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

## 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*

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| Responsible Parties | Activities | Target Population | Data Indicators | 2016Baseline | 2019 | 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** | 7 Trainings | **Mid-Atlantic AETC** |
| Clinical providersHealth care facilities | Implement site appropriate routine HIV screening policies[1](#_bookmark0) | People aged 13 to 65 | **# of HIV tests in healthcare settings****# of new HIV diagnoses in healthcare settings** | **98,676 tests in healthcare settings**[**2**](#_bookmark1) **in Philadelphia****152 new diagnoses in Philadelphia** | **36,895 tests in healthcare settings in Philadelphia****99 new diagnoses in Philadelphia at healthcare settings** | **PDPH Evaluation Web** |

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)*

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| Responsible Parties | Activities | Target Population | Data Indicators | 2016Baseline | 2019 | Source |
| Community- based providersPDPH-funded providersCDC-funded providers | Community outreach and provision of the best testing technology for the site, including 4th generation testing where feasible | NHASpopulationsEIIHApopulationsPeople 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** | **19,088 community-based tests****1.04% positive rate****52 new diagnoses** | **PDPH Evaluation Web** |
| PDPHCommunity- based providers | HIV testing of priority populations | NHASpopulations EIIHApopulations People who are experiencing homelessness | **HIV positivity rate in Philadelphia for PDPH funded testing****# of HIV tests by PDPH funded non- healthcare providers offering focused testing to priority populations** | **1.16%****positivity rate** **18,036 tests** | **1.04% positivity rate****Positivity rate of NHAS and EIIHA populations:** **Youth (13-24) = 0.6%** **Adult MSM = 3.1%****Trans-WSM= 4.7%** **MSM = 2.3%****Black/Latino = 0.9%****PWID = 2.3%****Trans-W = 5.7%****19,088 community-based tests** | **PDPH Evaluation Web** |
| 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** | 22,255 tests in Philadelphia jails81 positive tests in Philadelphia jails | **PDPH Evaluation Web** |

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

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| **Responsible Parties** | **Activities** | **Target Population** | **Data Indicators** | **2016****Baseline** | **2019** | **Source** |
| HIV clinical providers HIV testing providers Health care facilities | Refer all diagnosed PLWH to partner services | Diagnosed PLWH304  | **# 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** | 483 index partners reported to partner services424 index patients eligible for Partner Services | PDPHEvaluationWeb |
| DIS – PADepartment of Health (PADOH), NJDepartment 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** | 238 partners interviewed by Partner Services304 partners named for whom the information provided by the index patient or otherwise available 64 partners tested21 partners were newly diagnosed with HIV | PDPHEvaluationWeb |

### Objective 1.2: Reduce the number of new HIV infections

*Strategy 1.2.1: Ensure condom access and promote condom use*

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| Responsible Parties | Activities | Target Population | Data Indicators | 2016Baseline | 2019 | Source |
| PDPH PADOH NJDPH | Continue widespread access to condoms through public schools, community- based providers and mail order | MSMHigh risk heterosexuals Youth aged 13-24Trans women | **# of condoms distributed****# of condom distribution sites** | **1,633,012****condoms distributed through Philadelphia STD control****242****distribution sites in Philadelphia** | 612,793 condoms distributed through Philadelphia STD control34 provider distribution sites in Philadelphia | PDPH STDControl |
| 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** | Data not availableData not availableData not available | PDPH STDControl |
| 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** | 2018 - 65.7% RW O/AHS clients reported condom use at last encounter2019 - 58.3% RW O/AHS clients reported condom use at last encounter | CAREWare |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2018/19 | Source |
| PDPHPDPH-funded providersNJDPH PADOH | Coordinate provision of PrEP and nPEP | Hight risk HIV- individuals PWIDTrans women Black women LatinasMSM 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** | **MSM (2017)****35% had discussed PrEP with dr and 26.5% had taken PrEP,**  HET (2019) 1.6% had discussed PrEP with doctor, 0% had taken PrEP PWID (2018)29.3% had discussed PrEP with doctor 2.8% had taken PrEP 34 Providers throughout Philadelphia734 people accessed PrEP and nPEP at City Health Centers | National HIV Behavioral Surveillance - CDCPDPH Prep Provider listPhila. Ambulatory Health Services |
| PDPH | Develop and implement a plan to inform the public about the availability of PrEP and nPEP | High risk HIV- individuals PWIDTrans women Black women LatinasMSMYouths 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** | MSM (2017)73.5% had heard about PrEPHET (2019) 28.5% had heard about PrEPPWID (2018) 40.7% 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*

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| Responsible Parties | Activities | Target Population | Data Indicators | 2016Baseline | 2019 | Source |
| HIPCPDPHSubstance use service providers | Expand syringe access services throughout the EMA | PWIDPLWH 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** | 8 sites total3.9 million syringes exchanged in Philadelphia | OHPPrevention Point Philadelphia |
| HIPCPDPHSubstance use service providers | Expand access to medication-assisted treatment for opioid dependency throughout the EMA | PWIDPLWH with opioid dependency | **# of persons receiving MAT at RW medical providers offering MAT** | **Data to be reported as of 2018** | 52 PLWH receiving MAT through RW provider | RW Medical Providers |
| HIPCPDPHSubstance use service providers | Expand access to and capacity of substance use treatment throughout the EMA | PWIDPLWH 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)** | 94.1% of new RW patients16,747 outpatient units (15 min) | CAREWare |

*Strategy 1.2.4: Reduce the amount of HIV virus within communities*

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| **Responsible parties** | **Activity** | **Target Populations** | **Data Indicators** | **2016****Baseline** | **2019** | **Source** |
| PDPH PADOH NJDPH HIPCMedical 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** | 8,425 SPBP clients in the 5 PA counties. NJ data not provided.86% of PLWH on ARVs in the 5 PA counties. | Special Pharmaceutical Benefits Program (PA) AIDS Drugs Distribution Program (NJ) |
| PDPH PADOH NJDPH HIPCClinical 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 counseled on adherence** | 65.6% of eligible MCM clients counseled on adherence[[1]](#footnote-1) | CAREWare |

*Strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA*

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| **Responsible parties** | **Activity** | **Target Populations** | **Data Indicators** | **2016 Baseline** | **2019** | **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 womenHIV+ 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.** | 17 cases reviewed8 recommendations. More ongoing. | Fetal Infant Mortality Review Community Action Team Report |
| Clinical providers PDPH | Promote perinatal medical case management program | HIV+ pregnant womenHIV+ 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*

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPHHospitals Health care provider organizations | Promote the implementation of 4th generation HIV testing | NHASpopulations People aged 13 to 65 | **# of acute infections identified** | **32 acute infections identified in Philadelphia** | 58 acute infections identified in Philadelphia (all ages over 13) | PDPH HIVSurveillance Unit |
| Clinical providers PDPHTesting 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%** | Linked in 14 days: 86%Linked in 30 days: 95% | PDPH HIVSurveillance Unit |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PADOH PDPH NJDPHSchool 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** | 86% of NJ and 66.7% of PA schools taught HIV and STD prevention (2018)Data not reported | School Health Education Profiles – CDC (2016)[3](#_bookmark2) |
| 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** | Data not availableData not available | PDPH STDControl |
| PDPHPhiladelphia 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** | 612,793 condoms distributed through Philadelphia STD controlData not available | PDPH STDControl |

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*

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | 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 navigationprograms | Newly- diagnosed PLWHPLWH never linked to care | **# of navigation services clients****# of successfully linked navigation clients** | **ARTAS clients: 438****(Philadelphia only)****302 ARTAS****clients linked** | 158 ARTAS clients (Philadelphia only)[[2]](#footnote-2)107 ARTAS clients successfully linkedD2C (Data to Care):Out of the 335 referred patients:166 were re-linked within 90 days of referral (49.6%)170 were virally suppressed within 1 year of referral (50.7%)134 were virally suppressed prior to referral and remained virally suppressed at 1 year post-referral (40.0%)36 were not virally suppressed prior to referral but became virally suppressed by 1 year post-referral (10.7%) | 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** | 18.3% of RW clients had a gap in medical care16.5% of FY2019 RW Allocations17.26% of FY2019 Part A final spending  | CAREWareOHP/AACOFiscal |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPH NJDPH PADOH | Continue to support a range of co-located HIV testing andclinical services | NHASpopulations | **# of co-located testing and clinical sites** | **65 clinical sites also offer HIV testing** | 24 clinical sites also offer HIV testing (Philadelphia) | PDPHEvaluationWeb |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPH HIPC | Continue provision of centralized medical case management intake and HealthInformation Line | PLWH | **# clients linked to medical case management** | **1,887 linked to MCM via Central Intake** | 1,988 clients 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*

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPH NJDPH PADOH HIPCRW providers | Continue co-located clinical and supportive services, including mental health, substance use treatment, and medical casemanagement | 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)** | 93.8% RW clients with Mental Health screening94.1% RW clients with Substance Use screening | CAREWare |
| PDPH | Provide data-to-care activities including CoRECT and ARTAS to find and reengage clients to care who have been lost tocare. | 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** | 107 ARTAS clients linked[[3]](#footnote-3)87.6% RW clients | PDPHCAREWare |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPHRW providers HIPCMid-Atlantic AETCNJ 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** | 2 trainings by AETC | Mid-Atlantic AETC |
| PDPH HIPCMid-Atlantic AETCNJ AETC | Promote adoption of trauma-informed approaches | RW providers | **# of trainings for RW providers about trauma-informed practices** | **1 trauma training by AETC** | 1 training | Mid-Atlantic AETC |
| PDPHMid-Atlantic AETCNJ 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%)** | 1 training12,778 of 14,504 clients (88.1%) | Mid-Atlantic AETCCAREWare |

*Strategy 2.2.3: Reduce systemic barriers to retention in HIV care*

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016 Baseline | 2019 | 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** | Recommendation to mitigate barriers to retentions from CPC’s plan have been implemented by the Recipient | 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** | No further updates. PA DOH has not yet funded HIPCSA, the only state in the United States not to do so with Part B RW monies  | 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*

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| Responsible parties | Activity | Target Populations | Data Indicators | 2016Baseline | 2019 | Source |
| PDPH PADOH NJDPH HIPC | Ensure access to food banks and other food services. | PLWH NHASpopulations | **# 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** | 78,410 units30.3% intake clients reported a need for food assistance, including home-delivered meals, food banks, and vouchers. | CAREWarePDPH Client Services Unit data |
| PDPH | Provide high quality medical case management which develops and individualized plan to addressadherence with clients | PLWH | **HAB18 measure of service care plan** | **65.1% of RW****MCM clients have service care plan** | 62.1% of RW MCM clients have a service care plan | CAREWare |

*Strategy 2.3.2: Reduce individual barriers to ART*

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPHRW 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** | 88.2% of RW clients had any health insurance[[4]](#footnote-4) | CAREWarePA Special Pharmaceutical Benefits ProgramNJ 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** | 1,828 LPAP units[[5]](#footnote-5)319 EFA medications units267 LPAP clients213 EFA medications clients | CAREWare |

*Strategy 2.3.3: Reduce systemic barriers to ART*

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | 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.** | **NJ ADDP****formulary is open - all FDA approved treatment covered.** | PA Special Pharmaceutical Benefits ProgramNJ 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*

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPH HIPC | Provide direct emergency financial assistance for rent and utilities | RW clients | **# of EFA units****# of EFA- Housing Assistance clients** | **27,060 Housing assistance units****120 EFA units****120 EFA****clients** | 124Housing assistance units (units changed)120 units124 EFA Clients | CAREWare |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPH HIPC DHCD PADOHNJ 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 households served for Philadelphia, 91 tenant based rental assistance in Camden****72 clients** | 582 tenant based rental assistance households served in Philadelphia85 households served in Camden63 clients | HUD report |
| PDPH HIPC | Investigate feasibility of RW fundedHousing First project | PLWHexperiencinghomelessness | **Completion of feasibility report** | **To be discussed in****2019** | Shallow Rent/Homelessness prevention proposal approved and implemented 2020 | HIPC meeting minutes |

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

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPH MCMproviders | Ensure medical case managers assess and address housing instability when developing andreviewing care plan | RW client | **% of RW MCM clients with current housing status collected by MCM** | 78.4% of RW MCM clients | 97.7% of RW MCM clients | 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*

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPHNavigation 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[[6]](#footnote-6)****34 linkages to supportive services****10 linkages****(October 1-****December 31,****2016)** | 1143 navigation clients# of linkages to behavioral and social services:mental health: 73substance abuse: 14 housing: 73employment: 52transportation:151education:27insurance:87640 linkages to PrEP | Club 1509 Provider Data Exports - CAREWare |
| PDPH | Develop and sustain the Philadelphia 1509 Collaborative to implement comprehensive HIV prevention and care services for MSM ofcolor | Collaborative partners | **Number of MOUs and collaborative protocols developed** | **26 MOUs and collaborative projects** | 23 MOUs and collaborative projects | Club 1509 Provider Data Exports - CAREWare |

*Strategy 3.1.2: Increase access to biomedical prevention interventions*

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| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| PDPH PADOH NJDPH | Ensure the provision of PrEP and nPEP to at risk populations | NHASpopulations | **# 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** | 34 providers on the AACO provider list of medical providers that offer and prescribe PrEP across the City**MSM (2017)****35% had discussed PrEP with dr and 26.5% had taken PrEP,**  HET (2019) 1.6% had discussed PrEP with doctor, 0% had taken PrEP PWID (2018)29.3% had discussed PrEP with doctor 2.8% had taken PrEP  | PDPH PrEPProvider ListNational HIV Behavior Surveillance - CDC |
| PDPH | Provide prevention navigation services that link MSM of color to PrEP and provide ongoingadherence support | MSM of color | **# linkages to PrEP** | **10 linkages to PrEP in Club 1509** | 640 linkages to PrEP | Provider Data Export - CAREWare |
| PDPH | Continue and expand community education activities about PrEP | MSM of color Community leadersHigh risk heterosexuals Sexual and drug using partners of PLWHPWIDTrans women | **# of technical assistance (TA) sessions provided by PDPH Clinical Advisor****# of persons reached during TA****sessions** | **30 TA sessions****670 persons reached** | Data not available500+ people reached | PDPH PrEPClinical Coordination Program |
| PDPHMid-Atlantic AETCNJ AETC | Continue and expand clinical education about PrEP | Primary care providers | **# of TA units** | **22 trainings about PrEP by AETC** | 64 trainings  | 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** | CDC estimate of 3,719 persons on PrEP in Philadelphia in 2019  | PDPHMonitoring 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 | 2019 | Source |
| PDPH RW MCMproviders HIPC PADOH NJDPH | Provide culturally competent medical case management services in clinical and community-basedsettings throughout the EMA. | PLWH NHASpopulations | **# of MCM clients****# of MCM providers** | **5,999 clients****30 RW MCM****providers** | 5,718 MCM clients26 RW 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** | 7.7% reported need for Substance Abuse Treatment services at intake2,068 RW Mental Health Counseling clients272 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 | 2019 | Source |
| PDPHRW clinical providers RW MCMproviders HIPC | Ensure quality improvement efforts to address disparities along the care continuum in the RW clinical and MCMservices | MSM of color Youth aged 13to 24Trans women NHASpopulations | **# 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** | 16 QIP or other activities to reduce disparities at RW-funded medical and MCM providers | PDPH/AACOInformation Services Unit |
| PDPHRW clinical providers RW MCMproviders HIPC | Ensure clinical and support services that address the unique needs and life experiences of disproportionately affected populations | Black MSM Latino MSM LatinasBlack women Trans women LGBTQ youth Youth aged 13-24PWIDPeopleexperiencing 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** | 16 QIP or other activities to reduce disparities at RW-funded medical and MCM providers | PDPH/AACOInformation Services Unit |
| PDPH HIPC PADOH NJDPH | Support a comprehensive and geographically diverse RW care system to ensure access to ARVs and treatment adherenceservices. | PLWH | **% of RW clients virally suppressed** | **84.1% of RW****Outpatient Ambulatory Care clients were virally suppressed** | 87.6% 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 | 2019 | Source |
| PDPHRW clinical providers RW MCMproviders HIPC | Ensure clinical and support services address the unique needs and life experiences of disproportionately affected populations | Black MSM Latino MSM LatinasBlack women Trans women LGBTQ youth Youth aged 13-24PWIDPeople experiencinghomelessness | **# 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** | 54 MCMs attended trauma-informed care129 MCMs attended cultural competency training  | Case Management Coordination Project |
| PDPHMid-Atlantic AETC | Support training and technical assistance on trauma-informed care | Clinical providers MCMproviders | **# of technical assistance sessions on trauma-informed care** | **1 training on trauma informed care to providers by AETC** | **2 trainings 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 | 2019 | Source |
| PDPH PADOH NJDPHClinical 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** | 160 SPBP clients received HCV treatment in the PA5. NJ data not provided. | SPBP ADDP |
| PDPHRW 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** | 83.0% of RW clients screened for syphilis 90.2% of MSM clients screened for syphilis 77.0% of MSM clients screened for gonorrhea 67.8% RW clients screened for Hep B  | CAREWare |

## Goal 4: Achieve a more coordinated response to the HIV epidemic[4](#_bookmark3)

### 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 | 2019 | Source |
| PDPH | Continue centralized grant administration of RW Parts, CDC, and other local funds for HIV prevention and care services in theEMA. | NA | **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 |
| PDPHMid-Atlantic AETCNJ 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.** | 78 trainings | 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 | 2019 | Source |
| OHP | Develop and implement a HIV services resource inventory database for public use | RW providers PLWHSocial workers Clinical providers People seeking HIVprevention services Healthnavigators | **Product launch** | **Launched December 2017 at hivphilly.org** | Database on hivphily.org – updated and expanded ongoing | OHP |
| OHP | Develop and disseminate materials that are accessible, usable, and audience- centered using both traditional and digital methods to support informed community planning | HIPCFederal partners Local stakeholders PADOH NJDPHCounty health departments PLWHRW providers HIVpreventionproviders | **NA** | **NA** | NA | OHP |
| OHP PDPH PADOH NJDPH | Improve efforts to provide HPG and HIPC with timely, accurate, and accessible data to inform decision-making | HIPCstakeholders | **Planning body survey results** | **Data to be collected in 2019** | Ongoing efforts to collect feedback and evaluation data from HIPC members and community members about documents and other resources | 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 PADOHHIPC co-chairs NJ HPG co-chairsPA HPG co-chairs | **# of meetings** **# of attendees** | **To be scheduled** | Ongoing collaboration through formal means like state planning meetings and data requests, and informal means through ongoing communication between PDPH, OHP, PA DOH and NJ DOH |  |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | Source |
| OHP | Continueparticipation inrelevant regionalmeetings and events | NA | **NA** | **Ongoing****participation as****required/feasible** | Ongoing participation by OHP and PDPH at state planning meetings in NJ and PA |  |
| PDPH |  |  |
|  |  |  |
|  |  |  |
| OHP | Explore | NA | **NA** | **The Ryan White** | Ongoing | HIPC meeting |
| PDPH | opportunities for |  |  | **Planning Council** |  | minutes |
| HIPC | further integration of |  |  | **and the** |  |  |
|  | the HIPC and |  |  | **Philadelphia** |  |  |
|  | Philadelphia HPG |  |  | **Prevention** |  |  |
|  |  |  |  | **Planning Group** |  |  |
|  |  |  |  | **integrated in** |  |  |
|  |  |  |  | **April 2017** |  |  |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Responsible parties | Activity | Target Populations | Data Indicators | Baseline 2016 | 2019 | 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 resourceallocations. | 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** | Average of 30 PLWH at each monthly meeting34% HIPC membership is unaligned PLWH as of April 2019 | Meeting minutesMembership data |
| OHP PDPH HIPC | Develop, implement and disseminate results of needs assessment activities as necessary and required | HIPC PLWHFederal partners County health departments Localstakeholders | **NA** | **NA** | Report of 2017 RW consumer survey presented to HIPC, RW Directors, and other community stakeholders. Needs Assessment reports are available at hivphilly.org | OHP |
| OHP PDPH HIPC | Engage stakeholders and community members by using traditional and digital methods, including but not limited to language interpretation andtranslation | Local stakeholders PLWHHIPC | **NA** | **NA** | NA | NA |

# B: Collaborations, Partnerships and Stakeholder Involvement

## 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.

## 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.

## 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

## 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.

## 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.

## 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.

## 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.

1. Note: denominator includes any HIV+ client who received at least 2 MCM services, at least 3 months apart, and who were prescribed ART [↑](#footnote-ref-1)
2. *Note: Numbers declined significantly due to fewer programs being funded for ARTAS in Philadelphia.* [↑](#footnote-ref-2)
3. Lower numbers are due to fewer providers funded for ARTAS in Philadelphia [↑](#footnote-ref-3)
4. Note: denominator is any client who had insurance status entered. If denominator is expanded to any client who had a service (including blank insurance values) the outcome becomes 81.4% [↑](#footnote-ref-4)
5. LPAP unit changed from 30 day to 14 day prescriptions because enrollment into SPBP/ADDP became more efficient. Patient access to medications were not affected. [↑](#footnote-ref-5)
6. Please note that this was a CDC funded 4-year demonstration project with a one year extension year, 9/30/2019 to 9/29/2020, in which prevention navigation services were not funded. [↑](#footnote-ref-6)