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 HIV Integrated Planning Council, the Philadelphia Department of Public Health, AIDS Activities Coordinating Office and the Office of HIV Planning to engage service delivery providers, people living with HIV, persons at higher risk for HIV acquisition, and other community stakeholders. The EMA demonstrates a sustained commitment to HIV service system integration, funding coordination, quality management, and planning.

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 testing and prevention and care services that mitigate social, structural, economic, and personal barriers. The following objectives and strategies were developed in keeping with the NHAS goals and objectives, and with the understanding of the local epidemic and currently available resources.

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

For this update, some of the strategies, activities, data indicators were changed in order to best reflect current data collection, programs, and resources available. These changes are minimal and necessary. All subsequent updates will reflect these changes. If you require additional information, contact the Office of HIV Planning.

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

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
PDPH and partners	Provide training on third-party billing and integrating routine HIV screening into patient flow	Clinical providers Health care facilities	**# of trainings delivered**	**3 trainings by Mid-Atlantic AETC**	Mid-Atlantic AETC
Clinical providers Health care facilities	Implement site appropriate routine HIV screening policies[1]	People aged 13 to 65	**# of HIV tests in healthcare settings** **# of new HIV diagnoses in healthcare settings**	**98,676 tests in clinical settings[2] in Philadelphia** **152 new diagnoses in Philadelphia**	PDPH EvaluationWeb

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

[2] For healthcare settings only, client-level tests plus aggregate testing reports from 5 hospitals (aggregate: 21,183 negative and 10 positive)

Strategy 1.1.2: Offer targeted HIV screening and linkage to HIV medical care or PrEP for individuals who test negative, 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)

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
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**	**23,050 community-based tests** **1.16% Positivity rate** **118 new diagnoses**	PDPH EvaluationWeb
PDPH Community-based providers	HIV testing of priority populations	NHAS populations EIIHA populations People who are experiencing homelessness	**HIV positivity rate in Philadelphia for PDPH funded testing** **# of HIV tests by PDPH funded non-healthcare providers in offering focused testing to priority populations**	**1.16% positivity rate** **18,036 tests**	PDPH EvaluationWeb
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 in jails**	**23,590 tests in Philadelphia jails** **117 positive tests in Philadelphia jails**	PDPH EvaluationWeb

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

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
HIV clinical providers HIV testing providers Health care facilities	Refer all diagnosed PLWH to partner services	Diagnosed PLWH	**# of index patients reported to Partner Services** **# of index patients eligible for Partner Services**	**1,191 index patients reported to Partner Services** **1,183 index patients eligible for Partner Services**	PDPH EvaluationWeb
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 (index patient) named and initiated for Partner Services** **# notifiable names partners, not known to be previously diagnosed HIV positive** **# of partners of PLWH tested** **# of partners who were newly diagnosed HIV positive**	**745 partners initiated for Partner Services** **274 partners notifiable** **215 partners tested who were not previously identified as HIV positive** **12 newly-diagnosed partners**	PDPH EvaluationWeb

Objective 1.2: Reduce the number of new HIV infections

Strategy 1.2.1: Ensure condom access and promote condom use

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
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**	**1,633,012 condoms distributed through Philadelphia STD control** **242 distribution sites in Philadelphia**	PDPH STD Control
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 for Do You Philly and Take Control Philly** **# of condoms distributed through mail order requests**	**9,636 views at Do You Philly website** **103,353 social media views for Take Control Philly** **2,500 condoms distributed through mail order requests**	PDPH STD Control
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**	**79.1% RW Ambulatory Outpatient Care clients reported condom use at last encounter**	CAREWare

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH PDPH-funded providers NJDPH PADOH	Coordinate provision of PrEP and nPEP	Hight risk HIV-individuals PWID Trans women Black women Latinas MSM of color Youth 13-24	**NHBS survey data** **# of PrEP providers on PDPH PrEP provider list** **# of people accessing PrEP and nPEP at the publicly funded Philadelphia City Health Centers**	**MSM (2017) 35% had discussed PrEP with dr and 26.5% had taken PrEP, HET (2016) <1% had discussed PrEP with dr and <1% had taken PrEP** **PWID (2015) 4% had discussed PrEP with dr and <1% had taken PrEP Data to be reported as of 2017** **Data to be reported as of 2017**	National HIV Behavioral Surveillance - CDC PDPH Prep Provider list Phila. Ambulatory Health Services
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**	**MSM (2017) 73.5% had heard about PrEP, HET (2016) 4.5% had heard about PrEP, PWID (2015) 12% had heard about PrEP**	National HIV Behavioral Surveillance - CDC

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

Responsible Parties	Activities	Target Population	Data Indicators	2016 Baseline	Source
HIPC PDPH Substance use service providers	Expand syringe access services throughout the EMA	PWID PLWH with opioid dependency	**# of syringe access sites** **# of syringes exchanged**	**7 sites - 6 in Philadelphia and 1 in Camden** **2.4 million syringes exchanged in Philadelphia**	OHP Prevention Point Philadelphia
HIPC PDPH Substance use service providers	Expand access to medication-assisted treatment for opioid dependency throughout the EMA	PWID PLWH with opioid dependency	**# of persons receiving MAT at RW medical providers offering MAT**	**Data to be reported as of 2018**	RW Medical Providers
HIPC PDPH Substance use service providers	Expand access to and capacity of substance use treatment throughout the EMA	PWID PLWH with opioid dependency	**% of new patients with a diagnosis of HIV who were screened for substance use (alcohol and drug usage)** **# of RW SA units provided**	**92.5% of new RW patients** **10,210 outpatient units (15 min units)**	CAREWare

Strategy 1.2.4: Reduce the amount of HIV virus within communities

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH PADOH NJDPH HIPC Medical case management providers	Ensure equitable access to ARVs	PLWH	**# of ADAP clients** **Percentage of diagnosed PLWH on ARVs**	**3,903 SPBP clients in 5 PA counties, 577 ADDP clients in NJ counties** **59.29% of diagnosed PLWH on ARVs in 5 PA counties**	Special Pharmaceutical Benefits Program (PA) AIDS Drugs Distribution Program (NJ)
PDPH PADOH NJDPH HIPC Clinical providers	Support treatment adherence activities	PLWH	**% of eligible medical case management clients who were assessed and counseled for adherence two or more times at least three months apart**	**89.5% of eligible MCM clients**	CAREWare

Strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
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**	**16 cases reviewed** **4 recommendations implemented in 2016. Much more ongoing.**	Fetal Infant Mortality Review Community Action Team Report
Clinical providers PDPH	Promote perinatal medical case management program	HIV+ pregnant women HIV+ women who want to become pregnant	**# of perinatal case management clients**	**196 perinatal case management clients**	Client Services Unit

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
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**	**32 acute infections identified in Philadelphia**	PDPH HIV Surveillance Unit
Clinical providers PDPH 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**	**Linked in 14 days: 75%, Linked in 30 days: 85%**	PDPH HIV Surveillance Unit

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
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	**% of secondary schools teaching HIV prevention** **% of secondary schools teaching human sexuality**	**89.8% of NJ schools** **84.9% of PA schools** **92.3% of NJ schools** **82.1% of PA schools**	School Health Education Profiles – CDC (2016)[3]
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**	**2,500 condoms distributed through Do You Philly and Take Control Philly** **9,636 views at Do You Philly website, 103,353 social media views for Take Control Philly**	PDPH STD Control
PDPH Philadelphia high schools	Continue condom distribution program and Take Control Philly campaign	Youth aged 13-24	**# of condoms distributed** **# of condom requests**	**1,633,012 condoms distributed through Philadelphia STD control** **2500 condoms distributed through Do You Philly and Take Control Philly**	PDPH STD Control

[3] NJ mandates sexual health education and HIV prevention in secondary schools - abstinence should be stressed and information on condoms is presented. PA does not mandate sexual health education for secondary schools, but does mandate HIV prevention information. Abstinence must be stressed.

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
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**	**ARTAS clients: 438 (Philadelphia only)** **302 ARTAS clients linked**	PDPH AACO
PDPH PADOH NJDPH HIPC	Expand access to supportive services that enable timely linkage to care, including transportation and psycho-social support	PLWH	**HAB RW Gap in Medical Care measure** **% of RW Part A funding allocated to Supportive Services**	**14.5% RW Clients** **17.56% of FY2016 RW Part A allocations** **19.0% of FY2016 RW Part A spending**	CAREWare OHP/AACO Fiscal

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
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**	**65 clinical sites also offer HIV testing**	PDPH EvaluationWeb

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH HIPC	Continue provision of centralized medical case management intake and Health Information Line	PLWH	**# clients linked to medical case management**	**1,887 linked to MCM via Central Intake**	PDPH Client Services Unit

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH NJDPH PADOH HIPC RW providers	Continue co-located clinical and supportive services, including mental health, substance use treatment, and medical case management	PLWH	**# of RW clinical provider sites with co-located supportive services**	**16 clinical sites that also have supportive services**	RW clinical providers
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 – 16 and 17**	**92.8%- RW clients with Mental Health screening (HAB16)** **92.5% RW clients with Substance Use screening (HAB17)**	CAREWare
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**	**302 ARTAS clients linked** **84.1% RW clients**	PDPH CAREWare

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH RW providers HIPC Mid-Atlantic AETC NJ AETC	Ensure all RW services are linguistically and culturally competent and LGBTQ affirming	RW clients	**# of trainings for RW providers on cultural competency and related topics**	**14 trainings by AETC**	Mid-Atlantic AETC
PDPH HIPC Mid-Atlantic AETC NJ AETC	Promote adoption of trauma-informed approaches	RW providers	**# of trainings for RW providers about trauma-informed practices**	**1 trauma training by AETC**	Mid-Atlantic AETC
PDPH Mid-Atlantic AETC NJ AETC	Support vigorous pursuit of health insurance enrollment of all eligible RW clients	RW providers	**# of trainings about health insurance eligibility and enrollment** **# of enrolled RW eligible clients**	**1 health insurance enrollment training by the Mid-Atlantic AETC** **12,710 RW clients (90.6%)**	Mid-Atlantic AETC CAREWare

Strategy 2.2.3: Reduce systemic barriers to retention in HIV care

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
HIPC PDPH	Develop a plan to address documented barriers to retention in care, including transportation	PLWH	**Plan completed**	**Comprehensive Planning Committee of HIPC developed recommendations and directives for the recipient in June 2018**	HIPC meeting minutes
PDPH HIPC PADOH	Determine the most efficient, cost-effective, and feasible mechanism to provide health insurance cost-sharing assistance	RW clients	**Assessment completed**	**HIPC and PDPH are in communication with PADOH about the implementation of a PA-wide program**	HIPC and PA HPG minutes and correspondence

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

Responsible parties	Activity	Target Populations	Data Indicators	2016 Baseline	Source
PDPH PADOH NJDPH HIPC	Ensure access to food banks and other food services.	PLWH NHAS populations	**# of RW food bank units** **CSU MCM centralized intake data about food needs**	**80,481 units** **2.2% intake clients reported need for home delivered meals** **26.8% intake clients reported need for food** **22.9% intake clients reported need of food vouchers**	CAREWare PDPH Client Services Unit data
PDPH	Provide high quality medical case management which develops and individualized plan to address adherence with clients	PLWH	**HAB18 measure of service care plan**	**65.1% of RW MCM clients have service care plan**	CAREWare

Strategy 2.3.2: Reduce individual barriers to ART

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH RW providers PADOH NJDPH	Vigorously pursue health insurance and ADAP enrollment for eligible clients	PLWH	**# of insured RW clients** **# of SPBP/ADAP clients**	**12,710 (90.6%) insured RW clients** **3,900 in PA 5 counties** **577 ADDP clients in NJ counties**	CAREWare PA Special Pharmaceutical Benefits Program NJ AIDS Drug Distribution Program
PDPH HIPC	Minimize interruptions to ART adherence through provision of emergency pharmaceutical assistance	PLWH	**# of Rx units dispensed** **# of emergency pharmaceutical assistance clients**	**2111 units of local pharmaceutical assistance** **741 units in EFA medications** **319 local pharm assistance clients,** **423 clients in EFA medications**	CAREWare

Strategy 2.3.3: Reduce systemic barriers to ART

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH PADOH NJDPH	Support comprehensive ADAP formulary, including access to Hepatitis C treatment	PLWH	**% of FDA approved treatment regimens on the formulary**	**91% of FDA approved treatment regimens on SPBP formulary. NJ ADDP formulary is open - all FDA approved treatment covered. PDPH has a grant to cure HCV in all co-infected PLWH.**	PA Special Pharmaceutical Benefits Program NJ AIDS Drug Distribution Program PDPH

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH HIPC	Provide direct emergency financial assistance for rent and utilities	RW clients	**# of DEFA units** **# of DEFA- Housing Assistance clients**	**Housing assistance units: 27,060** **DEFA units: 120** **120 DEFA clients**	CAREWare

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH HIPC 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 clients**	**655 tenant based rental assistance for Philadelphia, 91 tenant based rental assistance in Camden** **72 clients**	HUD report
PDPH HIPC	Investigate feasibility of RW funded Housing First project	PLWH experiencing homelessness	**Completion of feasibility report**	**To be discussed in 2019**	

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH MCM providers	Ensure medical case managers assess and address housing instability when developing and reviewing care plan	RW client	**% of RW MCM clients with current housing status collected by MCM**	78.4%	CareWare

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 for MSM of Color that address social determinants of HIV risk

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH Navigation services provider	Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support	HIV-negative MSM of color	**# of navigation clients** **# of linkages to behavioral health and social services** **# of linkages to PrEP in PDPH-funded programs**	**83 Club 1509 clients** **34 linkages to supportive services** **10 linkages (October 1-December 31, 2016)**	Club 1509 Provider Data Exports - CAREWare
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**	**26 MOUs and collaborative projects**	Club 1509 Provider Data Exports - CAREWare

Strategy 3.1.2: Increase access to biomedical prevention interventions

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH PADOH NJDPH	Ensure the provision of PrEP and nPEP to at risk populations	NHAS populations	**# of providers prescribing PrEP** **NHBS data on PrEP use**	**Data to be reported as of 2017** **MSM (2017) 35% had discussed PrEP with dr and 26.5% had taken PrEP, HET (2016) <1% had discussed PrEP with dr and <1% had taken PrEP,** **PWID (2015) 4% had discussed PrEP with dr and <1% had taken PrEP**	PDPH PrEP Provider List National HIV Behavior Surveillance - CDC
PDPH	Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support	MSM of color	**# linkages to PrEP**	**10 linkages to PrEP in Club 1509**	Provider Data Export - CAREWare
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 technical assistance (TA) sessions provided by PDPH Clinical Advisor** **# of persons reached during TA sessions**	**30 TA sessions** **670 persons reached**	PDPH PrEP Clinical Coordination Program
PDPH Mid-Atlantic AETC NJ AETC	Continue and expand clinical education about PrEP	Primary care providers	**# of TA units**	**22 trainings about PrEP by AETC**	Mid-Atlantic AETC
PDPH HIPC	Monitor population level PrEP uptake in key populations in Philadelphia	High risk HIV-individuals Trans women MSM of color Youths aged 13-24	**# of HIV negative Philadelphians on PrEP** **# of HIV negative MSM on PrEP**	**Data to be reported as of 2019**	PDPH Monitoring and Evaluation Plan

Strategy 3.1.3: Provide services that address social and behavioral health needs of people living with HIV that promote treatment adherence and HIV prevention

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH RW MCM providers HIPC 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**	**5,999 clients** **30 Part A MCM providers**	CAREWare
HIPC PDPH	Monitor access to and availability of substance use treatment and mental health treatment	PLWH	**CSU intake data** **# RW Mental Health clients** **# RW Substance Abuse Treatment clients**	**6% reported need for Substance Abuse Treatment services at intake** **2,137 RW Mental Health clients** **223 RW Substance Abuse Treatment Outpatient clients**	CAREWare

Objective 3.2: Reduce disparities in viral suppression

Strategy 3.2.1: Continue RW-funded activities to retain in medical care and achieve viral load suppression for priority populations

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH RW clinical providers RW MCM providers HIPC	Ensure quality improvement efforts to address disparities along the care continuum in the RW clinical and MCM services	MSM of color Youth aged 13 to 24 Trans women NHAS populations	**# of Quality Improvement Plans or other activities to reduce disparities at RW-funded medical and MCM provider sites**	**Data to be reported as of 2018**	PDPH/AACO Information Services Unit
PDPH RW clinical providers RW MCM providers HIPC	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	**# of Quality Improvement Plans of other activities to reduce disparities at RW-funded Medical and MCM provider sites**	**Data to be reported as of 2018**	PDPH/AACO Information Services Unit
PDPH HIPC 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**	**84.1% of RW outpatient Ambulatory Care clients were virally suppressed**	CAREWare

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH RW clinical providers RW MCM providers HIPC	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	**# of medical case managers who attend trauma-informed care and/or cultural competency training in a measurement year through the Case Management Coordination Project**	**Data to be reported as of 2017**	Case Management Coordination Project
PDPH Mid-Atlantic AETC	Support training and technical assistance on trauma-informed care	Clinical providers MCM providers	**# of technical assistance sessions on trauma-informed care**	**1 training on trauma informed care to providers by AETC**	Mid-Atlantic AETC

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
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**	**27 SPBP clients that receive HCV treatment (PA5) 1 ADDP client received Hep C treatment (NJ)** **NJ and PA Medicaid cover HCV treatment for eligible beneficiaries**	SPBP ADDP
PDPH RW clinical providers	Increase STI screening at RW funded sites	Sexually-active RW clients	**RW Ambulatory Outpatient Medical Care HAB and local measures**	**80.7% RW clients screened for Chlamydia** **79.9% RW clients screened for syphilis** **83.7% RW clients screened for Hep B** **88.1% RW MSM clients screened for syphilis** **54.1% RW MSM clients screened for gonorrhea**	CAREWare

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

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

Strategy 4.1.1: Continue coordination of resources

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
PDPH	Continue centralized grant administration of RW Parts, CDC, and other local funds for HIV prevention and care services in the EMA.	NA	**NA**	**NA**	NA

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
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	**# of trainings**	**22 trainings about PrEP, 3 trainings about third-party billing, and one training on trauma for clinical providers by the AETC.**	Mid-Atlantic AETC

[4] 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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
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**	**Launched December 2017 at hivphilly.org**	OHP
OHP	Develop and disseminate materials that are accessible, usable, and audience-centered using both traditional and digital methods to support informed community planning	HIPC Federal partners Local stakeholders PADOH NJDPH County health departments PLWH RW providers HIV prevention providers	**NA**	**NA**	OHP
OHP PDPH PADOH NJDPH	Improve efforts to provide HPG and HIPC with timely, accurate, and accessible data to inform decision-making	HIPC stakeholders	**Planning body survey results**	**Data to be collected in 2019**	OHP

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

Strategy 4.2.1: Foster relationships between health departments within the EMA

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
OHP	Hold a meeting of integrated planning partners to further collaboration, communication, and coordination	PDPH NJDPH PADOH HIPC co-chairs NJ HPG co-chairs PA HPG co-chairs	**# of meetings** **# of attendees**	**To be scheduled**	

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
OHP PDPH	Continue participation in relevant regional meetings and events	NA	**NA**	**Ongoing participation as required/feasible**	
OHP PDPH HIPC	Explore opportunities for further integration of the HIPC and Philadelphia HPG	NA	**NA**	**The Ryan White Planning Council and the Philadelphia Prevention Planning Group integrated in April 2017**	HIPC meeting minutes

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

Responsible parties	Activity	Target Populations	Data Indicators	Baseline 2016	Source
OHP HIPC PDPH	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** **% HIPC membership who are unaligned PLWH**	**Average of 25 PLWH at each monthly meeting** **51% of membership as of July 2016**	Meeting minutes Membership data
OHP PDPH HIPC	Develop, implement and disseminate results of needs assessment activities as necessary and required	HIPC PLWH Federal partners County health departments Local stakeholders	**NA**	**NA**	OHP
OHP PDPH HIPC	Engage stakeholders and community members by using traditional and digital methods, including but not limited to language interpretation and translation	Local stakeholders PLWH HIPC	**NA**	**NA**	NA

B: Collaborations, Partnerships and Stakeholder Involvement

a. Stakeholder Contributions

In April 2017, the Philadelphia EMA Ryan White Planning Council and the Philadelphia HIV Planning Group integrated and became the Philadelphia HIV Integrated Planning Council (HIPC). The new planning body has a membership that meets the requirements of both planning councils and HPGs and has strong community and PLWH participation. The integrated body's Comprehensive Planning Committee and Prevention Committee have worked closely with the Office of HIV Planning and PDPH on the monitoring and evaluation of this plan, as well as in the development of this update.

The Philadelphia HIV Integrated Planning Council (HIPC) members are consumers and providers of HIV services, including many PLWH. The members of the planning council reflect the community that they serve to ensure that the decisions made by HIPC are in the best interest of individuals receiving HIV prevention and care services. The planning activities 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 HIPC 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, the Prevention Committee, and the Positive Committee (membership consists of PLWH and those who receive HIV prevention services in the EMA).

In fall of 2017, the PrEP workgroup formed under the Prevention Committee, to get stakeholder feedback and guidance on PrEP implementation. The workgroup reports to the Prevention Committee and HIPC and is jointly convened by PDPH and the HIPC. The majority of the work group membership are providers and prescribers of PrEP within Philadelphia. A few workgroup members have since become members of the HIPC and there are several HIPC members who attend PrEP workgroup meetings.

The Office of HIV Planning (OHP) provides the administrative and technical support for the HIPC. OHP responsibilities include: assessing community needs through a variety of methods, including qualitative and quantitative research activities; conducting community outreach and educational activities; writing the integrated plan and the EMA's integrated epidemiological profile; 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 HIPC. The OHP maintains an active presence at community meetings and events 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, 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. 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 HIPC, as well as continue to find ways for these stakeholders to provide valuable input into service planning and delivery.

c. Letter of Concurrence

See attachment for Letters of Concurrence to the goals and objectives of this plan in the appendix.

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 HIPC and its committees and workgroups 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 phone lines.

b. PLWH and community participation in plan development

Approximately half of the members of HIPC are PLWH. PLWH members and non-members of HIPC participate in the decision-making processes and regularly attend HIPC meetings. The Positive Committee has supported the engaged and informed participation of PLWH in all community planning activities for two decades. The committee meets monthly to discuss 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 HIPC. The Positive Committee meetings regularly have attendance between 25-35 people. About half of the regular attendees of the Positive Committee are also HIPC members, this number changes over time. Positive Committee members were an integral part of the integrated plan development and have

contributed meaningfully to all steps along the integrated planning process from needs assessment to development and monitoring of strategies and activities.

c. Methods for community engagement

The HIPC, PDPH and OHP work together to design mechanisms to collect community and consumer needs and challenges. These mechanisms include regular monthly meetings of the HIPC 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 HIPC, 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. PLWH and those at risk for HIV participated in those focus groups and consumer survey, 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 and providers to address their individual and community-level barriers to health information and needed services. During the FY2019 allocations process, several issues were raised about service access and OHP, HIPC, and PDPH worked together to assess the services gaps and barriers and to develop plans to ease access to needed services like food vouchers and medical transportation.