrated plan primarily occurs through the EMA's CQM program, which includes defined indicators across the continuum of care. The objectives and goals of the plan are closely aligned with the National HIV/AIDS Strategy (NHAS). The EMA's plan is coordinated with planning activities and embedded in the recipient's administrative activities, which include procuring and monitoring a multi-agency system that impacts all stages of the care continuum through the provision of HIV care and prevention services. All of the CQM activities that PDPH undertakes fall within one or more of these domains, and are supported by efforts to promote a culture of clinical quality at all levels of the system based on defined service standards, performance measures, client- and system-level outcomes, and high quality data for decision-making, planning, program monitoring, and service procurement. PDPH utilizes a comprehensive and cohesive process for quality management. This process includes the regular and systematic monitoring of provider services, defined performance measures for all service categories, uniform documentation and reporting, regular analysis and feedback to subrecipients, quality improvement at both the provider and system levels, dissemination of results and best practices in regional and individual meetings with subrecipients, and capacity building.

Program Measures by Service Category

Performance Measure	O/AMC	MCM	Other Core	Support
PHL01 Two or More Viral Load Counts	X			
PHL02 MSM Receiving Syphilis Screening	X			
PHL03 Gonorrhea Screening	X			
PHL04 MSM Receiving Gonorrhea Screening	X			
PHL05 Cervical Cancer Screening	X			
PHL06 Colposcopy After Abnormal Pap	X			
HAB01 Viral Load Suppression	X		X	X
HAB02 Prescription of ART	X	X		
HAB03 HIV Medical Visit Frequency	X	X		X
HAB04 Gap in HIV Medical Visits	X	X	X	X
HAB05 PCP Prophylaxis	X			
HAB06 Adherence Assessment	X	X		
HAB07 Hepatitis B Vaccination	X			
HAB08 Hepatitis C Screening	X			
HAB09 HIV Risk Counseling	X			
HAB10 Lipid Screening	X			
HAB11 Syphilis Screening	X			
HAB12 TB Screening	X			
HAB13 Chlamydia Screening	X			
HAB14 Hepatitis B Screening	X			
HAB15 Influenza Vaccination	X			
HAB16 Mental Health Screening	X			
HAB17 Substance Use Screening	X			
HAB18 Service Care Plan		X		
HAB19 Dental and Medical History			X	
HAB20 Dental Treatment Plan			X	
HAB21 Oral Hygiene Education			X	

PDPH monitors the degree to which providers adhere to the service provisions that define the administrative and programmatic requirements for each service category. Process monitoring is conducted to measure the extent to which programs are implemented as planned. This includes monitoring of numbers of clients served, numbers of services provided, and the target populations reached. In addition, performance standards are defined for all service areas. These standards are based on Public Health Service (PHS guidelines) for medical care for PWLH, other federal guidance such as the Morbidity and Mortality Weekly Report (MMWR) for prevention with positives, and professional and locally developed guidelines. The service provisions describe requirements for staff training and accreditation, service procedures, documentation, reporting, and participation in the EMA's CQM

initiatives. These standards are promulgated in Requests for Proposals and continuation funding processes and incorporated into contracts. Through this investment in quality assurance, the recipient evaluates progress toward impacting the care continuum through the implementation of site-appropriate routine screening policies in healthcare settings, the utilization of 4th generation HIV testing, protocols for immediate linkage to care for people who test in community settings, documentation of the vigorous pursuit of insurance enrollment, and the provision of services that address psychosocial barriers to medical retention and medication adherence in the integrated plan. These services are regularly and systematically monitored through chart reviews and data extraction from CAREWare and EvaluationWeb. Progress toward goals is evaluated at prescribed intervals, and contextualized in quarterly provider narratives and chart reviews. Another component of quality assurance is the recipient's formal grievance process, which responds to objectives in the EMA's Comprehensive Plan calling for an efficient process to handle consumer conflicts and concerns with their services and to analyze trends for use in planning.

Outcomes monitoring and evaluation tracks performance with respect to client outcomes. The outcomes are derived from PHS guidelines and professional standards. In addition to client-level outcomes, the EMA's integrated plan incorporates the monitoring of systems- and provider-level outcomes related to NHAS goals and the continuum of care. PDPH also monitors an array of defined performance outcomes delineated in the integrated HIV care and prevention plan that include STI screenings, condom use, women's health and preconception counseling, behavioral health, social determinants of HIV risk, accessibility of services, insurance enrollment, and disparities among subpopulations. Defined performance measures for all service categories are primarily documented in CAREWare, while outcomes related to prevention are calculated from reports generated from EvaluationWeb and through PDPH's surveillance unit. CAREWare and EvaluationWeb allow the recipient to readily collect, combine, interpret, and provide feedback in a diverse system, and these standardized tools facilitate capacity building. PDPH regularly collects this data and provides feedback reports to subrecipients to inform and prioritize quality improvement projects (QIPs).

Continuous quality improvement (CQI) focuses on translating this data to action by solving problems to improve processes and the overall system, and to ensure delivery of exceptionally high quality clinical services and customer satisfaction. CQI links to outcomes evaluation and performance management in that low performance for an outcome is one factor that triggers the recipient initiating a CQI plan. CQI includes the collection of annual quality improvement projects (QIPs) and quarterly updates from prevention and care subrecipients. CQI projects are required of all funded providers. Providers are encouraged to use the FOCUS PDSA model for QI activities.[81] Regional priorities determine whether QIPs are directed at one measure or if they are based on whether a provider is meeting the performance threshold(s) for targeted measure(s). PDPH collects QIPs on a quarterly basis and provides detailed feedback to subrecipients on all QIPs and quarterly updates. Dissemination of CQI results and best practices occurs at regional QM meetings between PDPH and its subrecipients. These meetings provide

[81] For examples and instructions on the FOCUS PDSA model see the Agency of Healthcare Quality and Research website: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool2b.html

a forum for providers to present QI strategies and tools, and for content experts to provide best practices in service delivery. PDPH also disseminates results to a joint meeting of the RWPC and HPG, and provides updates on progress towards the goals.

Improvement activities at the systems level are primarily directed by the PDPH's Continuum Workgroup. The Continuum Workgroup consists of PDPH's HIV Program Director, Program Implementation Administrator, Medical Director, unit managers, and supervisors. The committee is scheduled to meet weekly to review data and coordinate activities around the care continuum. The Continuum Workgroup serves as PDPH's CQM committee for HIV care and prevention services and oversees progress toward achieving the goals outlined in the integrated plan. The Comprehensive Planning Committee and the Integrated Joint Executive Committee work with PDPH to review outcomes and plan implementation of activities and programs.

Strategy to use surveillance and program data to improve health outcomes

The Comprehensive Planning Committee uses the EMA Care Continuum to plan RW service priorities and inform RWPC Part A allocation decisions. RWPC and HPG regularly review RW program, prevention system, surveillance, and local epidemiological data to determine which activities will best improve health outcomes for PLWH and reduce incidence in the EMA. OHP uses program and surveillance data to inform the development of needs assessment activities. These data help the RWPC and HPG identify emerging trends and community needs. OHP provides a compendium of data for the RWPC Part A allocations process that includes program, epidemiological, and other data to ensure allocations decisions meet community needs and improve health outcomes.

PDPH employs a multifaceted approach to epidemiologic and surveillance data for prevention program planning and evaluation. The recipient's Medical Director/Medical Epidemiologist represents the HIV Surveillance Unit at weekly Continuum Workgroup meetings and provides updates on the most recent epidemiologic and surveillance data. The Continuum Workgroup consists of HIV surveillance, program, and evaluation leadership. Its scope encompasses HIV care and treatment programs (Ryan White Part A and B in Philadelphia), CDC, State, and locally funded HIV prevention programs. The Workgroup develops strategies for improving outcomes throughout the HIV continuum of care. The Workgroup reviews program data, incidence and prevalence data, Medical Monitoring Project data, and data from the National HIV Behavioral Surveillance project conducted in Philadelphia. Other relevant data, such as information on disparities in care and access, are also reviewed. Select HIV Care Continuum data in aggregate and by subpopulation are also presented to the Workgroup, to providers, and the community at large.

Surveillance and Program Data Monitored for Care Continuum

Stage of Care Continuum	2014 – 2015 Outcome
Undiagnosed	7.0%
Late Diagnosis	26.6%
Linkage to HIV Medical Care	78.1%
HIV Medical Visit Frequency	65.0%
Prescription of ART	90.1%
HIV Viral Load Suppression	80.2%

PDPH's Surveillance Unit also collaborates with the Information Services Unit to create maps that overlay HIV prevalence and recent diagnoses with prevention service sites and testing data. These maps are used to redirect programs to target underserved geographic areas and for assessment and planning purposes. Additionally, the two units collaborate to match HIV testing data submitted by PDPH-funded providers. The match is conducted quarterly in order to determine newly-identified positives, previously-identified positives, linkage to care among all positives, and linkage to care among all positives within one month of an HIV test. The match includes confirmed positives and preliminary positives. This information is reviewed by PDPH management and at Continuum Workgroup meetings. In addition to collaboration with evaluation activities, PDPH uses surveillance data for various data-to-care efforts.

START Care

PDPH provides technical support to Ryan White Program-funded clinics to identify persons living with HIV/AIDS who have been out of clinical care. Staff from each participating clinic generate a list of all patients meeting these criteria and securely transfers the list to PDPH. Upon receipt, PDPH cross-matches it with the Enhanced HIV Reporting System (eHARS) and other databases, which identifies patients that have transferred care to other providers, migrated out of the city, are incarcerated, or are deceased. Finally, PDPH returns the revised and updated case list to the clinic, which then uses the revised list to conduct protocol-driven, clinic-led outreach to persons who are out of care with the goal of reengaging the patient in HIV care. If errors in classification are identified by the Ryan White facility, feedback is provided to the HIV surveillance staff so that errors can be resolved within eHARS. As part of its START Care initiative, a stakeholder group with participation from the recipient and funded providers has developed best practice protocols around routine screening, linkage to care, and the reengagement of patients with gaps in medical visits.

CoRECT

The Cooperative Agreement Re-Engagement Controlled Trial (CoRECT) project is a 5-year CDC-funded study initiated in 2014 in three U.S. jurisdictions, and will evaluate an intervention to identify HIV-infected persons who are out-of-care and engage them in HIV care. In Philadelphia, CoRECT builds on the re-engagement standards established by the START Care stakeholder group. Patients who have been determined to be out-of-care for at least six months at eight HIV care provider locations are randomized

to receive either field follow up by a disease intervention specialist (DIS) or outreach through the program's routine re-engagement protocols to assess the impact of a DIS-based model on patient reengagement.

PDPH generates an out-of-care list using HIV laboratory surveillance data; collaborating medical facilities will concurrently generate out-of-care lists using appointment data. The combined out-of-care list is reconciled by the PDPH and medical facilities, and discussed at monthly case conferences. All individuals determined to be out of care are randomized to receive either: usual linkage and engagement in standard of care (SOC) or an active PDPH DIS intervention in addition to SOC. Individuals randomized to the intervention arm receive DIS to locate, contact, and provide assistance to access HIV medical care. Services provided as part of the intervention may include assistance with expedited medical appointments, transportation, and access to community resources such as medical case management.

The Philadelphia CoRECT site aims to enroll 600 out-of-care HIV-infected individuals during a 2-year enrollment period. Outcomes related to reengagement, retention, viral suppression and durable viral suppression will be compared between out-of-care HIV-infected individuals receiving the study intervention to those receiving SOC. Overall, CoRECT will demonstrate the feasibility of a joint health department-medical facility intervention to identify recently out-of-care individuals and the effectiveness of an active health department intervention to (re-)engage these individuals in HIV medical care.

Disposition data from case conferences and through DIS outreach are used to regularly update eHARS including current address, vital status, and current gender.

Data Sharing with Hepatitis and STD Programs

Sharing information between HIV and STD surveillance/Partner Services programs is important for comprehensive disease intervention and offers many potential mutual benefits including updating demographic and risk information and ensuring timely reporting and linkage to care. AACO continues to provide line listings of newly diagnosed HIV cases to the STD program on a weekly basis to initiate HIV Partner Services. In addition, the PDPH STD Control program submits lists of newly diagnosed syphilis and gonorrhea cases to the HIV surveillance program for matching. All newly diagnosed syphilis and gonorrhea cases that are co-infected with HIV are prioritized for Partner Services. Linkage and/or engagement in care information including date, facility and value of the last viral load is provided to the Partner Services program. This allows the Partner Services' Disease Intervention Specialists (DIS) to provide linkage and re-engagement services to those in need of these services.

Given the increasing incidence of injection drug use (IDU) among young people in Philadelphia, collaboration between AACO and the viral Hepatitis Program (HEP) within the PDPH is of high priority. The recent surge in injection drug use has resulted in a rise in hepatitis C virus (HCV) mono-infection, as well as HCV-HIV co-infection. HIV data is matched to Hepatitis data monthly and enables the HEP to prioritize co-infected patients for investigation. Because viral hepatitis infections are often exacerbated in the presence of HIV, identifying co-infected patients ensures that these particularly high-risk populations receive the hepatitis care they need. Hepatitis Investigators also ensure linkage to care for

newly diagnosed HIV cases, recommend that patients who have not had a recent HIV viral load return to their providers for testing, and alert AACO staff of any new HBV or HCV diagnoses within its patient population. Matches also allow for updating of demographic and risk information in both surveillance systems.

Molecular HIV Surveillance

Understanding the transmission dynamics of the HIV epidemic is critical to effective intervention. Several types of analyses are used to track HIV transmission in Philadelphia. Used independently, each strategy captures a component of transmission dynamics, but has important limitations based on the veracity, timeliness, and completeness of the data inputted. PDPH, in collaboration with the University of Pennsylvania Center for AIDS Research (CFAR), is funded to conduct an integrated analysis of HIV transmission networks in Philadelphia using multiple overlapping sources of data and analysis strategies. PDPH/CFAR will construct a layered series of network analyses that link: i) phylogenetic data derived from viral sequences obtained through clinical resistance testing, ii) individuals reported as partners identified through contact tracing, and iii) reported social networks, including venues and social media sites where sexual contacts are initiated. The layered HIV network analysis that is constructed will be able to predict and trend changes in the transmission dynamics within Philadelphia at individual and social levels, in real time, through a PDPH accessible web-based platform. The PDPH will then evaluate the potential of the near real-time network analyses to enhance the piloting of interventions prioritizing HIV testing, enhanced Partner Services, and treatment as prevention methodologies with the goal of disrupting transmission in identified clusters.

FIMR-HIV

The goal of the Fetal Infant Mortality Review for HIV Prevention (FIMR-HIV) is to improve perinatal HIV prevention systems by using the FIMR case review and community action process. FIMR-HIV is based on the premise that the pregnancy experiences of women with HIV infection are sentinel events that warrant review to inform interventions that will improve systems of care for the mother and infant. By collecting comprehensive quantitative and qualitative data via medical record abstraction and maternal interview, the methodology provides an in-depth look at the systems that result in a perinatal HIV exposure or transmission. This examination allows communities to identify system strengths, missed opportunities for prevention and, more rarely, failures of interventions to prevent perinatal transmission. Communities can then develop and implement improvements to the systems of care for women with HIV infection and their infants.

The EMA's plan for monitoring and improvement focuses on the coordination and use of client-level program and surveillance data along with other innovative efforts to achieve the objectives of the National HIV/AIDS Strategy (NHAS). The EMA's Data-to-Care strategy has resulted in directing resources to aggressive interventions at critical points along the HIV Continuum of Care. Outcomes are regularly disseminated to stakeholders and used for administration and planning. PDPH monitors trends in the HIV Care Continuum and utilizes data for targeted improvement projects. These initiatives are closely monitored by the recipient, PDPH's Continuum Workgroup, OHP and the RWPC to measure the EMA's progress in achieving the goals outlined in the integrated plan.

Appendices:

A: List of Public and Private Provider Agencies and Workforce Capacity

B: Signed Letters of Concurrence

C: Glossary

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Appendix A: List of Public and Privately Funded Provider Agencies and Workforce Capacity Tables

Non-Exhaustive List of Public and Privately Funded Provider Agencies

A list of providers by service for both publically and privately funded sites is displayed below. This is a non-exhaustive compilation with the name of the organization/agency and its website. More detailed information about provider services is available at the AIDS Library of Philadelphia FIGHT, http://www.aidslibrary.org/our-publications/resource-guide-publications/ and through the Choice Information Hotline, http://www.choice-philadelphia.org/. All providers with services contracted through the AIDS Activities Coordinating Office are in ***bold and italics***. The organization's phone number is provided is a website is not available.

Ambulatory Care

11th Street Family Health Services of Drexel University	www.drexel.edu/11thStreet
Abbottsford-Falls Family Practice	***www.fpcn.com***
AIDS Care Group- Edgmont Ave	***www.aidscaregroup.org***
AIDS Care Group-Sharon Hill	***www.aidscaregroup.org***
Albert Einstein Medical Center	***www.einstein.edu***
Albert Einstein Medical Center Immunodeficiency Center	***www.einstein.edu***
Aria Health Hospital (formerly Frankford Hospital)	www.ariahealth.org
Asociacion Puertorriquenos en Marcha - Community Health Clinic	www.apmphila.org
Bergen Lanning Health Center	(856) 757-1770
Brandywine Valley Infectious Diseases	(610) 383-9333
Broad Street Health Center (Spectrum Health Services)	www.spectrumhs.org
Bryn Mawr Family Practice	www.mainlinehealth.org
Bryn Mawr Hospital (Jefferson Health Care)	www.mainlinehealth.org
Burlington County Health Dept. @ Raphael Meadow	www.co.burlington.nj.us/290/Health-Department
Cam Care Pediatrics	www.camcare.net/pediatric
ChesPenn Health Services	***www.chespenn.com***
Children's Hospital Of Philadelphia - Cobbs Creek	www.chop.edu
Children's Hospital Of Philadelphia - Special Immunology Family Care Center	***www.chop.edu***
Children's Hospital Of Philadelphia Adolescent Clinic	***www.chop.edu/centers-programs/adolescent-initiative***
Coatesville VA Medical Center	www.coatesville.va.gov
Congreso De Latinos Unidos, Inc.	***www.congreso.net***
Cooper At BMA/Willingboro	www.cooperhealth.org
Cooper University Hospital Regional Family HIV Treatment Center	***www.cooperhealth.org***
Crozer-Chester Medical Center	www.crozer.org
Delaware Co. Memorial Hospital	www.crozer.org

Einstein Medical Center Montgomery	www.einstein.edu
Einstein Medical Center: Immunodeficiency Clinic	www.einstein.edu
Episcopal Hospital	http://episcopal.templehealth.org
Esperanza Health Center – Hunting Park Clinic	***www.esperanzahealthcenter.org***
Esperanza Health Center – 5th street Clinic	***www.esperanzahealthcenter.org***
Esperanza Health Center – Kensington Clinic	***www.esperanzahealthcenter.org***
Fairmount Primary Care Center	***www.dvch.org***
Family Practice & Counseling Network Health Annex	***www.fpcn.com***
Girard Medical Center	www.nphs.com/girard_home.html
GPHA-4th Street Medical Suite	www.gphainc.org
GPHA-Hunting Park Health Center	www.gphainc.org
GPHA-South Philadelphia Health Center	www.gphainc.org
GPHA-Southeast Health Center	www.gphainc.org
GPHA-Wilson Park Medical Center	www.gphainc.org
GPHA-Woodland Ave	www.gphainc.org
Haddington Health Center - Spectrum Health Services	www.spectrumhs.org
Hospital of the UPENN/ MacGregor Infectious Disease Clinic	***www.pennmedicine.org***
J. Edwin Wood Clinic	***www.pennmedicine.org/providers/practice/j-edwin-wood-clinic***
Jefferson University Hospital Methodist Division	http://hospitals.jefferson.edu/find-a-location/locations/methodist-hospital/
John Bell Health Center	***www.fight.org***
Jonathan Lax Treatment Center	***www.fight.org***
Kennedy Health Systems-Garden State Infectious Disease Associates, P.A.	***www.kennedyhealth.org***
Kennedy Memorial Hospital - Washington Township	www.kennedyhealth.org
Kensington Hospital	***215-426-8100***
Kensington Hospital-Erie Clinic	***215-426-8100***
Maria de los Santos Health Center	***http://dvch.org/locations/maria-de-los-santos-health-center/***
Mazzoni Center	***www.mazzonicenter.org***
Mazzoni Center Family and Community Medicine	***www.mazzonicenter.org***
Memorial Hospital of Salem County-Clinic	www.mhschealth.com
Mercy Fitzgerald Hospital - Friday Clinic	www.mercyhealth.org
Mercy Hospital HIV Services	www.mercyhealth.org/mercyphiladelphia
Norristown Regional Health Center	***www.dvch.org***
Our Lady of Lourdes Medical Center	www.lourdesnet.org
Partnership Comprehensive Care Practice	***www.drexelmedicine.org/patient-services/infectious-diseases/services/hiv-care/***
PDPH Health Care Center #10	***www.phila.gov/health/ambulatoryhealth/hc10.html***
PDPH Health Care Center #2	***www.phila.gov/health/ambulatoryhealth/hc2.html***
PDPH Health Care Center #3	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH Health Care Center #4	***www.phila.gov/health/ambulatoryhealth/hc4.html***

PDPH Health Care Center #5	***www.phila.gov/health/ambulatoryhealth/hc5.html***
PDPH Health Care Center #6	***www.phila.gov/health/ambulatoryhealth/hc6.html***
PDPH Health Care Center #9	***www.phila.gov/health/ambulatoryhealth/hc9.html***
Pediatric Infectious Disease Center @ Cooper	www.cooperhealth.org/departments-programs/pediatric-infectious-diseases
Penn Community Practice at Presbyterian	***www.pennmedicine.org/penn-presbyterian-medical-center/services-programs.html***
Philadelphia Department of Public Health	www.phila.gov/health
PHMC Care Clinic	***www.phmc.org/site/programs/health-care-centers***
Puentos de Salud Clinic	http://puentesdesalud.org
QCHC Meade Family Health Center	***www.qchc.org/AboutUs.htm***
QCHC Vaux Family Health Center	www.qchc.org/AboutUs.htm
QCHC-Cooke Family Health Center	***www.qchc.org/AboutUs.htm***
Quality Community Health Care	***www.qchc.org/index.htm***
South Jersey Family Medical Center	www.sjfmc.org/
Spectrum Community Health Center - Broad St Health Center	***www.spectrumhs.org***
Spectrum Community Health Center - 5201 Haverford Ave	***www.spectrumhs.org***
St. Christopher's Hospital for Children	***www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2***
Strawberry Mansion Health Center	***www.phila.gov/health/ambulatoryhealth/hcStrawberry.html***
Temple University Comprehensive HIV Program	***www.temple.edu/medicine/departments_centers/clinical_departments/medicine_gim_hiv.htm***
Thomas Jefferson University Infectious Diseases	***http://hospitals.jefferson.edu/departments-and-services/infectious-diseases/***
Urban Solutions	***http://myuhi.org/***
Valley Forge Medical Center and Hospital	www.vfmc.net/index.html
Veterans Affairs Medical Center - ID Clinic	www.philadelphia.va.gov/

Case Management

ACLAMO Family Centers of Montgomery County	www.aclamo.org
ACT One (Achievement Through Counseling and Treatment)	www.jevshumanservices.org
ACT Two (Achievement Through Counseling and Treatment)	www.jevshumanservices.org
Action Wellness- 1026 Arch Street	***www.actionwellness.org***
Action Wellness- Delaware County Office	***www.actionwellness.org***
Action Wellness-West	***www.actionwellness.org***
African Family Health Organization (AFAHO)	www.afaho.net/
AIDS Care Group	www.aidscaregroup.org
AIDS Community Care Alternatives Program (ACCAP)	www.state.nj.us/humanservices/dds/ohcs/waiver/accap/

Asociacion de Puertorriquenos en Marcha- Main Office	www.apmphila.org
Attic Youth Center	www.atticyouthcenter.org
BEBASHI	***www.bebashi.org***
Bergen Lanning Health Center	(856) 757-1770
Black Women's Health Alliance	www.pbwha.org
Burlington County Health Dept. @ Raphael Meadow	www.co.burlington.nj.us/290/Health-Department
Camden County Division of Health - Special Child Health Services	www.state.nj.us/health/fhs/sch/index.shtml
Children's Hospital Of Philadelphia - Cobbs Creek	***www.chop.edu***
Children's Hospital Of Philadelphia - Special Immunology Family Care Center	***www.chop.edu***
Children's Hospital Of Philadelphia Adolescent Clinic	***www.chop.edu/centers-programs/adolescent-initiative***
Congreso De Latinos Unidos, Inc.	***www.congreso.net***
Cooper EIP	***www.cooperhealth.org***
Cooper University Hospital Regional Family HIV Treatment Center	***www.cooperhealth.org***
Covenant House Health Services	www.covenanthousepa.org
Delaware Co. Office of Behavioral Health	www.delcohsa.org/behavioralhealth.html
Delaware County Department of Health	www.co.delaware.pa.us/intercommunity
Easton Area Neighborhood Centers, Inc	www.eastonareaneighborhoodcenter.org
Episcopal Hospital	http://episcopal.templehealth.org
Esperanza Health Center – Hunting Park Clinic	www.esperanzahealthcenter.org
Esperanza Health Center – 5th street Clinic	www.esperanzahealthcenter.org
Esperanza Health Center – Kensington Clinic	www.esperanzahealthcenter.org
Family and Community Service of Delaware County	***www.fcsdc.org***
Family Practice & Counseling Network Health Annex	www.fpcn.com
Family Service Association of Bucks County	***www.fsabc.org***
Family Service of Chester County	***www.familyservice.us***
Family Services of Montgomery County	***www.fsmontco.org***
Gay & Lesbian Latino AIDS Education Initiative (GALAEI) Project	www.galaei.org
Good Shepard Program of St. Johns Hospice	http://saintjohnshospice.org
GPHA-4th Street Medical Suite	www.gphainc.org
GPHA-Hunting Park Health Center	www.gphainc.org
GPHA-Southeast Health Center	www.gphainc.org
GPHA-Wilson Park Medical Center	www.gphainc.org
GPHA-Woodland Ave	www.gphainc.org
Haddington Health Center - Spectrum Health Services	www.spectrumhs.org
Healthstart - Memorial Hospital Of Salem County	www.mhschealth.com
Holcomb Behavioral Health Systems	www.chimes.org/holcomb/
Hospital of the UPENN/ MacGregor Infectious Disease Clinic	www.pennmedicine.org

Jonathan Lax Treatment Center	***www.fight.org***
Kennedy Health Systems-Garden State Infectious Disease Associates, P.A.	***http://www.kennedyhealth.org***
Kennedy Health Systems-Raphael Meadow Center	***www.kennedyhealth.org***
Kensington Hospital	215-426-8100
Maria de los Santos Health Center	http://dvch.org/locations/maria-de-los-santos-health-center/
Mazzoni Center	***www.mazzonicenter.org***
ODAAT, North	***www.uac.org/partners/one-day-time-odaat***
Partnership Comprehensive Care Practice	***www.drexelmedicine.org/patient-services/infectious-diseases/services/hiv-care/***
PDPH Health Center 10	***www.phila.gov/health/ambulatoryhealth/hc10.html***
PDPH Health Center 2	***www.phila.gov/health/ambulatoryhealth/hc2.html***
PDPH Health Center 3	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH Health Center 4	***www.phila.gov/health/ambulatoryhealth/hc4.html***
PDPH Health Center 5	***www.phila.gov/health/ambulatoryhealth/hc5.html***
PDPH Health Center 6	***www.phila.gov/health/ambulatoryhealth/hc6.html***
PDPH Health Center 7	***www.phila.gov/health/ambulatoryhealth/hc9.html***
Philadelphia FIGHT	***www.fight.org***
PHMC Care Clinic	***www.phmc.org/site/programs/health-care-centers***
Prevention Point Philadelphia	www.ppponline.org
Project H.O.M.E.	www.projecthome.org
Puerto Rican Action Committee	www.pracnj.com
Puerto Rican Unity for Progress	www.prupnj.org
Quality Community Health Care	www.qchc.org
Salem County Social Services	http://health.salemcountynj.gov
St. Christopher's Hospital for Children	***www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2***
St. John's Hospice	http://saintjohnshospice.org
Strawberry Mansion Health Center	www.phila.gov/health/ambulatoryhealth/hcStrawberry.html
Temple University Comprehensive HIV Program	***www.temple.edu/medicine/departments_centers/clinical_departments/medicine_gim_hiv.htm***
The Attic Youth Center	www.atticyouthcenter.org/
Urban Solutions	***www.myuhi.org/***
Valley Forge Medical Center and Hospital	www.vfmc.net/index.html
Veterans Affairs Medical Center –ID clinic	www.philadelphia.va.gov
Veterans Affairs Medical Center –ID Clinic	www.philadelphia.va.gov
Women's Care Center	www.cooperhealth.org/departments-programs/ripa-center-womens-health-wellness
Women's Institute for Family Health	www.wifamilyhealth.org/

Condom Distribution

Crozier Keystone Health Systems	*www.crozer.org*
Delaware Valley Community Health	***www.dvch.org***
Esperanza Health Center – Hunting Park Clinic	***www.esperanzahealthcenter.org***
Esperanza Health Center – 5th street Clinic	***www.esperanzahealthcenter.org***
Esperanza Health Center – Kensington Clinic	***www.esperanzahealthcenter.org***
GALAEI	***www.galaei.org***
PDPH Health Center #1	***www.phila.gov/health/ambulatoryhealth/hc1.html***
Quality Community Health Care - Cooke Family Health Center	***www.qchc.org***
Quality Community Health Care - Meade Family Health Center	***www.qchc.org***
Quality Community Health Care- 2501 Lehigh Ave	***www.qchc.org***
Spectrum Community Health Center - Broad St Health Center	***www.spectrumhs.org***
Spectrum Community Health Center - 5201 Haverford Ave	***www.spectrumhs.org***

Dental Care

11th Street Family Health Services of Drexel University	www.drexel.edu/11thStreet
Abbottsford-Falls Family Practice	www.fpcn.com
AIDS Care Group	***www.aidscaregroup.org***
ChesPenn Health Services	www.chespenn.com
Delaware Valley Community Health Inc.- Fairmount Health Center	***www.dvch.org***
Esperanza Health Center - Kensington Clinic	***www.esperanzahealthcenter.org***
Fairmount Primary Care Center	www.dvch.org
Family Practice & Counseling Network Health Annex	www.fpcn.com
Family Service Association of Bucks County	www.fsabc.org
GPHA-Dental and Behavorial Healthcare	www.gphainc.org
GPHA-Hunting Park Health Center	www.gphainc.org
GPHA-Snyder Avenue Dental Center	www.gphainc.org
GPHA-Southeast Health Center	www.gphainc.org
GPHA-Wilson Park Medical Center	www.gphainc.org
Maria de los Santos Health Center	***http://dvch.org/locations/maria-de-los-santos-health-center/***
PDPH Health Center 10	www.phila.gov/health/ambulatoryhealth/hc10.html
PDPH Health Center 2	www.phila.gov/health/ambulatoryhealth/hc2.html
PDPH Health Center 3	www.phila.gov/health/ambulatoryhealth/hc3.html
PDPH Health Center 4	www.phila.gov/health/ambulatoryhealth/hc4.html
PDPH Health Center 5	www.phila.gov/health/ambulatoryhealth/hc5.html
PDPH Health Center 6	www.phila.gov/health/ambulatoryhealth/hc6.html
PDPH Health Center 7	www.phila.gov/health/ambulatoryhealth/hc9.html

Quality Community Health Care	***www.qchc.org/index.htm***
South Jersey Family Medical Center	www.sjfmc.org/
Strawberry Mansion Health Center	www.phila.gov/health/ambulatoryhealth/hcStrawberry.html
Temple University Kornberg School of Denistry	***www.dentistry.temple.edu/***
University Dental Center At Somerdale	***www.sdm.rutgers.edu/about/admin_extramural.htm***
University of Pennsylvania School of Dentistry	***www.pennmedicine.org***

Direct Emergency Financial Assistance

Public Health Management Corporation	***www.phmc.org***
Utility Emergency Services Fund	www.uesfacts.org

Faith-based

Arch Street United Methodist Church	www.archstreetumc.org
Bright Hope Baptist Church	www.brighthopebaptist.org
Broad Street Ministry	www.broadstreetministry.org
Calvary United Methodist Church	www.allmeansall.org
Church of the Advocate	www.churchoftheadvocate.org
Enon Tabernacle Baptist Church	www.enontab.org
First United Methodist Church of Germantown	www.fumcog.org/
Germantown Mennonite Church	www.germantownmennonite.org
Saint Luke's Church	www.stlukeandtheepiphany.org
Saint Mary of Grace Parish	www.inclusivecatholics.org
Saint Michael's Lutheran Church	www.stmichaelsgermantown.org/

Food Bank, Home Delivered and Congregate Meals

AIDS Care Group	***www.aidscaregroup.org***
Apostles' Lutheran Church, Caring Circle Program	www.gloucestercountynj.gov/depts/s/boardss/emerfp.asp
BEBASHI	***www.bebashi.org***
Broad Street Health Center (Spectrum Health Services)	www.spectrumhs.org/
Catholic Charities	www.catholiccharitiescamden.org/basicneeds/
Congreso De Latinos Unidos, Inc.	***www.congreso.net/***
Covenant House Health Services	www.covenanthousepa.org
Easton Area Neighborhood Centers, Inc.	www.eastonareaneighborhoodcenter.org
Food Resource Guide	www.pcacares.org/foodresources
Food Stamp Hotline/ Greater Philadelphia Coalition Against Hunger	www.hungercoalition.org
Food Stamp Hotline/ Greater Philadelphia Coalition Against Hunger	www.hungercoalition.org
Gloucester County Division of Social Services	www.gloucestercountynj.gov/depts/s/boardss/default.asp

Jewish Family and Children's Services	https://www.jfcsphilly.org/main-home-page/children-teens-families/financial-assistance/
MANNA- Metropolitan Area Neighborhood Nutrition Alliance	***www.mannapa.org/***
Mazzoni Center	***www.mazzonicenter.org***
Meals on Wheels of Salem County, Inc.	www.scmealsonwheels.org/services/
ODAAT, North	***www.uac.org/partners/one-day-time-odaat***
Public Health Management Corp. – Food Vouchers	www.Phmc.org
Puerto Rican Action Committee	www.pracnj.com/pracservices.html
Salem County Board of Social Services	www.scbssnj.org
Spirit Life Fellowship/Oasis Kitchen	www.spiritlifefellowship.net/oasis-kitchen.php
St. Andrew The Apostle RC Church	www.churchofsaintandrews.org
St. John's Hospice	www.saintjohnshospice.org
St. Vincent DePaul	hwww.vincentdepaul.org
Volunteers of America Homeless Prevention	www.voadv.org
Women's Institute for Family Health	***www.wifamilyhealth.org***

General Information, Prevention Education & Referral Services

Access Matters	www.accessmatters.org
Aclamo Family Centers	www.aclamo.org/
Action AIDS- 1026 Arch Street	***www.actionaids.org***
AIDS Activities Coordinating Office	www.phila.gov/health/aaco/index.html
AIDS Law Project in Pennsylvania	***www.aidslawpa.org***
AIDS Library	***www.aidslibrary.org***
AIDS Treatment News	www.aidsnews.org
American Red Cross of Southeastern PA Chapter	www.redcross.org/pa/philadelphia
Aspira, Inc. of Pennsylvania	www.aspirapennsylvania.org/
Attic Youth Center	***www.atticyouthcenter.org***
BEBASHI	***www.bebashi.org***
Bucks County Health Department: Doylestown	www.buckscounty.org
Bucks County Health Department: Levittown	www.buckscounty.org
Burlington County Board Of Social Services	www.bcbss.org/
Burlington County Community Action Program	www.bccap.org/
Camden Area Health Education Center (AHEC)	www.camden-ahec.org
CATA - El Comite de Apoyo a Los	www.cata-farmworkers.org/
Catholic Charities - Family & Community Center	www.catholiccharitiescamden.org/
Catholic Social Services- Philadelphia	www.css-phl.org
Center for Family Services- Family Support Center-Gloucester	www.centerffs.org/
Chester County Health Department	www.chesco.org/health
Children's Hospital Of Philadelphia - Special Immunology Family Care Center	***www.chop.edu***
Children's Hospital Of Philadelphia Adolescent Clinic	***www.chop.edu/centers-programs/adolescent-initiative***

CHOICE	www.choice-phila.org
Coatesville VA Medical Center	www.coatesville.va.gov
COLOURS	***www.coloursorganization.org***
Community Health and Education Outreach (CHEO)	www.cheoinc.com
Contact of Burlington County	www.contactburlco.org
Crossroads Programs	www.crossroadsprograms.org/about_crossroads/our-programs.html
Delaware County Department of Health	www.co.delaware.pa.us/intercommunity
Easton Area Neighborhood Centers, Inc	www.eastonareaneighborhoodcenter.org/Services.html
Fam Care, Inc.	www.famcare8.wwwssr10.supercp.com/services/
Family Service of Chester County	***www.familyservice.us***
Family Services of Montgomery County	***www.fsmontco.org***
Gay & Lesbian Latino AIDS Education Initiative (GALAEI) Project	***www.galaei.org***
Gloucester County Division of Social Services	www.gloucestercountynj.gov/depts/s/boardss/default.asp
Hispanic Family Center of Southern NJ, Inc.	www.hispanicfamilycenter.com/
HIV/AIDS Fact line -CHOICE	www.choice-phila.org
Jewish Family and Children's Services	www.jfcsphilly.org/main-home-page/children-teens-families/financial-assistance/
Jewish Family and Children's Services	www.jfcsphilly.org/main-home-page/children-teens-families/family-life-educational-programs-workshops/
Mazzoni Center	***www.mazzonicenter.org***
Philadelphia FIGHT	***www.fight.org***
Planned Parenthood of Chester County	www.plannedparenthood.org/health-center/pennsylvania/west-chester/19382/west-chester-health-center-3356-91460
Prevention Plus of Burlington County	www.prevplus.org
Puerto Rican Action Committee	www.pracnj.com/pracservices.html
Puerto Rican Unity for Progress	www.prupnj.org/charity-organization-contact-us
Salem County Office for the Disabled	www.salemcountynj.gov/departments/office-of-disability-services
Salem County Social Services	http://health.salemcountynj.gov
St. Christopher's Hospital for Children	***www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2***
Women's Care Center	www.cooperhealth.org/departments-programs/ripa-center-womens-health-wellness
Youth Outreach Adolescent Community Awareness Program (YOACAP)	***http://www.yoacap.org/***

HIV Testing

11th Street Family Health Services of Drexel University	www.drexel.edu/11thStreet
AACO Partner Services/Philadelphia Department of Public Health (PDPH)	www.phila.gov/health/aaco/Prevention.html
Abbottsford-Falls Family Practice	www.fpcn.com
Access Matters	***www.accessmatters.org***
ActionAIDS	***www.actionaids.org***
ActionAIDS- North – Casa Nueva	***www.actionaids.org***
ActionAIDS- Washington West Project	***www.actionaids.org***
African Family Health Organization (AFAHO)	www.afaho.net
AIDS Care Group - Sharon Hill	***www.aidscaregroup.org***
AIDS Care Group - Edgmont Ave	***www.aidscaregroup.org***
Albert Einstein Medical Center: Immunodeficiency Center	www.einstein.edu
Attic Youth Center	***www.atticyouthcenter.org***
Broad St Health Center-Spectrum Community Health Center	***www.spectrumhs.org/***
Bucks County Health Department: Doylestown	www.buckscounty.org
Bucks County Health Department: Levittown	www.buckscounty.org
Camden Area Health Education Center (AHEC)	www.camden-ahec.org
ChesPenn Health Services-Center for Family Health	**www.chespenn.com**
Children's Hospital Of Philadelphia Adolescent Clinic	***www.chop.edu/centers-programs/adolescent-initiative***
COLOURS	***www.coloursorganization.org***
***Congreso De Latinos Unidos, Inc.*- Programa Esfuerzo**	***www.congreso.net/***
Congreso De Latinos Unidos, Inc.-Somerset	***www.congreso.net/***
Cooper University Hospital	***www.cooperhealth.org***
Delaware County State Health Center	***www.co.delaware.pa.us/intercommunity/pastatedelcocenter.html***
Esperanza Health Center – Hunting Park Clinic	www.esperanzahealthcenter.org
Esperanza Health Center – 5th street Clinic	***www.esperanzahealthcenter.org***
Esperanza Health Center – Kensington Clinic	***www.esperanzahealthcenter.org***
Fairmount Primary Care Center	www.dvch.org
Fam Care, Inc.	www.famcareinc.org
Family Practice & Counseling Network Health Annex	**www.fpcn.com**
Family Services of Montgomery County	***www.fsmontco.org***
Family Services of Montgomery County-Pottstown office	***www.fsmontco.org***
Frankford Avenue Health Center	***www.gphainc.org***
Gay & Lesbian Latino AIDS Education Initiative (GALAEI) Project	***www.galaei.org***
GPHA- Chinatown Medical Services	***www.gphainc.org***
GPHA-Hunting Park Health Center	***www.gphainc.org***
GPHA-Southeast Health Center	***www.gphainc.org***

GPHA-Wilson Park Medical Center	***www.gphainc.org***
GPHA-Woodland Ave	***www.gphainc.org***
Kensington Hospital	**215-426-8100**
Kensington Hospital- Erie Clinic	**215-426-8100**
Neighborhood United Against Drugs (NUAD)	***www.uac.org/partners/neighborhood-united-against-drugs-nuad***
ODAAT	***www.uac.org/partners/one-day-time-odaat***
Partnership Comprehensive Care Practice	***www.drexelmedicine.org/patient-services/infectious-diseases/services/hiv-care/***
PDPH Health Care Center #10	***www.phila.gov/health/ambulatoryhealth/hc10.html***
PDPH Health Care Center #1	***www.phila.gov/health/ambulatoryhealth/hc1.html***
PDPH Health Care Center #2	***www.phila.gov/health/ambulatoryhealth/hc2.html***
PDPH Health Care Center #3	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH Health Care Center #4	***www.phila.gov/health/ambulatoryhealth/hc4.html***
PDPH Health Care Center #5	***www.phila.gov/health/ambulatoryhealth/hc5.html***
PDPH Health Care Center #6	***www.phila.gov/health/ambulatoryhealth/hc6.html***
PDPH Health Care Center #9	***www.phila.gov/health/ambulatoryhealth/hc9.html***
Penn Community Practice at Presbyterian	***www.pennmedicine.org/penn-presbyterian-medical-center/services-programs.html***
Philadelphia FIGHT	***www.fight.org***
Planned Parenthood - Bensalem	***www.plannedparenthood.org/health-center/pennsylvania/bensalem/19020/bensalem-medical-center-2513-91410***
Planned Parenthood - Bristol	***www.plannedparenthood.org/health-center/pennsylvania/bristol/19007/bristol-medical-center-2511-91410/birth-control***
Planned Parenthood - Castor Ave	***www.plannedparenthood.org/health-center/pennsylvania/philadelphia/19152/castor-ave.-health-center-2512-91460***
Planned Parenthood - Chester County	www.plannedparenthood.org/health-center/pennsylvania/west-chester/19382/west-chester-health-center-3356-91460
Planned Parenthood - Coatesville	***www.plannedparenthood.org/health-center/pennsylvania/coatesville/19320/coatesville-health-center-2724-91460***
Planned Parenthood - Elizabeth Blackwell Center	***www.plannedparenthood.org/health-center/pennsylvania/philadelphia/19107/elizabeth-blackwell-health-center-2516-91460***
Planned Parenthood - Locust St	***www.plannedparenthood.org/health-center/pennsylvania/philadelphia/19107/locust-street-surgical-center-3360-91460***
Planned Parenthood - Media	***www.plannedparenthood.org/health-center/pennsylvania/media/19063/media-health-center-2338-91460***

Planned Parenthood - Norristown	*www.plannedparenthood.org/health-center/pennsylvania/norristown/19401/norristown-health-center-3440-91460*
Planned Parenthood - Pottstown	*www.plannedparenthood.org/health-center/pennsylvania/pottstown/19464/pottstown-health-center-2340-91460*
Planned Parenthood - Quakertown	*www.plannedparenthood.org/health-center/pennsylvania/quakertown/18951/quakertown-health-center-2515-91410*
Planned Parenthood - The Atrium	*www.plannedparenthood.org/health-center/all/all/18974*
Planned Parenthood - Upper Darby	*www.plannedparenthood.org/health-center/pennsylvania/upper-darby/19082/upper-darby-health-center-4094-91460*
Planned Parenthood - West Chester	*www.plannedparenthood.org/health-center/pennsylvania/west-chester/19382/west-chester-health-center-3356-91460*
Prevention Point Philadelphia- Indiana Outreach Site	*http://ppponline.org*
Prevention Point Philadelphia- North Central Philadelphia Outreach Site	*http://ppponline.org*
Prevention Point Philadelphia-Kensington Ave	*http://ppponline.org*
Prevention Point Philadelphia-North Philadelphia Outreach Site	*http://ppponline.org*
Prevention Point Philadelphia-South Philadelphia Outreach Site	*http://ppponline.org*
Prevention Point Philadelphia-West Philadelphia Outreach Site	*http://ppponline.org*
QCHC Meade Family Health Center	*www.qchc.org*
QCHC Vaux Family Health Center	*www.qchc.org*
QCHC-Cooke Family Health Center	*www.qchc.org*
Quality Community Health Care-West Lehigh Ave	*www.qchc.org*
Spectrum Community Health Center-Haverford Ave	*www.spectrumhs.org*
St. Christopher's Hospital for Children	*www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2*
Strawberry Mansion Health Center	*www.phila.gov/health/ambulatoryhealth/hcStrawberry.html*
Temple University Comprehensive HIV Program	*www.temple.edu/medicine/departments_centers/clinical_departments/medicine_gim_hiv.htm*
Urban Solutions	*http://myuhi.org*
Youth Health Empowerment Project (YHEP)	*www.fight.org*
Youth Outreach Adolescent Community Awareness Program (YOACAP)	*www.yoacap.org*

Home Health Care

Abington Health Association	www.npvna.org
Affilia Home Health	www.affiliahomehealth.org
Coatesville VA Medical Center	www.coatesville.va.gov
Delaware County Memorial Hospital	www.crozer.org
Hahnemann University Hospital	www.hahnemannhospital.com
Keystone Home Health and Hospice	***www.keystonecare.com/hospice.aspx***

Housing Assistance/Shelter

ACHIEVEability	www.achieveability.org
ACLAMO Family Centers of Montgomery County	www.aclamo.org
Action AIDS- 1216 Arch Street	***www.actionaids.org***
ActionAIDS-North-Casa Nueva	***www.actionaids.org***
AIDS Activities Coordinating Office	***www.phila.gov/health/aaco/Housing.html***
AIDS Care Group - Sharon Hill	***www.aidscaregroup.org***
AIDS Law Project in Pennsylvania	www.aidslawpa.org
Asociacion de Puertorriquenos en Marcha- Main Office	www.apmphila.org
Asociacion de Puertorriquenos en Marcha-Housing	www.apmphila.org
Asociacion Puertorriquenos en Marcha - Community Health Clinic	www.apmphila.org
BEBASHI	www.bebashi.org
Bethesda Project	www.bethesdaproject.org
Bucks Villa	www.bucksvilla.org
Burlington County Board Of Social Services	www.bcbss.org
Burlington County Community Action Program	www.bccap.org/
Calcutta House-Independence Place	***www.calcuttahouse.org***
Calcutta House-Serenity Court	***www.calcuttahouse.org***
Camden County Council on Economic Opportunity, Inc	www.camdencountyoeo.com
Center for Family Services, Inc.	www.centerffs.org
Coatesville VA Medical Center	www.coatesville.va.gov
COMHAR	***www.comhar.org/services/adult***
Commission on Human Relations/Fair Housing Commission	www.phila.gov/humanrelations
Congreso De Latinos Unidos, Inc.-Somerset	***www.congreso.net/***
Crossroads Programs	www.crossroadsprograms.org
Easton Area Neighborhood Centers, Inc.	www.eastonareaneighborhoodcenter.org
Families Forward Philadelphia	www.taphilly.org
Family and Community Service of Delaware County	***www.fcsdc.org***
Family Service Association of Bucks County	***www.fsabc.org***
Family Services of Montgomery County	www.fsmontco.org
Frankford Avenue Health Center	www.gphainc.org
Friends Rehabilitation Program	www.friends-frp.com

Gay & Lesbian Latino AIDS Education Initiative (GALAEI) Project	www.galaei.org
Gloucester County Division of Social Services	www.gloucestercountynj.gov/depts/s/boardss/default.asp
Good Shepherd Program	***www.saintjohnshospice.org***
Homelessness Prevention Program	www.state.nj.us/dca/divisions/dhcr/offices/hpp.html
Interfaith Homeless Outreach Council	www.ihocsj.org
Mazzoni Center	www.mazzonicenter.org
Moorestown Ecumenical Neighborhood Development (MEND)	www.mendinc.org
Project H.O.M.E.	https://projecthome.org/
Puerto Rican Action Committee	www.pracnj.com/pracservices.html
Puerto Rican Unity for Progress	www.prupnj.org/charity-organization-contact-us
Ralph Moses House	www.fcsdc.org
Salem County Board of Social Services	www.scbssnj.org
St. John's Hospice	www.saintjohnshospice.org
Utility Emergency Services Fund	www.uesfacts.org

Legal Services

AIDS Law Project of Pennsylvania	***www.aidslawpa.org***
AIDS Law Project of Southern New Jersey	***www.aidslawnj.org***
American Civil Liberties Union (ACLU) of Pennsylvania	www.aclupa.org
Burlington County Bar Foundation - Lawyers Referral	http://burlcobar.org/bar-foundation
Community Legal Services	www.clsphila.org
Covenant House Health Services	www.covenanthousepa.org
Department of Law and Public Safety, Division of Civil Rights	www.nj.gov/oag/dcr/index.html
Gloucester County Bar Foundation	http://www.gcbarfoundation.org
Legal Assistance of Southeastern PA	http://lasp.org
Mazzoni Center	***www.mazzonicenter.org***
Puerto Rican Action Committee	http://www.pracnj.com/pracservices.html
South Jersey Legal Services	http://www.lsnj.org/sjls

Medications and on Site Pharmacy

AIDS Drug Distribution Program of New Jersey (ADDP)	**www.nj.gov/health/aids/freemeds.shtml**
Albert Einstein Medical Center Immunodeficiency Center	www.einstein.edu
Children's Hospital Of Philadelphia - Special Immunology Family Care Center	www.chop.edu
Children's Hospital Of Philadelphia Adolescent Clinic	www.chop.edu/centers-programs/adolescent-initiative
Community A Walgreens Pharmacy	www.walgreens.com

Community Health and Education Outreach (CHEO)	www.cheoinc.com
Esperanza Health Center – Hunting Park Site	www.esperanzahealthcenter.org
Esperanza Health Center – 5th street Site	www.esperanzahealthcenter.org
Esperanza Health Center – Kensington Site	www.esperanzahealthcenter.org
Family Practice & Counseling Network Health Annex	www.fpcn.com
GPHA-4th Street Medical Suite	www.gphainc.org
GPHA-Hunting Park Health Center	www.gphainc.org
GPHA-Wilson Park Medical Center	www.gphainc.org
GPHA-Woodland Ave	www.gphainc.org
Hospital of the UPENN/ MacGregor Infectious Disease Clinic	www.pennmedicine.org
Lax Center	www.fight.org
PDPH Health Care Center #10	***www.phila.gov/health/ambulatoryhealth/hc10.html***
PDPH Health Care Center #2	***www.phila.gov/health/ambulatoryhealth/hc2.html***
PDPH Health Care Center #3	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH Health Care Center #4	***www.phila.gov/health/ambulatoryhealth/hc4.html***
PDPH Health Care Center #5	***www.phila.gov/health/ambulatoryhealth/hc5.html***
PDPH Health Care Center #6	***www.phila.gov/health/ambulatoryhealth/hc6.html***
PDPH Health Care Center #9	***www.phila.gov/health/ambulatoryhealth/hc9.html***
Special Pharmaceutical Benefits Program – Pennsylvania ADAP	www.dhs.pa.gov/provider/healthcaremedicalassistance/specialpharmaceuticalbenefitsprogram/
Strawberry Mansion Health Center	***www.phila.gov/health/ambulatoryhealth/hcStrawberry.html***
Valley Forge Medical Center and Hospital	www.vfmc.net/index.html
Veterans Affairs Medical Center	www.philadelphia.va.gov
Walgreen's - 1101 Locust St	***www.walgreens.com***
Walgreen's - 1227 Locust St	***www.walgreens.com***
Walgreen's - 807 Locust St	***www.walgreens.com***

Mental and Behavioral Health Services

11th Street Family Health Services of Drexel University	www.drexel.edu/11thStreet
Abbottsford-Falls Family Practice	www.fpcn.com
Action AIDS- 1216 Arch Street	www.actionaids.org
AIDS Care Group	***www.aidscaregroup.org***
Albert Einstein Medical Center Immunodeficiency Center	www.einstein.edu
Asociacion Puertorriquenos en Marcha	www.apmphila.org
Belmont Center for Comprehensive Treatment	www.einstein.edu/locations/belmont-behavioral-health/
Bethanna	www.bethanna.org/bethanna
Black Women's Health Alliance	www.pbwha.org
Bridge Treatment Program	www.thebridgePhiladelphia.org
Burlington Comprehensive Counseling Inc.	http://burlingtoncomprehensive.com
Center for Family Services, Inc-	www.centerffs.org

Children's Hospital Of Philadelphia - Special Immunology Family Care Center/	***www.chop.edu***
Coatesville VA Medical Center	www.coatesville.va.gov
COMHAR	www.comhar.org/services/adult
COMHAR - Community Living Room	www.comhar.org/services/adult
COMHAR – PACT	www.comhar.org/services/adult
Community Behavioral Health (CBH)	www.phila.gov/dbhids
Community Council for Health	www.cchss.org
Consortium	www.consortium-inc.org
Cooper EIP	www.cooperhealth.org
Crisis Response Center at Einstein-Germantown Community Center	www.eistein.edu
Crisis Response Center at Friends Hospital	www.friendshospital.com
Crisis Response Center at Hall Mercer/ Pennsylvania Hospital	www.mercyhealth.org/mercyPhiladelphia
Crisis Response Center at Temple/ Episcopal Hospital	www.episcopal.templehealth.org
Delaware Co. Office of Behavioral Health	www.delcohsa.org/behavioralhealth.html
Department of Behavioral Health and Intellectual DisAbility Services	www.dbhids.org
Drenk Behavioral Health Center	http://www.drenk.org/
Episcopal Hospital	http://episcopal.templehealth.org/
Esperanza Health Center	www.esperanzahealthcenter.org
Esperanza Health Center – Hunting Park Site	www.esperanzahealthcenter.org
Esperanza Health Center – 5th street Site	www.esperanzahealthcenter.org
Esperanza Health Center – Kensington Site	www.esperanzahealthcenter.org
Family and Community Service of Delaware County	***www.fcsdc.org***
Family Practice & Counseling Network Health Annex	www.fpcn.com
Family Service Association of Bucks County	www.fsabc.org
Family Service of Chester County	***www.familyservice.us***
Family Services of Montgomery County	www.fsmontco.org
Gaudenzia Inc.	http://www.gaudenzia.org.
Gaudenzia, Inc.	http://www.gaudenzia.org
GPHA-4th Street Medical Suite	www.gphainc.org
GPHA-Frankford Ave Behavioral Health Center	www.gphainc.org
Healthcare Commons, Inc.	www.hcommons.com
Hispanic Family Center of Southern NJ, Inc.	www.hispanicfamilycenter.com
Holcomb Behavioral Health Systems	www.chimes.org/holcomb
Horizon House	www.hhinc.org
Horizon House	www.hhinc.org
Human Services, Inc.	www.hsi-cmhs.com
Jonathan Lax Treatment Center	***www.fight.org***
Kennedy Health Systems-Garden State Infectious Disease Associates, P.A.	www.kennedyhealth.org
Kennedy University Hospitals, Inc. - Behavioral Health	www.kennedyhealth.org

Kensington Hospital	215-426-8100
Kirkbride Rehabilitation Center	www.kirkbridecenter.org
Maryville, Inc.	http://maryvillenj.org
Mazzoni Center	***www.mazzonicenter.org***
Northeast Treatment Center	http://netcenters.org
Partnership Comprehensive Care Practice	***www.drexelmedicine.org/patient-services/infectious-diseases/our-locations/***
PDPH Health Care Center #3	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH Health Care Center #4	***www.phila.gov/health/ambulatoryhealth/hc4.html***
Philadelphia Mental Health Care Corporation	http://pmhcc.org
St. Christopher's Hospital for Children	***www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2***
Strawberry Mansion Health Center	***www.phila.gov/health/ambulatoryhealth/hcStrawberry.html***

Nutrition Services and Assessment

11th Street Family Health Services of Drexel University	www.drexel.edu/11thStreet
AIDS Care Group	www.aidscaregroup.org
Children's Hospital Of Philadelphia - Special Immunology Family Care Center	***www.chop.edu***
Community Health and Education Outreach (CHEO)	www.cheoinc.com
Esperanza Health Center – Hunting Park Clinic	www.esperanzahealthcenter.org
Esperanza Health Center – 5th street Clinic	www.esperanzahealthcenter.org
Esperanza Health Center – Kensington Clinic	www.esperanzahealthcenter.org
MANNA- Metropolitan Area Neighborhood Nutrition Alliance	***www.mannapa.org/***
Partnership Comprehensive Care Practice	***www.drexelmedicine.org/patient-services/infectious-diseases/our-locations/***
PHMC Care Clinic	***www.phmc.org/site/programs/health-care-centers***
Temple University Comprehensive HIV Program	***www.temple.edu/medicine/departments_centers/clinical_departments/medicine_gim_hiv.htm***

Pre Exposure Prophylaxis (PrEP) Providers

AIDS Care Group- Edgemont Ave		***www.aidscaregroup.org***
AIDS Care Group-Sharon Hill		***www.aidscaregroup.org***
Albert Einstein Medical Center ***If patient of Einstein Hospital***	Robert A Fischer, MD	***www.einstein.edu***
Brandywine Valley Infectious Disease Associates	Raida Rabah, MD	(610) 383-9333
Children's Hospital of Philadelphia Adolescent Initiative	Steven D. Douglas, MD	***www.chop.edu/centers-programs/adolescent-initiative***
Congreso De Latinos Unidos, Inc.		***www.congreso.net/***

Dorothy Mann Center for Pediatric and Adolescent HIV at St. Christopher's Hospital for Children	Janet Chen, MD Daniel Conway, MD Jill Foster, MD Roberta Laguerre, MD Neil Rellosa, MD	***www.scfchildren.org/dorothy-mann-center-for-pediatric-and-adolescent-hiv-2***
Drexel University College of Medicine/Partnership Comprehensive Care Practice 1	Amy Baranoski, MD, MSc Jeffrey M. Jacobson, MD Dong Heun Lee, MD Zsofi Szep, MD, MSCE Stacey Trooskin, MD, PhD Christopher Vinnard, MD, MPH	***www.drexelmedicine.org/patient-services/infectious-diseases/our-locations/***
Family Practice & Counseling Network Health Annex	Ani Maitin, CRNP	***www.fpcn.com***
Family Practice & Counseling Network-Abbottsford Falls		***www.fpcn.com***
Garden State Infectious Diseases Associates, P.A (Kennedy Health Systems)	David V. Condoluci, D.O. Mark J. Fussa, D.O.	***www.gsida.org***
GPHA - Woodland Avenue Health Center	Dr. Brenda Rogers Joseph Ondercin, PA	www.gphainc.org
GPHA -Southeast Health Center	Dr. Luistro Anthony Josheph Ondercin, PA	www.gphainc.org
John Bell Health Center		www.fight.org
Jonathan Lax Treatment Center	Helen Koenig, MD Joe Garland, MD Angela Kapalko, MHS, PA-C	www.fight.org
Kennedy Health Systems-Raphael Meadow Center		***www.kennedyhealth.org***
Kennedy Health Systems-Voorhees		***www.kennedyhealth.org***
Kensington Hospital	Dr. Nicolas Ifft	215-426-8100
Mazzoni Center Family & Community Medicine	Dr. Robert Winn Nancy Brisbon, MD	***www.mazzonicenter.org/programs/medical-care***
PDPH District Health Center # 10	Dr. Sarah Messick	***www.phila.gov/health/ambulatoryhealth/hc10.html***
PDPH District Health Center #2	Dr. Stacey Parker-Johnson, DO Dr. V B. Marshall Jr, DO	***www.phila.gov/health/ambulatoryhealth/hc2.html***
PDPH District Health Center #3	Dr. Esther Chernak	***www.phila.gov/health/ambulatoryhealth/hc3.html***
PDPH District Health Center #4	Blake Marshall, DO	***www.phila.gov/health/ambulatoryhealth/hc4.html***
PDPH District Health Center #5	Dr. Rita Eburuoh	***www.phila.gov/health/ambulatoryhealth/hc5.html***
PDPH District Health Center #6	Blake Marshall, DO	***http://www.phila.gov/health/ambulatoryhealth/hc6.html***

PDPH District Health Center #9	James Dean, MD Eileen Donaghy, CRNP	***www.phila.gov/health/ambulatoryhealth/hc9.html***
PDPH Strawberry Mansion Health Center	Dr. Millen Gebreselassie Dr. Tanya Malone Dr. Helena Kwakwa Jeanette Skipper-Thomas Charlotta Swain	***www.phila.gov/health/ambulatoryhealth/hcStrawberry.html***
Penn Infectious Diseases and Travel Medicine		www.pennmedicine.org/providers/practice/infectious-diseases-travel-medicine-pennsylvania-hospital
Penn Presbyterian Medical Center-Infectious Diseases	Brendan J. Kelly, MD Jay R. Kostman, MD Carol A. McLaughlin, MD Vincent Lo Re, III, MD Naasha J. Talati, MD	***www.pennmedicine.org/infectious-diseases/***
PHMC Care Clinic ****Will provided if patient of clinic****	Helena Kwakwa, MD Roberta Lee Powell, MD Alvin Kingcade, PA Katie Huynn, PA	***www.phmc.org/site/programs/health-care-centers/375-phmc-care-clinic***
Spectrum Health Services Inc.	Kheng Lim, MD Carlotta Lindsay, MD Daniel Moscow, MD	***www.spectrumhs.org/***
Temple University Comprehensive HIV Program		***www.temple.edu/medicine/departments_centers/clinical_departments/medicine_gim_hiv.htm***
The MacGregor Clinic Hospital of the University of Pennsylvania	Valerianna K. Amorosa, MD Katharine J. Bar, MD Todd Barton, MD Emily A. Blumberg, MD Neil O. Fishman, MD Ian Frank, MD Phillip A. Green, MD Robert Gross, MD, MSCE Janet Hines, MD Rahul M. Kohli, MD, PhD	www.pennmedicine.org/infectious-diseases
Thomas Jefferson University Infectious Diseases	Bryan D. Hess, MD Kathleen Squires, MD	***http://hospitals.jefferson.edu/departments-and-services/infectious-diseases/***
Youth Health Empowerment Project (YHEP)		www.fight.org

Substance Use Treatment Services

ACT One (Achievement Through Counseling and Treatment)	www.jevshumanservices.org

ACT Two (Achievement Through Counseling and Treatment)	www.jevshumanservices.org
Al-Anon Info Service of Delaware Valley	AISDV.org
Al-Anon Southern Jersey Information	www.southjerseyal-anon.org/index.html
Alcoholics Anonymous, Southeastern Pennsylvania InterGroup Association (SEPIA)	www.sepennaa.org
Asociacion de Puertorriquenos en Marcha	www.apmphila.org
Behavioral Health Special Initiative (BHSI)	www.dbhids.org/behavioral-health-special-initiative
Belmont Center for Comprehensive Treatment	www.einstein.edu/locations/belmont-behavioral-health/
Bridge Treatment Program	www.thebridgePhiladelphia.org
Bridges Step Down	www.phmc.org
Center for Family Services	www.centerffs.org
Children's Hospital Of Philadelphia - Cobbs Creek	www.chop.edu
Children's Hospital Of Philadelphia Adolescent Clinic	www.chop.edu
Cocaine Anonymous	www.caphilly.org
Community Behavioral Health (CBH)	www.phila.gov/dbhids
Community Council for Health Systems	www.cchss.org
Consortium	www.consortium-inc.org
Council of Southeast Pennsylvania	www.councilsepa.org
Council on Addictive Diseases (COAD)	www.coadgroup.com
Crisis Response Center at Einstein-Germantown Community Center	www.eistein.edu
Crisis Response Center at Friends Hospital	www.friendshospital.com
Crisis Response Center at Mercy Hospital	www.mercyhealth.org/mercyPhiladelphia
Crisis Response Center at Temple/ Episcopal Hospital	www.episcopal.templehealth.org
Crozer Keystone Health Systems	***www.crozer.org***
Department of Behavioral Health and Intellectual DisAbility Services	www.dbhids.org
Eagleville Hospital	www.eaglevillehospital.org
Family and Community Service of Delaware County	www.fcsdc.org
Frankford Avenue Health Center	www.gphainc.org
Gaudenzia, Inc.	www.gaudenzia.org
Good Shepard Program of St. Johns Hospice	www.saintjohnshospice.org
GPHA/AL-ASSIST Behavioral Health Care Center	www.gphainc.org
GPHA-Wilson Park Medical Center	www.gphainc.org
Holcomb Behavioral Health Systems	www.chimes.org/holcomb/
Kensington Hospital	**215-426-8100**
Kensington Hospital-Erie Clinic	**215-426-8100**
Maria de los Santos Health Center	www.dvch.org/locations/maria-de-los-santos-health-center
Maryville, Inc.	http://maryvillenj.org
Northeast Treatment Center	http://netcenters.org
ODAAT	http://www.uac.org/partners/one-day-time-odaat

Office of Addiction Services	www.dbhids.org/office-of-addicitive-services
Penn Behavioral Health	www.med.upenn.edu/pbh
Philadelphia Fight	***www.fight.org***
Prevention Point Philadelphia- Indiana Outreach Site	http://ppponline.org
Prevention Point Philadelphia- North Central Philadelphia Outreach Site	http://ppponline.org
Prevention Point Philadelphia-Kensington Ave	http://ppponline.org
Prevention Point Philadelphia-North Philadelphia Outreach Site	http://ppponline.org
Prevention Point Philadelphia-South Philadelphia Outreach Site	http://ppponline.org
Prevention Point Philadelphia-West Philadelphia Outreach Site	http://ppponline.org
Ready, Willing and Able	www.rwaphiladelphia.org
Resources for Human Development	www.rhd.org
Valley Forge Medical Center and Hospital	www.vfmc.net

Transportation

AIDS Care Group	www.aidscaregroup.org
Bucks County Transport	www.bctransport.org
Community Transit of Delaware County	www.ctdelco.org
Public Health Management Corp - Transportation	***www.phmc.org***
Puerto Rican Action Committee	www.pracnj.com/pracservices.html

Work Force Capacity Table

The table specifically compares the ratio of the identified area's concentration of an occupation type to the national average. This information is conveyed using the location quotient. A location quotient greater than one indicates the occupation has a higher share of employment than average, and a location quotient less than one indicates the occupation is less prevalent in the area than average. Occupations with a location quotient less than one have been highlighted in orange.

Occupation Title[82]	Area[83]	Estimated Number of Positions[84]	Location Quotient[85]	Occupation Description[86]
Community and Social Service Occupations	Burlington, Camden and Gloucester Co.	9,950	1.37	Community health workers collect data and discuss health concerns with members of specific populations and or are concerned with improving society and the lives of individuals. These workers perform a diverse array of duties that may include counseling individuals with substance abuse and behavioral problems, providing social assistance to improve the social and psychological functioning of families, and offering spiritual and moral guidance to members of a faith.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	39,990	1.50	
Community Health Workers	Burlington, Camden and Gloucester Co.	90	0.51	Health educators teach people about behaviors that promote wellness. They develop and implement strategies to improve the health of individuals and communities. Community health workers collect data and discuss health concerns with members of specific populations or communities.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	440	0.67	
Counselors, All Other	Burlington, Camden and Gloucester Co.	290	2.69	All counselors not listed separately.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	200	0.51	
Dental Assistants	Burlington, Camden and Gloucester Co.	1,410	1.19	Dental assistants have many tasks, ranging from providing patient care and taking x rays to recordkeeping and scheduling appointments. Their duties vary by state and by the dentists' offices where they work.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,450	1.03	

[82] Occupation Title- All the information was obtained from the United States Department of Labor, Bureau of Labor Statistics, http://www.bls.gov/ooh/occupation-finder.htm

[83] Area-Metropolitan Statistical Area. For this table two areas were used Camden, NJ Metropolitan Division (15804) and the Philadelphia, PA Metropolitan Division (37964). Salem County is NOT included in these divisions.

[84] Estimated number of positions-Estimated total employment rounded to the nearest 10 (excludes self-employed)

[85] Location Quotient-The location quotient is the ratio of the identified area's concentration of occupational employment as compared to the national average concentration. A location quotient greater than one indicates the occupation has a higher share of employment than average, and a location quotient less than one indicates the occupation is less prevalent in the area than average. The location quotient represents the ratio of an occupation's share of employment in a given area as compared to that occupation's share of employment in the U.S. as a whole.

[86] Occupation Description-Based on the descriptions in the Occupation Outlook Handbook, May 2014

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Dental Hygienists	Burlington, Camden and Gloucester Co.	790	1.07	Clean teeth and examine oral areas, head, and neck for signs of oral disease. May educate patients on oral hygiene, take and develop x rays, or apply fluoride or sealants.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,880	1.06	
Dentists, All Other Specialists	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	50	0.61	Examine, diagnose, and treat diseases, injuries, and malformations of teeth and gums. May treat diseases of nerve, pulp, and other dental tissues affecting oral hygiene and retention of teeth. May fit dental appliances or provide preventive care. Excludes "Prosthodontists" (29-1024), "Orthodontists" (29-1023), "Oral and Maxillofacial Surgeons" (29-1022) and "Dentists, All Other Specialists" (29-1029).
Dentists, General	Burlington, Camden and Gloucester Co.	400	1.09	Dentists diagnose and treat problems with a patient's teeth, gums, and related parts of the mouth. They provide advice and instruction on taking care of teeth and gums and on diet choices that affect oral health.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,470	1.09	
Dietitians and Nutritionists	Burlington, Camden and Gloucester Co.	120	0.55	Dietitians and nutritionists are experts in food and nutrition. They advise people on what to eat in order to lead a healthy lifestyle or achieve a specific health-related goal.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,130	1.38	
Emergency Medical Technicians and Paramedics	Burlington, Camden and Gloucester Co.	1,390	1.57	Emergency medical technicians (EMTs) and paramedics care for the sick or injured in emergency medical settings. People's lives often depend on their quick reaction and competent care. EMTs and paramedics respond to emergency calls, performing medical services and transporting patients to medical facilities.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	3,100	0.95	
Epidemiologists	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	50	0.70	Epidemiologists are public health professionals who investigate patterns and causes of disease and injury in humans. They seek to reduce the risk and occurrence of negative health outcomes through research, community education, and health policy.

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Family and General Practitioners	Burlington, Camden and Gloucester Co.	470	1.00	Physicians and surgeons diagnose and treat injuries or illnesses. Physicians examine patients; take medical histories; prescribe medications; and order, perform, and interpret diagnostic tests. They counsel patients on diet, hygiene, and preventive healthcare. Surgeons operate on patients to treat injuries, such as broken bones; diseases, such as cancerous tumors; and deformities, such as cleft palates.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,900	1.68	
Health Educators	Burlington, Camden and Gloucester Co.	100	0.45	Health educators teach people about behaviors that promote wellness. They develop and implement strategies to improve the health of individuals and communities. Community health workers collect data and discuss health concerns with members of specific populations or communities.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,230	1.56	
Healthcare Practitioners and Technical Occupations	Burlington, Camden and Gloucester Co.	32,580	1.10	All healthcare practitioners and technical workers not listed separately.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	120,170	1.11	
Healthcare Support Occupations	Burlington, Camden and Gloucester Co.	19,640	1.33	This major group comprises the all healthcare support occupations
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	69,620	1.28	
Healthcare Support Workers, All Other	Burlington, Camden and Gloucester Co.	**	**	All healthcare support workers not listed separately
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	400	0.29	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Home Health Aides	Burlington, Camden and Gloucester Co.	3,530	1.18	Home health aides help people who are disabled, chronically ill, or cognitively impaired. They often help older adults who need assistance. In some states, home health aides may be able to give a client medication or check the client's vital signs under the direction of a nurse or other healthcare practitioner.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	21,670	1.97	
Internists, General	Burlington, Camden and Gloucester Co.	150	0.82	Diagnose and provide non-surgical treatment of diseases and injuries of internal organ systems. Provide care mainly for adults who have a wide range of problems associated with the internal organs. Include subspecialists, such as cardiologists and gastroenterologists, with "All Other Physicians" (29-1069).
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	560	0.84	
Lawyers	Burlington, Camden and Gloucester Co.	2,390	1.05	Lawyers advise and represent individuals, businesses, and government agencies on legal issues and disputes.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	13,450	1.62	
Licensed Practical and Licensed Vocational Nurses	Burlington, Camden and Gloucester Co.	2,550	0.97	Licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) provide basic nursing care. They work under the direction of registered nurses and doctors.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	10,670	1.11	
Medical and Clinical Laboratory Technicians	Burlington, Camden and Gloucester Co.	370	0.61	Perform routine medical laboratory tests for the diagnosis, treatment, and prevention of disease. May work under the supervision of a medical technologist.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,440	2.01	
Medical and Health Services Managers	Burlington, Camden and Gloucester Co.	1,290	1.10	Medical and health services managers, also called healthcare executives or healthcare administrators, plan, direct, and coordinate medical and health services. They might manage an entire facility or specialize in managing a specific clinical area or department, or manage a medical practice for a group of physicians. Medical and health services managers must be able to adapt to changes in healthcare laws, regulations, and technology.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,660	1.09	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Medical Assistants	Burlington, Camden and Gloucester Co.	2,300	1.05	Medical assistants complete administrative and clinical tasks in the offices of physicians, podiatrists, chiropractors, and other health practitioners. Their duties vary with the location, specialty, and size of the practice.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	7,170	0.89	
Medical Records and Health Information Technicians	Burlington, Camden and Gloucester Co.	290	0.41	Medical records and health information technicians, commonly referred to as health information technicians, organize and manage health information data. They ensure its quality, accuracy, accessibility, and security in both paper and electronic systems. They use various classification systems to code and categorize patient information for insurance reimbursement purposes, for databases and registries, and to maintain patients' medical and treatment histories.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,820	1.11	
Medical Scientists, Except Epidemiologists	Burlington, Camden and Gloucester Co.	140	0.37	Medical scientists conduct research aimed at improving overall human health. They often use clinical trials and other investigative methods to reach their findings.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	3,250	2.34	
Mental Health and Substance Abuse Social Workers	Burlington, Camden and Gloucester Co.	460	1.12	Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	3,260	2.16	
Mental Health Counselors	Burlington, Camden and Gloucester Co.	560	1.24	Mental health counselors and marriage and family therapists help people manage and overcome mental and emotional disorders and problems with their family and relationships. They listen to clients and ask questions, to help the clients understand their problems and develop strategies to improve their lives.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,260	2.57	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Nurse Practitioners	Burlington, Camden and Gloucester Co.	540	1.17	Nurse anesthetists, nurse midwives, and nurse practitioners, also referred to as advanced practice registered nurses (APRNs), provide and coordinate patient care and they may provide primary and specialty health care. The scope of practice varies from state to state.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,510	0.90	
Nursing Assistants	Burlington, Camden and Gloucester Co.	7,770	1.45	Nursing assistants and orderlies help provide basic care for patients in hospitals and residents of long-term care facilities, such as nursing homes.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	26,560	1.35	
Obstetricians and Gynecologists	Burlington, Camden and Gloucester Co.	110	1.32	Diagnose, treat, and help prevent diseases of women, especially those affecting the reproductive system and the process of childbirth.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	90	0.30	
Opticians, Dispensing	Burlington, Camden and Gloucester Co.	160	0.58	Dispensing opticians help fit eyeglasses and contact lenses, following prescriptions from ophthalmologists and optometrists. They also help customers decide which eyeglass frames or contact lenses to buy.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	710	0.71	
Optometrists	Burlington, Camden and Gloucester Co.	160	1.29	Optometrists examine the eyes and other parts of the visual system. They also diagnose, and treat visual problems, and manage diseases, injuries, and other disorders of the eyes. They prescribe eyeglasses or contact lenses as needed.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	240	0.52	
Pediatricians, General	Burlington, Camden and Gloucester Co.	220	1.90	Physicians who diagnose, treat, and help prevent children's diseases and injuries.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	30	0.07	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Personal Care Aides	Burlington, Camden and Gloucester Co.	1,140	0.24	Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	20,670	1.19	
Pharmacists	Burlington, Camden and Gloucester Co.	1,380	1.26	Pharmacists dispense prescription medications to patients and offer expertise in the safe use of prescriptions. They also may provide advice on how to lead a healthy lifestyle, conduct health and wellness screenings, provide immunizations, and oversee the medications given to patients.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,300	1.07	
Pharmacy Technicians	Burlington, Camden and Gloucester Co.	1,280	0.92	Pharmacy technicians help licensed pharmacists dispense prescription medication to customers or health professionals.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,790	0.94	
Phlebotomists	Burlington, Camden and Gloucester Co.	420	0.99	Phlebotomists draw blood for tests, transfusions, research, or blood donations. Some explain their work to patients and provide assistance when patients have adverse reactions after their blood is drawn.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,540	1.00	
Physical Therapist Aides	Burlington, Camden and Gloucester Co.	530	2.88	Physical therapist assistants (sometimes called PTAs) and physical therapist aides work under the direction and supervision of physical therapists. They help patients who are recovering from injuries and illnesses regain movement and manage pain.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	730	1.08	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Physical Therapist Assistants	Burlington, Camden and Gloucester Co.	140	0.50	Physical therapist assistants (sometimes called PTAs) and physical therapist aides work under the direction and supervision of physical therapists. They help patients who are recovering from injuries and illnesses regain movement and manage pain.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,460	1.38	
Physical Therapists	Burlington, Camden and Gloucester Co.	950	1.26	Physical therapists, sometimes called PTs, help injured or ill people improve their movement and manage their pain. These therapists are often an important part of rehabilitation and treatment of patients with chronic conditions or injuries.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	3,270	1.18	
Physician Assistants	Burlington, Camden and Gloucester Co.	250	0.73	Physician assistants, also known as PAs, practice medicine on a team under the supervision of physicians and surgeons. They are formally educated to examine patients, diagnose injuries and illnesses, and provide treatment.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	1,600	1.27	
Physicians and Surgeons, All Other	Burlington, Camden and Gloucester Co.	2,140	1.83	All physicians and surgeons not listed separately.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	4,240	0.99	
Psychiatric Aides	Burlington, Camden and Gloucester Co.	1,140	4.17	Psychiatric technicians and aides care for people who have mental illness and developmental disabilities. Technicians typically provide therapeutic care. Aides help patients in their daily activities and ensure a safe, clean environment.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	750	0.75	
Psychiatric Technicians	Burlington, Camden and Gloucester Co.	70	0.29	Psychiatric technicians and aides care for people who have mental illness and developmental disabilities. Technicians typically provide therapeutic care. Aides help patients in their daily activities and ensure a safe, clean environment.

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Psychiatrists	Burlington, Camden and Gloucester Co.	80	0.88	Physicians who diagnose, treat, and help prevent disorders of the mind.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	450	1.30	
Psychologists, All Other	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	160	0.94	Psychologists study cognitive, emotional, and social processes and human behavior by observing, interpreting, and recording how people relate to one another and their environments.
Registered Nurses	Burlington, Camden and Gloucester Co.	11,460	1.14	Registered nurses (RNs) provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their family members.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	43,040	1.16	
Rehabilitation Counselors	Burlington, Camden and Gloucester Co.	260	0.66	Rehabilitation counselors help people with emotional and physical disabilities live independently. They work with clients to overcome or manage the personal, social, and professional effects of disabilities on employment or independent living.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,820	1.97	
Social and Community Service Managers	Burlington, Camden and Gloucester Co.	510	1.17	Social and community service managers coordinate and supervise social service programs and community organizations. They direct and lead staff who provide social services to the public.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,130	1.33	
Social and Human Service Assistants	Burlington, Camden and Gloucester Co.	3,870	2.90	Social and human service assistants help people get through difficult times or get additional support. They assist other workers, such as social workers, and they help clients find benefits or community services.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	7,460	1.53	
Social Scientists and Related Workers, All Other	Burlington, Camden and Gloucester Co.	80	0.64	All social scientists and related workers not listed separately.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	130	0.29	

Occupation Title	Area	Estimated Number of Positions	Location Quotient	Occupation Description
Social Workers, All Other	Burlington, Camden and Gloucester Co.	150	0.66	Social workers help people solve and cope with problems in their everyday lives. One group of social workers, clinical social workers, also diagnose and treat mental, behavioral, and emotional issues.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	350	0.41	
Sociologists	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	**	**	Sociologists study society and social behavior by examining the groups, cultures, organizations, social institutions, and processes that people develop.
Substance Abuse and Behavioral Disorder Counselors	Burlington, Camden and Gloucester Co.	410	1.29	Substance abuse and behavioral disorder counselors advise people who suffer from alcoholism, drug addiction, eating disorders, or other behavioral problems. They provide treatment and support to help the client recover from addiction or modify problem behaviors.
	Bucks, Chester, Delaware, Montgomery and Philadelphia Co.	2,800	2.39	

Appendix B: Letters of Concurrence

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
1101 Market Street - 9th Floor
Philadelphia, PA 19107

THOMAS FARLEY, MD, MPH
Health Commissioner

CAROLYN C. JOHNSON, MD
Deputy Health Commissioner

COLEMAN TERRELL
Director
AIDS Activities Coordinating Office

July 27, 2016

Roderick Joiner,
Project Officer
1600 Clifton Rd
Atlanta, GA 30333

Dear Mr. Joiner:

The Philadelphia HIV Prevention Planning Group (HPG), concurs with the following submission by the City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The HPG, has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The HPG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201.

The HPG looks forward to continuing our highly valued partnerships with our grantee, the City of Philadelphia, service providers throughout our community, and the many diverse people affected by this epidemic. With this level of collaboration and through combining our divergent views, diverse skills, and different ideas, we hope to stop the spread of HIV.

The signature below confirms the concurrence of the HPG with the Integrated HIV Prevention and Care Plan.

Signature: Date: 7/27/2016

Philadelphia HIV Prevention Planning Group Co-Chair

7/27/2016

Philadelphia HIV Prevention Planning Group
Interim Co-Chair

CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
1101 Market Street - 9th Floor
Philadelphia, PA 19107

THOMAS FARLEY, MD, MPH
Health Commissioner

CAROLYN JOHNSON, MD
Deputy Health Commissioner

COLEMAN TERRELL
Director
AIDS Activities Coordinating Office

July 27, 2016

Ms. Marean Duarte
Project Officer
Health Resources & Services Administration
HIV/AIDS Bureau, Division of Metropolitan
HIV/AIDS Programs, Northeast Services Branch
5600 Fishers Lane, HAB DMHAP
Rockville, MD 20857

Dear Ms. Duarte:

The Philadelphia Ryan White Part A Planning Council (RWPC), concurs with the following submission by the City of Philadelphia, Department of Public Health, AIDS Activities Coordinating Office in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The RWPC, has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The RWPC concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements set forth by the Ryan White HIV/AIDS Program legislation and program guidance.

The RWPC looks forward to continuing our highly valued partnerships with our grantee, the City of Philadelphia, service providers throughout our community, and the many diverse people affected by this epidemic. With this level of collaboration and through combining our divergent views, diverse skills, and different ideas, we hope to stop the spread of HIV.

The signature below confirms the concurrence of the RWPC with the Integrated HIV Prevention and Care Plan.

Signature: Karen Coleman Date: 7/27/2016

Philadelphia Ryan White Part
A Planning Council Co-Chair

Philadelphia Ryan White Part
A Planning Council Co-Chair

7/27/2016

APPENDIX C: GLOSSARY

This glossary combines definitions of terms found in HRSA's glossary of terms for the Ryan White HIV/AIDS Program, the CDC's glossary of HIV prevention terms as associated with FOA PS11-1113, the CDC's glossary of terms as contained in the HIV Planning Guidance, and HRSA and CDC's list of terms in their integrated guidance for developing epidemiologic profiles.

A

AIDS Drug Assistance Program (ADAP). Administered by States and authorized under Part B of the Ryan White Treatment Modernization Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

AIDS (Acquired Immunodeficiency Syndrome). A disease caused by the human immunodeficiency virus

AIDS Service Organization (ASO). An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

B

Behavioral data. Information collected from studies that examine human behavior relevant to disease risk. For instance, relevant behavioral data for HIV risk may include sexual activity, substance use, condom use, etc.

Behavioral intervention. See "Intervention."

C

Capacity. Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved PLWH in the EMA.

Capacity building. Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act). Federal legislation created to address the unmet health care and service needs of people living with HIV Disease (PLWH) disease and

their families. It was enacted in 1990 and reauthorized in 1996 and 2000. Reauthorized in 2006 as the Ryan White Treatment Modernization Act.

Case. A condition, such as HIV infection (e.g., an HIV case) diagnosed according to a standard case definition.

Case fatality. The number of deaths among persons with a diagnosis of the disease of interest. Usually expressed as a rate (number of deaths after disease onset or diagnosis divided by the number of persons with the disease); measures the effect of the disease on persons with a diagnosis.

Centers for Disease Control and Prevention (CDC). The lead federal agency for protecting the health and safety of people, providing credible information to enhance health decisions, and promoting health through strong partnerships. Based in Atlanta, Georgia, this agency of the U.S. Department of Health and Human Services serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Centers for Medicare and Medicaid Services (CMS). Federal agency within HHS that administers the Medicaid, Medicare, and the Children's Health Insurance Program (CHIP).

Collaboration. Working with another person, organization, or group for mutual benefit by exchanging information, sharing resources, or enhancing the other's capacity, often to achieve a common goal or purpose.

Community-Based Organization (CBO). An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

Community forum or public meeting. A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Community members. 1) consumers/ members of the priority population that are receiving services, or 2) people who are not affiliated with organizations but are infected or affected by HIV and have a passion to address HIV.

Co-morbidity. A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Comprehensive planning. The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

Conflict of interest. Conflict between the private interests and public obligations of a person in an official position.

Confidentiality. The treatment of information that an individual or institution has disclosed in a relationship of trust, with the expectation that the information will not be divulged to others in ways that are inconsistent with the individual's or institution's understanding when the individual or institution provided the information. It encompasses access to, and disclosure of, information in accordance with requirements of state law or official policy. For HIV surveillance data, confidentiality refers to the protection of private information collected by the HIV surveillance system.

Continuous Quality Improvement (CQI). An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.

Continuum of care. An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWHA.

Coordination. Aligning processes, services, or systems, to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information, such as progress reports, with state and local health departments or structuring prevention delivery systems to reduce duplication of effort

Core services. Grantee expenditures are limited to core medical services, support services, and administrative expenses. See Core Services and Support Services, which are also listed in the Ryan White legislation as follows: Part A (2604(c), Part B (2612(b), and Part C (2651(c).

Cost-effectiveness. The relative costs and effectiveness of proposed strategies and interventions, either demonstrated or probable

Counseling and testing. A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of tests results, HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and is provided testing to detect the presence of HIV antibodies.

Cultural competence. The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

Culturally appropriate. Conforming to a culture's acceptable expressions and standards of behavior and thoughts. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

Cumulative cases. The total number of cases of a disease reported or diagnosed during a specified time regardless of current vital status. Cumulative cases therefore include cases in persons who have already died.

D

Demographics. Characteristics of human populations such as age, race, ethnicity, sex used to classify them for statistical purposes.

Diversity. Individual differences along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, health or disease status, or other ideologies. The concept of diversity encompasses acceptance, respect, and understanding that each individual is unique.

E

Early Intervention Services (EIS). Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White HIV/AIDS Program, includes outreach, counseling and testing, information and referral services. Under Part C Ryan White HIV/AIDS Program, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Effective. Demonstrating the desired effect when widely used in practice or under real-world conditions that are considerably less rigorous and controlled than environments testing efficacy but that are still designed to ensure the desired effect can be attributed to the intervention in question.

Eligible Metropolitan Area (EMA). Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds to be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000.

Engagement process. A process used to identify strategies for increasing coordination between HIV programs of the state, jurisdiction, and tribal communities for the purpose of applying a collective vision for the benefit of the overall jurisdiction. Steps for engagement should include determining the activities of the Jurisdictional HIV Prevention Plan and whom to engage, developing engagement and retention strategies for previous partners, developing engagement strategies for new partnering agencies, prioritizing engagement activities, creating an implementation plan, monitoring progress, and maintaining the partner relationships.

Epidemic. The rapid spread, growth, or occurrence of cases of an illness, health-related behavior, or other health-related events in a community or region in excess of normal expectation

Epidemiological profile. A document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral, and clinical characteristics. The epidemiological profile 55 serves as the scientific basis of the identification and prioritization of HIV prevention and care needs in any given jurisdiction.

Epidemiology. The study of the causes, spread, control, and prevention of disease in human beings.

Estimate. In situations in which precise data are not available, an estimate may be made on the basis of available data and an understanding of how the data can be generalized to larger populations. In some instances, national or state data may be statistically adjusted to estimate local conditions. Good estimates are accompanied by statistical estimates of error (a confidence interval), which describe the limitations of the estimate.

Evidence-based. Behavioral, social, and structural interventions relevant to HIV risk reduction that has been tested using a methodologically rigorous design, and have been shown to be effective in a research setting. These evidence (or science-based interventions) have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group if a policy study); had no apparent bias when assigning persons to intervention or control groups or were adjusted for any apparent assignment bias; and, produced significantly greater positive results when compared to the control/comparison group(s), while not producing adverse consequences.

Exposure category. In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.

Ethnicity. The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic or Latino origin

F

Food and Drug Administration (FDA). Federal agency within HHS responsible for ensuring the safety and effectiveness of drugs, biologics, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood banking industry to safeguard the nation's blood supply.

Funding Opportunity Announcement (FOA). A CDC announcement informing the public of the availability of funds to develop and implement programs that meet a public health goal; including a solicitation of applications for funding. The FOA describes required activities and asks the applicants to describe how they will carry out the required activities.

G

Grantee. The recipient of Ryan White HIV/AIDS Program funds responsible for administering the award.

H

Health centers. Community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited

English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

Health disparity. A particular type of health difference that is closely linked with social or economic disadvantage based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion

Health Education/Risk Reduction (HE/RR). Organized efforts to reach people at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal is to reduce the spread of infection. Activities range from individual HIV prevention counseling to broad, community-based interventions.

Health equity. A desirable goal that entails special efforts to improve the health of those who have experienced social or economic disadvantage. It requires continuous efforts focused on elimination of health disparities, including disparities in health and in the living and working conditions that influence health, and continuous efforts to maintain a desired state of equity after particular health disparities are eliminated.

Health Insurance Continuity Program (HICP). A program primarily under Part B of the Ryan White HIV/AIDS Program that makes premium payments, co-payments, deductibles, and/or risk pool payments on behalf of a client to purchase/maintain health insurance coverage.

Health Resources and Services Administration (HRSA). The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

High-risk individual. Someone who has recently engaged in HIV risk behaviors where there is a high probability of becoming infected with HIV (see HIV risk behaviors).

Highly Active Antiretroviral Therapy (HAART). HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.

HIV/AIDS Bureau (HAB). The bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White HIV/AIDS Program.

HIV disease. Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

HIV infection, stage unknown. No reported information on AIDS-defining conditions and no information available on CD4 count or percentage.

HIV medical care/evaluation/treatment. Medical services that address HIV infection including evaluation of immune system function and screening, treatment, and prevention of opportunistic infection.

HIV planning group (HPG). The official HIV planning body that follows the HIV Planning Guidance to inform the development or update of the health department's jurisdictional HIV Prevention Plan that will contribute to the reduction of HIV infection in the jurisdiction.

HIV prevention counseling. An interactive process between client and counselor aimed at reducing risky sex and drug-injection behaviors related to HIV acquisition or transmission.

HIV risk behaviors. Persons likely to be at high risk for HIV include persons who have: had unprotected anal or vaginal sex with a person living with HIV, injected drugs with non-sterile, shared drug-injection equipment, had unprotected anal or vaginal sex in exchange for money or drugs, had unprotected anal or vaginal sex with more than one sex partner since their most recent negative HIV test, been diagnosed with a sexually transmitted disease (STD), and persons who have had unprotected anal or vaginal sex with anyone who had any of these risks.

Housing Opportunities for People With AIDS (HOPWA). A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWHA and their families.

HUD (U.S. Department of Housing and Urban Development). The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

I

Incidence. The number of new cases of a disease that occur during a specified time period.

Inclusion. Meaningful involvement of members in the process with an active role in making decisions. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included.

Injection Drug User (IDU). Someone who uses a needle to inject drugs into his or her body.

Intervention. A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

J

Jurisdiction. An area or region that is the responsibility of a particular governmental agency. This term usually refers to an area where a state or local health department monitors HIV prevention activities. (For example, Jonestown is within the jurisdiction of the Jones County Health Department.)

Jurisdictional HIV Prevention Plan. The health department, in collaboration with the HPG, previously developed a Jurisdictional HIV Prevention Plan. This plan has been replaced by the Integrated HIV Care and Prevention Plan, which incorporates plans for both the care and prevention systems.

L

Linkage. Actively assisting clients with accessing needed services through a time-limited professional relationship. The active assistance typically lasts a few days to a few weeks and includes a follow-up component to assess whether linkage has occurred. Linkage services can include: assessment, supportive counseling, education, advocacy, and accompanying clients to initial appointments.

Local Health Department. A health department and/or health department facility responsible for providing and/or supporting the provision of direct client services in a county or city.

M

Men who have Sex with Men (MSM). Men who report sexual contact with other men (that is, homosexual contact) and men who report sexual contact with both men and women (that is, bisexual contact), whether or not they identify as “gay”.

Metro Statistical Area (MSA). A core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core.

Met/Unmet need. A **met** need is a need within a specific target population for HIV prevention and or care services that is currently being addressed through existing resources. These resources are available to, appropriate for, and accessible to that population. For example, a project area with an organization for African American gay, bisexual, lesbian, and transgender individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts. An **unmet** need is a requirement for HIV prevention and or care services within a specific target population that is not being addressed through existing HIV prevention services and activities—either because no services are available or because available services are either inappropriate for, or inaccessible to, the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited English proficiency.

Minority AIDS Initiative (MAI). A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV/AIDS within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Morbidity. The presence of illness in the population.

Mortality. The total number of persons who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole.

MSM/IDU. Men who report both sexual contact with other men and injection drug use as risk factors for HIV infection.

N

National HIV/AIDS Strategy (NHAS). A comprehensive plan focused on: reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV related health disparities.

Navigation services. A process of service delivery to help a person obtain timely, essential and appropriate HIV-related medical and social services to optimize his or her health and prevent HIV transmission and acquisition. Navigation includes linking persons to health care systems, assisting with health insurance and transportation, identifying and reducing barriers to care and tailoring health education to the client to influence his or her health-related attitudes and behaviors.

Needs assessment. A process of collecting information about the needs of PLWHA (both those receiving care and those not in care), identifying current resources (Ryan White HIV/AIDS Program and other) available to meet those needs, and determining what gaps in care exist.

No identified risk (NIR). Cases in which epidemiologic follow-up has been conducted, sources of data have been reviewed—which may include an interview with the patient or provider—and no mode of exposure has been identified. Any case that continues to have no reported risk 12 or more months after the report date is considered NIR.

O

Office of Management and Budget (OMB). The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Opportunistic Infection (OI) or Opportunistic Condition. An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Examples include Kaposi's Sarcoma (KS); Pneumocystis jiroveci pneumonia (PCP); cryptosporidiosis; histoplasmosis; toxoplasmosis; other parasitic, viral, and fungal infections; and some types of cancers.

Outcome evaluation. Collection of data about outcomes before and after the intervention for clients as well as a similar group that did not participate in the intervention being evaluated (i.e., control group); determines if the intervention resulted in the expected outcomes.

Outcome monitoring. Involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes and behaviors or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.

Outreach. A process of engaging face-to-face with high-risk individuals in their own neighborhoods or venues where they typically congregate to provide HIV testing or referrals for testing. Outreach is often conducted by per or paraprofessional educators.

P

Parity. The ability of HIV planning group members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills-building to participate in the planning process and have an equal voice in voting and other decision-making activities.

Partner Services (PS). A systematic approach to notifying sex and needle-sharing partners of HIV-positive persons of their possible exposure to HIV so they can be offered HIV testing and learn their status, or, if already infected, prevent transmission to others. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Part A. The part of the Ryan White HIV/AIDS Program (formerly, Title I) that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic.

Part B. The part of the Ryan White HIV/AIDS Program (formerly, Title II) that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWHA and their families.

Part C. The part of the Ryan White HIV/AIDS Program (formerly, Title III) that supports outpatient primary medical care and early intervention services to PLWHA through grants to public and private non-profit organizations. Part C also funds capacity development and planning grants to prepare programs to provide EIS services.

Part D. The part of the Ryan White HIV/AIDS Program (formerly, Title IV) that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Part F (AETC) (AIDS Education and Training Center). Regional centers providing education and training for primary care professionals and other AIDS-related personnel. Part F (AETC)s are authorized under Part F of the Ryan White HIV/AIDS Program and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

Part F (Community Based Dental Partnership Program). The program within the HRSA HIV/AIDS Bureau's Division of Community Based Programs that delivers HIV/AIDS dental care while simultaneously training dental professionals in these areas in order to expand community capacity to deliver HIV oral health care.

Part F (HIV/AIDS Dental Reimbursement Program). The program within the HRSA HIV/AIDS Bureau's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWHA.

Part F (SPNS) (Special Projects of National Significance). A health services demonstration, research, and evaluation program funded under Part F of the Ryan White HIV/AIDS Program to identify innovative models of HIV care. Part F (SPNS) projects are awarded competitively.

Performance indicator. A program performance indicator (or measure) is a piece of information, fact, or statistic that provides insight into the performance of a program. It helps us understand progress toward specified outcomes, a jurisdiction's capacity to carry out its work, the activities it performs in carrying out its work, and the HIV prevention outcomes it is trying to achieve.

Planning Council (PC). A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Ryan White HIV/AIDS Program Part A funds.

Planning group. Refers to CDC- and HRSA-sponsored groups, such as HIV prevention planning groups (HPGs) and Ryan White HIV/AIDS planning councils and consortia.

Planning process. Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PLWHA. A person or persons living with HIV or AIDS.

Prevalence. The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

Prevalence rate. The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Prevention activity. Activity that focuses on behavioral interventions, structural interventions, capacity building, or information gathering.

Prevention program. An organized effort to design and implement one or more interventions to achieve a set of predetermined goals, for example, to increase condom use with non-steady partners.

Prevention services. Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other diseases. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Priority population. A population identified through the epidemiologic profile and community services assessment that requires prevention efforts due to high rates of HIV infection and the presence of risky behavior.

Priority setting. The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Probability sampling. A sampling technique that relies upon random selection to select persons from a defined population; all persons have a known chance of selection. Types of probability samples include simple random sample, systematic random sample, and stratified sample.

Process monitoring. The routine documentation and review of program activities, populations served, and resources used in order to improve the program.

Process objectives. Key program activities or tasks required to achieving outcome(s), or the steps initiated or required to realize a desired result.

Prophylaxis. Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has previously been brought under control (secondary prophylaxis).

Proportion. A portion of a population or a data set, usually expressed as a fraction or a percentage of the population or the data set.

PWID. Person (or people) who inject(s) drugs.

Q

Qualitative data. Non-numeric data, including information from sources such as narrative behavior studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of underlying meanings, common themes, and patterns of relationships rather than numeric or statistical analysis. Qualitative data often complement and help explain quantitative data.

Quality. The degree to which a health or social service meets or exceeds established professional standards and user expectations.

Quality of life. A subjective measure of the degree to which persons affected by a specific disease, injury, or form of treatment perceive themselves to be able to function physically, emotionally, and socially. Quality of life is useful for the planning of health services.

Quality Assurance (QA). The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Quality Improvement (QI). Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

Quantitative data. Numeric information -- such as numbers, rates, and percentages -- representing counts or measurements suitable for statistical analysis.

R

Race. A client's self-reported classification of the biological heritage with which they most closely identify. Standard OMB race codes are applied.

Rate. A measure of the frequency of an event compared with the number of persons at risk for the event. When rates are being calculated, it is usual for the denominator to be the general population rather than the population potentially exposed to HIV infection by various high-risk behaviors. The size of the general population is known from data from the U.S Census Bureau, whereas the size of a population at high risk is usually not known. For ease of comparison, the multiplier (100,000) is used to convert the resulting fraction to number of cases per 100,000 population. Although arbitrary, the choice of 100,000 is standard practice.

Raw data. Data that are in their original form (i.e., not coded or analyzed).

Recruitment. The process by which individuals are identified and invited to become participants in an intervention or other HIV prevention service, such as counseling, testing, and referral.

Referral. Directing clients to a service in-person or through telephone, written or other form of communication, and is generally a one-time event. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff, or as part of an outreach services program.

Referral follow-up. The method that will be used to verify that the client accessed the services to which he or she was referred. Referral Outcome: The current status of the referral based on activities to verify that the service was accessed.

Reflectiveness. The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Reliability. The consistency of a measure or question in obtaining very similar or identical results when used repeatedly; for example, if you repeated a blood test three times on the same blood sample, it would be reliable if it generated the same results each time.

Reporting delay. Reporting delays (time between diagnosis or death and the reporting of diagnosis or death to state/local surveillance program) may differ among demographic and geographic categories; for some, delays in reporting have been as long as several years. representative. A sample that is similar to the population from which it is drawn and thus can be used to draw conclusions about the population.

Representative. Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Request for Proposals (RFP). An open and competitive process for selecting providers of services (sometimes called RFA or Request for Application).

Resource allocation. The Part A planning council responsibility to assign Ryan White HIV/AIDS Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Results-oriented. Developing strategies/activities that will move the group towards accomplishing the objectives set forth in guidance or FOA. A feedback loop or a review process of the strategies/activities should be completed to ensure the desired results were accomplished.

Risk behaviors. Behaviors that can directly expose individuals to HIV or transmit HIV, if virus is present (e.g., unprotected sex, sharing unclean needles). Risk behaviors are actual behaviors in which HIV can be transmitted. Risk behaviors are behaviors in which a single instance of the behavior can result in a transmission.

Risk factors. Factors based on observations of behaviors and contexts in which HIV is likely to be transmitted (e.g., lifetime number of sex partners, crack use, environmental factors like membership in a demographic group highly impacted by HIV, using old expired-date condoms, internet use, etc.). Influencing factors of behavioral risk refers to associations with risk or risk correlates and risk contexts, not behavioral determinants.

Ryan White HIV/AIDS Program. The primary federal legislation created to address the needs for health and support services among persons living with HIV and their families in the United States; enacted in 1990 and reauthorized in 1996, 2000, 2006, and 2009.

Ryan White HIV/AIDS Program Services Report (RSR). Data collection and reporting system for reporting information on programs and clients served (Client Level Data).

Ryan White HIV/AIDS Act of 2009 (Ryan White HIV/AIDS Program). Enacted in 2009, this legislation reauthorized the Ryan White Program, formerly called the Ryan White CARE Act and the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

S

Sample. A group of people selected from a total population with the expectation that studying this group will provide important information about the total population.

Scalable. Interventions or combinations of interventions that can reach a significant portion of those in need, in a cost-efficient manner, and demonstrate population-level impact.

Statewide Coordinated Statement of Need (SCSN). A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize Ryan White HIV/AIDS Program coordination. The SCSN process is convened by the Part B grantee, with equal responsibility and input by all programs.

Science-based. See “Evidence-based.”

Section 340B Drug Discount Program. A program administered by the HRSA's Bureau of Primary Care, Office of Pharmacy Affairs established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain grantees of Federal agencies.

Seroconversion. The development of detectable antibodies to HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies to HIV appear in the blood, a person will test positive in the standard ELISA test for HIV.

Service gaps. All the service needs of all PLWH except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care ("in care").

Sexually Transmitted Disease (STD). Social determinants: are the economic and social conditions that influence the health of individuals, communities and jurisdictions and include conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and social exclusion.

Social network. A social network is a map of the relationships between individuals, indicating the ways in which they are connected through various social familiarities ranging from casual acquaintance to close familial bonds.

Social networking. A recruitment strategy in which a chain of referrals is based on high risk individuals using their personal influence to enlist their peers they believe to be high risk.

Sociodemographic factors. Background information about the population of interest (e.g., age, sex, race, educational status, income, geographic location). These factors are often thought of as explanatory because they help us to make sense of the results of our analyses.

Socioeconomic status (SES). A description of a person's societal status using factors or measurements such as income levels, relationship to the national poverty line, educational achievement, neighborhood of residence, or home ownership.

Special Projects of National Significance (SPNS). See "Part F".

Stakeholder. A person or representative who has personal or professional experience, skills, resources, or expertise in HIV.

Substance Abuse and Mental Health Services Administration (SAMHSA). Federal agency within HHS that administers programs in substance abuse and mental health.

Substance abuse services. Services for the treatment and prevention of drug or alcohol use.

Support services. Grantee expenditures are limited to core medical services, support services, and administrative expenses. See Core Services and Support Services, which are also listed in the Ryan White legislation as follows: Part A (2604(c), Part B (2612(b), and Part C (2651(c).cases).

Surveillance. An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., Centers for Disease Control and Prevention surveillance system for AIDS cases).

Syndemics. Two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population (e.g. STD, viral hepatitis, and substance use). Related concepts include linked 59 epidemics, interacting epidemics, connected epidemics, co-occurring epidemics, comorbidities, and clusters of health-related crises.

T

Target population. A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

Technical Assistance (TA). The delivery of practical program and technical support. TA is to assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating service delivery systems.

Transgender - Female to Male (FTM). An individual whose physical or birth sex is female but whose gender expression and/or gender identity is male.

Transgender - Male to Female (MTF). An individual whose physical or birth sex is male but whose gender expression and/or gender identity is female.

Transmission category. A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.

Trauma. An emotional response to a terrible event like an accident, assault or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions may include emotional, psychological and physical symptoms.

Trauma-informed. A program, organization, or system that is trauma-informed:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist *re-traumatization*.

Trend. A long-term movement or change in frequency, usually upward or downward; may be presented as a line graph.

U

Unmet need. The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.

V

Viral load. In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

Viral suppression. When antiretroviral therapy (ART) reduces a person's viral load (HIV RNA) to an undetectable level. Viral suppression does not mean a person is cured; HIV still remains in the body. An undetectable viral load means that there is only a very small chance of transmission to drug using or sexual partners.

Y

Year of diagnosis. The year in which a diagnosis of HIV infection was made.