



Program Collaboration and Service Integration

Enhancing the Prevention and Control of HIV/AIDS, viral hepatitis, STDs, and TB



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Associate Director
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National Center for HIV/AIDS, Viral Hepatitis,
STD, and TB Prevention (NCHHSTP), CDC



Webcast Agenda

- Presentations

- Dr. Kevin Fenton, director, CDC, NCHHSTP
- Julie Scofield, executive director, National Alliance of State and Territorial AIDS Directors
- Phil Griffin, director, TB Control and Prevention, Kansas Department of Health and Environment
- Dr. Shannon Hader, senior deputy director, HIV/AIDS, Hepatitis, STD, and TB Administration, Washington, D.C. Department of Health

- Question and Answer period



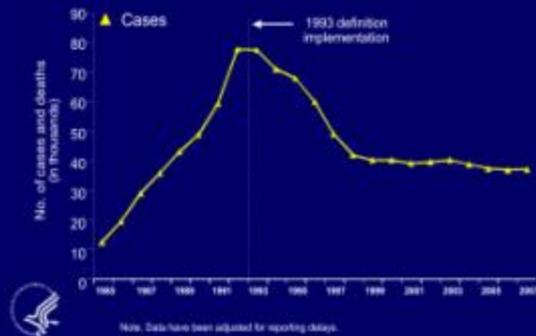
Kevin Fenton, MD, PhD, FFPH

Director
National Center for HIV/AIDS, Viral Hepatitis,
STD, and TB Prevention

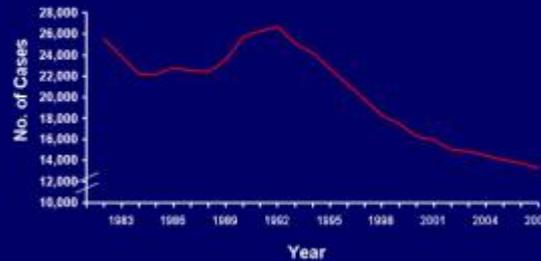


Heterogeneity in National Epidemics of HIV/AIDS, Viral Hepatitis, and STDs

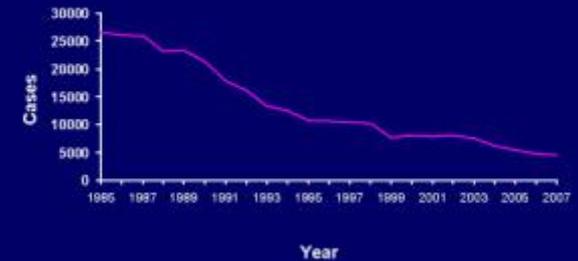
Estimated Numbers of AIDS Cases, Deaths, and Persons Living with AIDS, 1985–2007—United States and Dependent Areas*



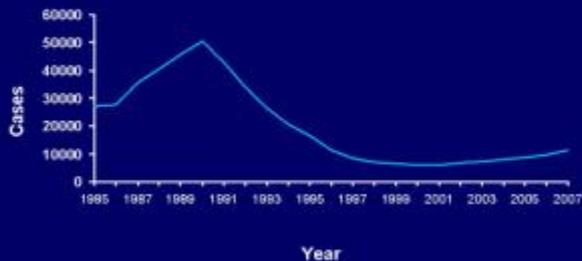
Reported TB Cases United States, 1982–2007



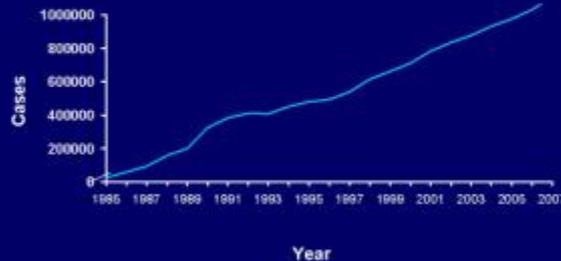
Reported Acute Cases of Hepatitis B, United States, 1985 – 2007



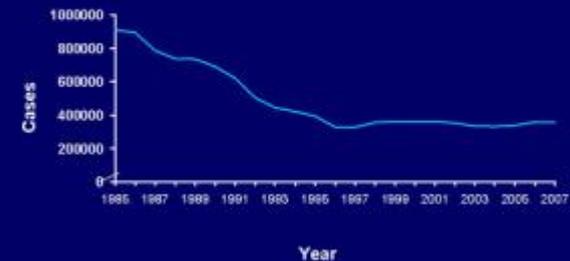
Reported Cases of Primary and Secondary Syphilis, United States, 1985 – 2007



Reported Cases of Chlamydia, United States, 1985 – 2007



Reported Cases of Gonorrhea, United States, 1985 – 2007



Syndemics (overlapping epidemics)

- Similar or overlapping at-risk populations
- Disease interactions
 - Common transmission for HIV, hepatitis, and STDs
 - STDs increase risk of HIV infection
 - HIV is the greatest risk factor for progression to TB disease
 - HIV accelerates liver disease associated with viral hepatitis, making hepatitis the leading cause of death among persons living with HIV/AIDS
 - Clinical course and outcomes influenced by concurrent disease
- Social determinants
 - Poor access to, and quality of, health care
 - Stigma, discrimination, homophobia
 - Socioeconomic factors, such as poverty
- Prevention and control
 - Control of TB, viral hepatitis, and STDS needed to protect health of HIV-infected persons
 - Challenges in funding, delivery, monitoring and quality of prevention services



Modernizing Prevention Responses

Traditional Public Health responses

- Vertical programs
- Focused on the infection
- Highly specialized
- Limited connectivity
- Targeted approach
- Clinical intervention

Syndemic approach

- Recognizes interactions
- Focuses on the client
- Connects specialities
- Networked approach
- Adopts holistic approach
- Structural intervention



What Is PCSI?

A mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate comprehensive delivery of services that is based on five principles:

- **Appropriateness**
- **Effectiveness**
- **Flexibility**
- **Accountability**
- **Acceptability**



Benefits of PCSI

- To maximize the health benefits
 - Increase service efficiency by combining, streamlining, and enhancing prevention services
 - Maximize opportunities to screen, treat, or vaccinate
 - Improve the health among populations negatively affected by multiple diseases
 - Enable service providers to adapt to and keep pace with changes in disease epidemiology and new technologies



Barriers to PCSI

- Lack of national guidelines on where and when best used
- Administrative requirements
- Data collection systems

Implementing PCSI

- High quality prevention services
- Performance indicators
- Ongoing local evaluation of impact
- Documentation of best practices
- Training and technical assistance

Key Steps for PCSI

- Integrated Surveillance to enhance quality and sharing of data across programs
- Integrated Training to ensure more holistic approach to health is practiced in community-based organizations, state and local health departments, health clinics and other venues
- Integrated Services to provide a multi-level approach to prevention services and interventions for the individual and the community



What Is Program Collaboration?

A mutually beneficial and well-defined relationship between two programs, organizations or organizational units to achieve common goals.



What Is Service Integration?

Provides persons with seamless comprehensive services from multiple programs without repeated registration procedures, waiting periods, or other administrative barriers.



Moving Forward

CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

- Open, active, and coordinated communication
 - Internal
 - External
- Cross collaboration among Branches, Divisions, and the Office of the Director
- Consistent, clear messages



Julie Scofield

Executive Director
National Alliance of State and Territorial AIDS
Directors



Public Health and PCSI

- Public health role of assuring services
- Importance of local health departments and community based organizations
- Important to implement in low, medium and high incidence jurisdictions
- Funders can encourage PCSI
 - Increase flexibility of funding
 - Reduce contractual barriers
- Era of shrinking resources



State Health Department Action

- PCSI implementation at the state level – many models exist:
 - Integrated partner services
 - HIV, hepatitis, STD, and TB screening; hepatitis A and B and other vaccination
 - Client services
 - Epidemiology and surveillance activities
 - Training and workforce development
 - Integrated health communication
 - Harm reduction



Service Integration

- CDC recommendations and new diagnostic technologies
 - Routine HIV testing
 - Partner services
 - Noninvasive urine-based testing for chlamydia and gonorrhea
- Multiple venues
 - STD, family planning, and TB clinics
 - Community health centers
 - Correctional and juvenile detention facilities
 - Prenatal clinics
 - Drug treatment centers
 - Hospital emergency departments



A Framework for integration?

Three levels of Service Integration

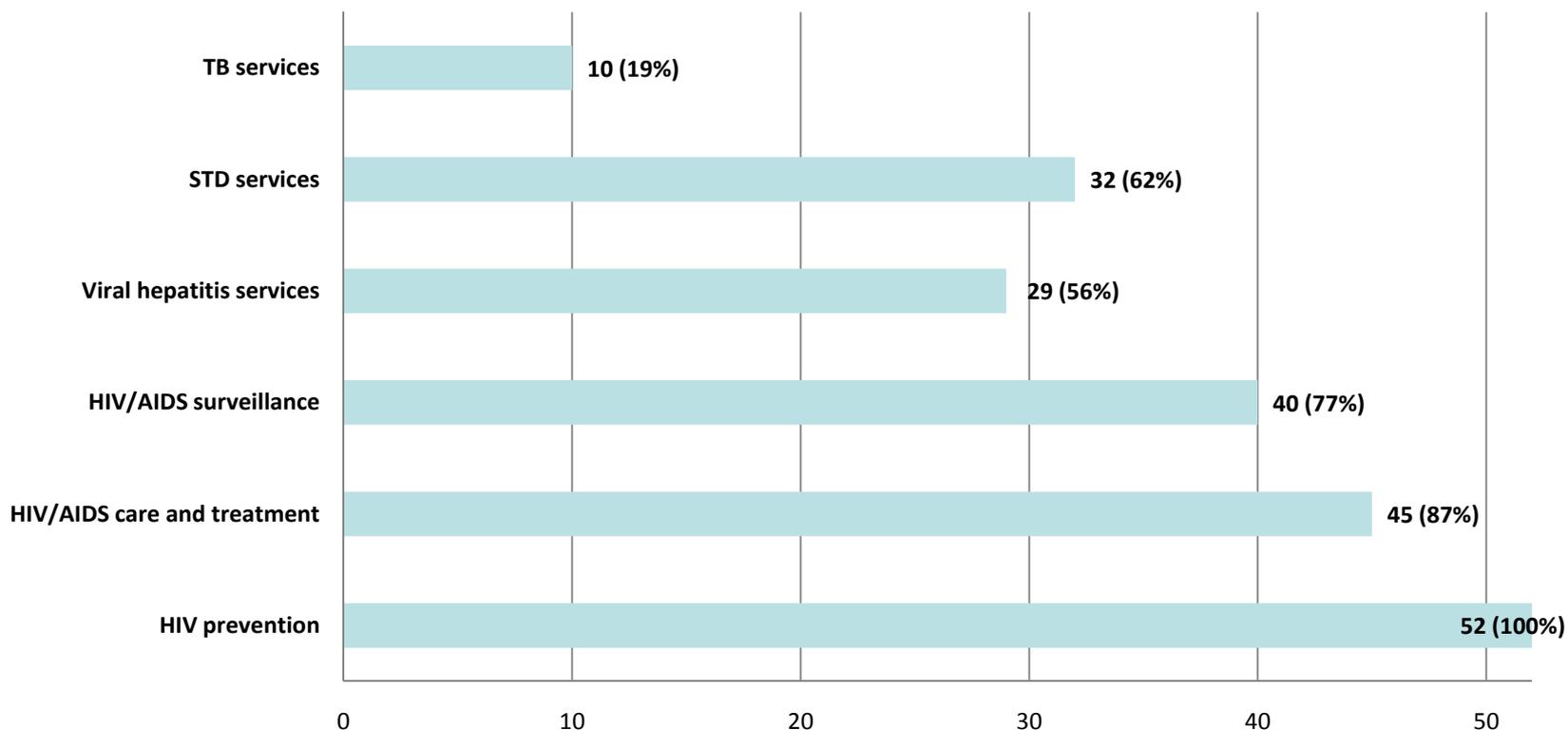
- **Level 1: Nonintegrated services**
 - Prevention services are completely separate or not integrated at the point of client care
- **Level 2: Core integrated services**
 - Basic package of services that integrates two or more CDC-recommended HIV/AIDS, viral hepatitis, STDs, and TB prevention, screening, testing or treatment services into clinical care
- **Level 3: Expanded integrated services**
 - Comprehensive package of best and promising evidence-based practices of prevention, screening, testing, or treatment services integrated into general and social services



Where we are now?

Collaboration and Integration

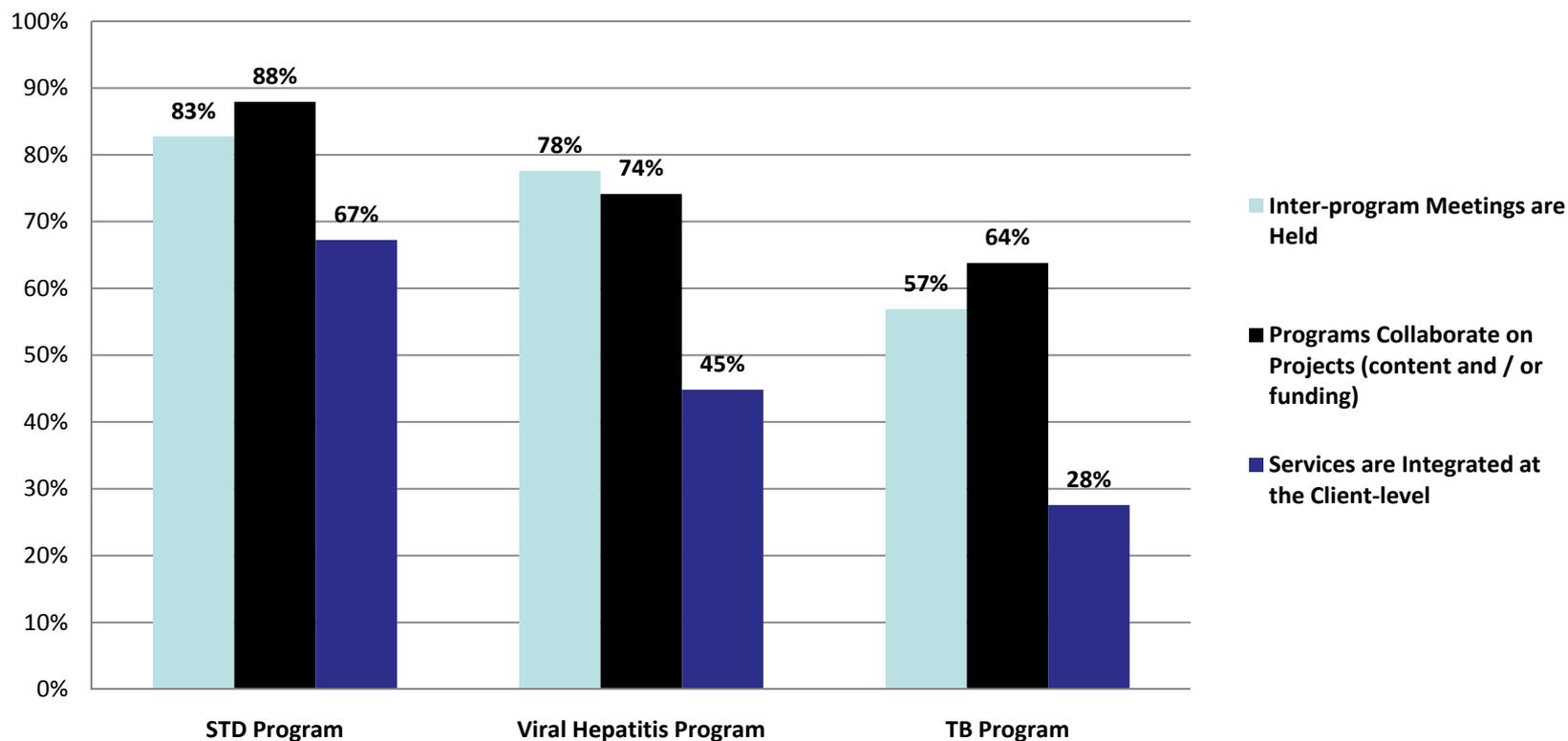
Combined Programs – HIV Prevention and Select Categories*
(n=52)



Where we are now?

Collaboration and Integration

Program Collaboration and Service Integration between HIV Prevention and Other Programs (n = 57)



Reality Check!

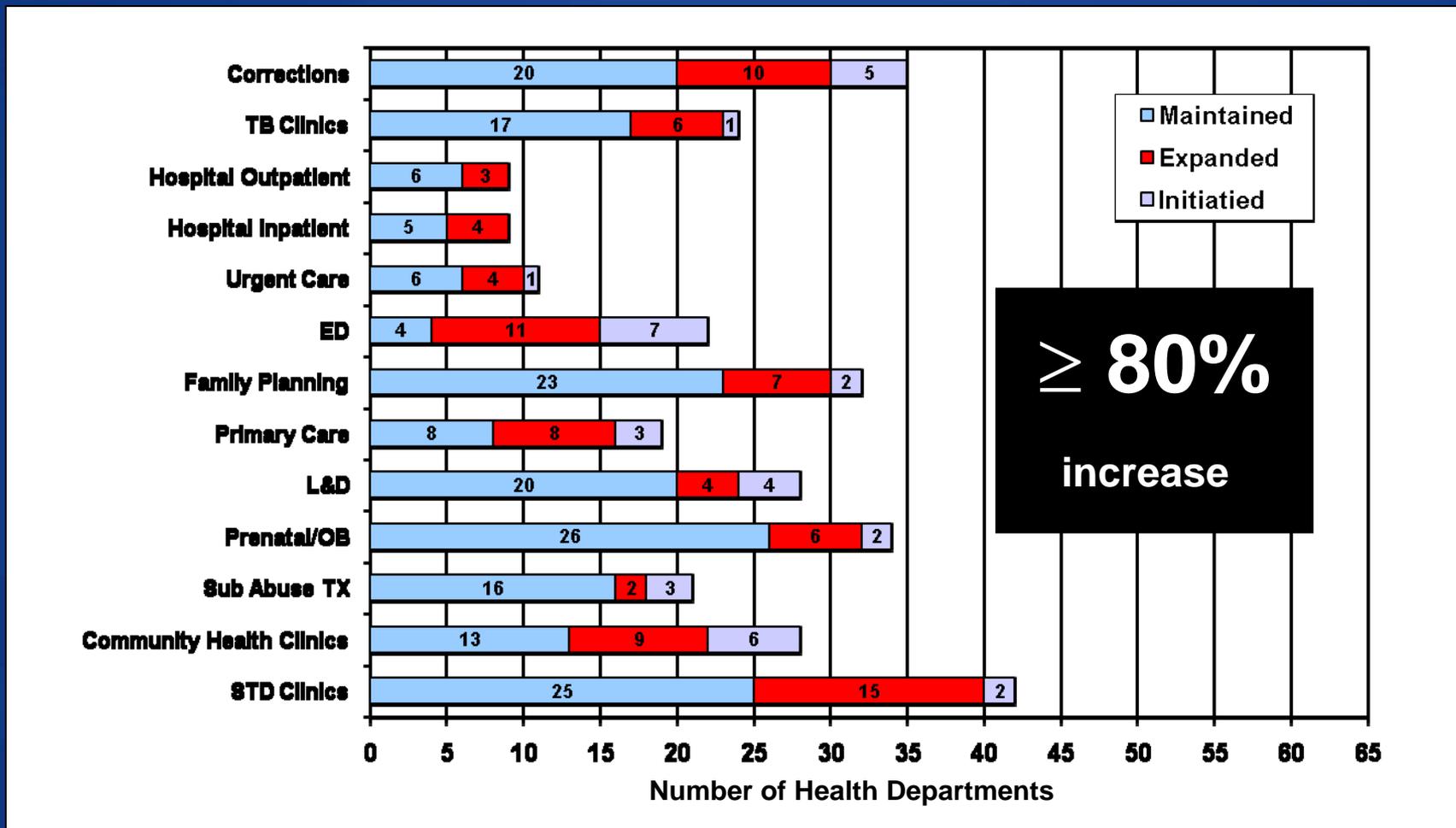
Fiscal Challenges Impacting PCSI

- In FY2009
 - More than \$170 million lost in state revenue for HIV and hepatitis programs
 - Nearly 200 open or unfilled positions in HIV and hepatitis programs
 - 1-36 day mandatory staff furloughs
 - There are still opportunities to collaborate and integrate services!

Identifying PCSI Opportunities

- CDC Funding Opportunity Announcements
 - Expanded HIV Testing Initiative
 - Exemplary FOA with PCSI language incorporated
 - More FOAs from NCHHSTP now include PCSI language
 - NCHHSTP encourages – but not mandatory
 - Jurisdictions must take advantage of these funding opportunities to fund their cutting edge programs

Opt-Out HIV Testing in Health Care Settings by Health Departments after the ETI (as of February 2008)



The National HIV Prevention Inventory: The State of HIV Prevention the U.S., A Report by NASTAD and the Kaiser Family Foundation (KFF), July 2009.



Steps for Local Implementation

- Assess and articulate how/where PCSI can improve local service delivery
- Adopt PCSI as a strategic imperative where appropriate
- Obtain clear political commitment
- Identify an appropriate “PCSI champion” and create a PCSI committee
- Support evidence-based practices in the adoption of PCSI and evaluate PCSI’s impact on behavioral and health outcomes



What do we gain?

- Can be applied in various settings
- Increased flexibility in how we respond to community needs
- Quality vs. quantity of services offered
- Greater client satisfaction
- Greater return on prevention investment
- Fewer missed opportunities



Phil Griffin, BBA

Director, TB Control and Prevention
Kansas Department of Health and Environment



Know Your Epidemic In 2008, the State of Kansas...

- Reported 2,107 AIDS cases to CDC, cumulatively from the beginning of the epidemic through December 2008
- Reported
 - Primary and secondary syphilis: 1.1 per 100,00
 - Cases co-infected with HIV: 35%
 - Chlamydia: 375 per 100,000 persons
 - Among women: 582 per 100,000
 - Among men: 165 per 100,000
 - Gonorrhea: 82 per 100,000 persons
- Since 1992, the overall rate of TB has declined slightly and even less among Black/African American and foreign born persons:
 - 64.9% of TB cases occurred in foreign born
 - 19.3% of TB cases occurred in African Americans
 - 11% of TB cases occurred in White Non Hispanics
 - 4% TB cases co-infected with HIV in 2008



Understanding Kansas

- Population – 2,818,747
 - White – 88.7%
 - White not Hispanic – 80.3%
 - Hispanic or Latin, All races – 9.1%
 - Black – 6.2%
 - Asian – 2.2%
 - Multi Racial – 1.8%
 - American Indian and Alaska native – 1.0%
 - Native Hawaiian/other Pacific Islander - 0.1%



Understanding Kansas (2)

- Land area – 81,814.88 square miles
 - 9 hour drive from NE KS to SW KS (580 miles)
- Persons per square miles – 32.9
- 105 Counties
 - 71 counties have less than 15,000 population
 - 52% of total population in 5 counties
- 100 Autonomous Health Departments
 - State health department has no direct authority over local health departments



Understanding Kansas (3)

- **TB Clinics** – 6 health departments have full time nurses assigned to TB, no full time physicians or other primary providers
- **STD Clinics** – 5 health departments have STD clinics – 85 trained to provide Family Planning Services including STD services
- **HIV Services** – 2 full time HIV clinics with 3 satellites where direct care is provided approximately every 6 weeks, 92 HIV counseling and testing sites
- **Adult Viral Hepatitis Services** – 31 contracted sites providing high risk Hepatitis A/B vaccinations



PCSI Priorities - Kansas

- Assess the level of integrated services currently available within the state
- Identify barriers to further integration of services
- Develop opportunities for eliminating the barriers
- Identify services needing further integration within NCHHSTP supported programs as well as those otherwise supported
- Implement new opportunities to optimize service integration at the state and local levels



Implementation in Kansas

- HIV, adult viral hepatitis, STD, and tuberculosis prevention programs joined with Immunization Program, Bureau of Disease Control and Prevention (BDCP)
- PCSI objectives included in most NCHHSTP cooperative agreement applications in current agreement cycles
- All BDCP programs will participate in a PCSI tour in the summer and fall of 2010, reaching six areas of the state
- Plan and conduct a formal evaluation of the current status of integrated services



Benefits of State Implementation

- Increased opportunities to achieve cooperation from clients
- Increased opportunities to better meet client needs
- Earlier detection of disease, preventing potential exposure to others
- Increased training opportunities using integrated training between programs
- More efficient use of resources at state and local level
- Increased trust among local partners and the public at large



Shannon Hader, M.D., MPH

Senior Deputy Director,
HIV/AIDS, Hepatitis, STD, TB Administration
Washington, D.C. Department of Health



Know Your Epidemic

In 2008, the District of Columbia...

- Reported 16,513 HIV/AIDS cases to CDC, cumulatively from the beginning of the epidemic through December 2008
- Reported 145 primary and secondary syphilis cases in 2008; 621 over the last 5 years with 160 cases co-infected with HIV
- Reported 3,530 persons living with chronic hepatitis B (2004-2008); 9.2% co-infected with HIV
- Reported 11,624 persons living with chronic hepatitis C (2004-2008); 8.5% co-infected with HIV
- Reported Chlamydia infection rate at 1,166 per 100,000 persons in 2008
- Although the overall rate of TB in DC has declined substantially since 1992 (54 cases in 2008; 321 TB cases 2004-2008), the rate decreased among Black/African American and foreign born has been smaller
 - 38.9% of TB cases occurred in U.S. born blacks
 - 51.9% of TB cases occurred in foreign born
 - 16.7% of TB cases co-infected with HIV in 2008



PCSI Priorities District of Columbia

- PCSI *when applicable...*



Impact, efficiencies



Redundancy, missed opportunities



Consistency...messages, standards, quality



Resiliency, back-up, surge capacity

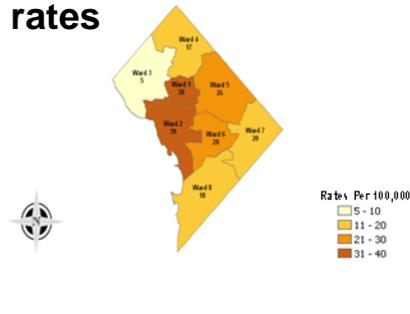
- Strategies

- Organizational Accountability
- Data-driven decision-making
- Standards of Care, Data Quality, Data Use
- Innovation in Programs for Expanded Impact

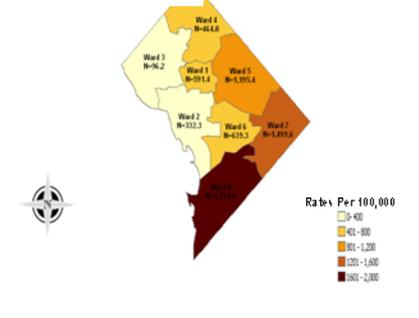


Syndemics (synergistically interacting epidemics)

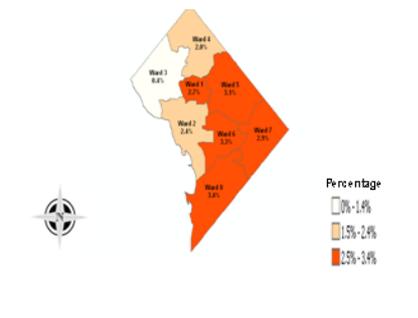
**HIV/AIDS--
rates**



Hep B #s



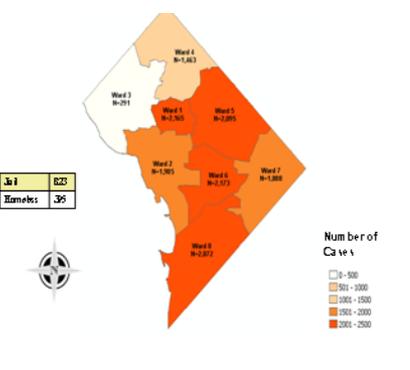
Chlamydia-rates



P&S Syph-rates



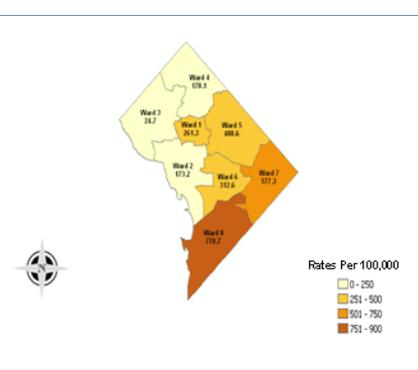
HIV/AIDS--#s



Hep C #s



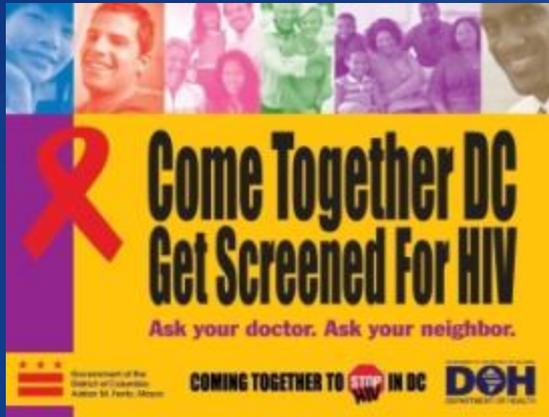
Gonorrhea-rates



TB #s

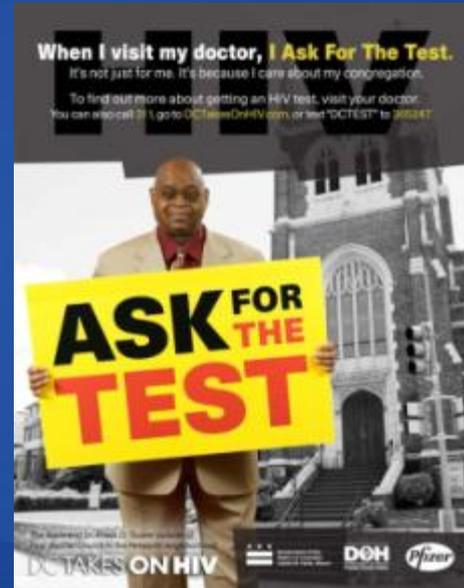


Routine HIV Testing Scale-up

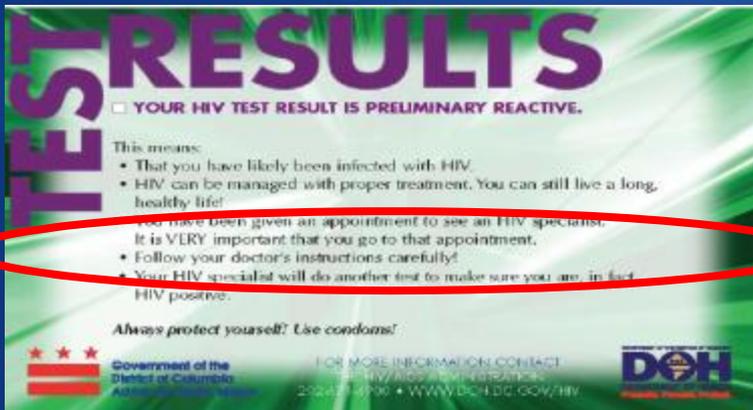


- 1) June 2006, Testing Campaign
- >50 Partners
- Rapid Test Expansion
- DC Jail

- 2) Focus on Medical Settings:
 - Ask for the Test
 - Offer the Test



- 3) Preliminary Positive?
 - Go directly to HIV care



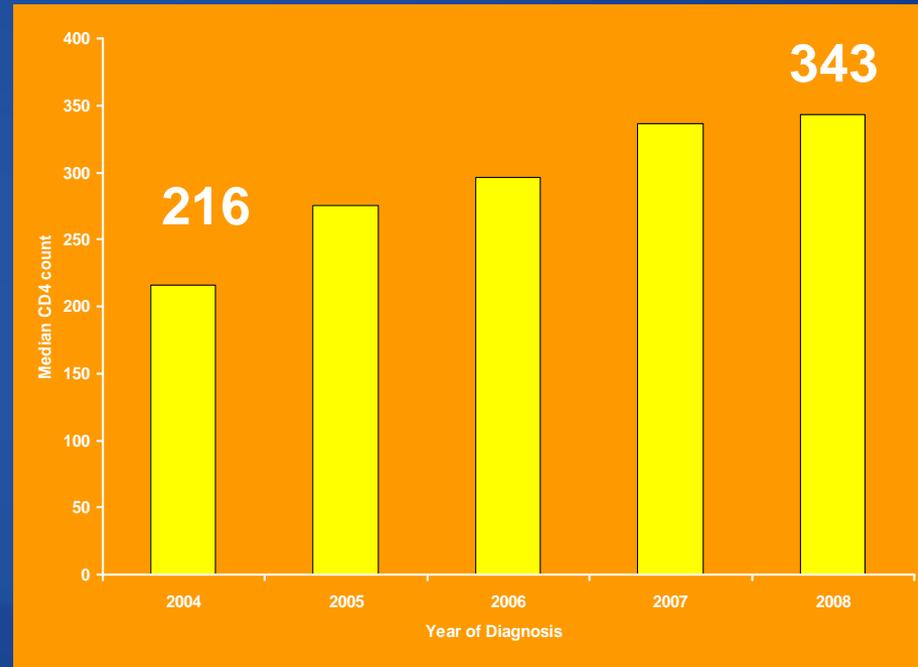
HIV Testing Expansion: More Tests, Earlier Diagnosis, Higher CD4+ Counts

of Publicly Funded HIV Tests



***2009: ~93,000 tests**
PEMS data

Median CD4+ Count at time of Dx



HARS HIV Surveillance Data



Partner Services: *Expanded & integrated*

- STD Syphilis DIS
- Service to be offered to all newly diagnosed
- Need partners to offer, help with partner solicitation
- DC outreach to partners (confidential) offering testing and support services

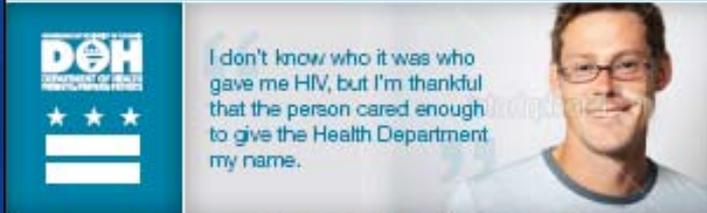


PARTNER SERVICES SAVE LIVES
PARTNER SERVICES STOP HIV AND STDS
PARTNER SERVICES ARE FOR EVERYONE IN DC

DC offers free voluntary partner services to people who test positive for HIV and STDs. The Health Department contacts your partners and will never give your name to anyone. Your partners get connected to testing and treatment if they need it.

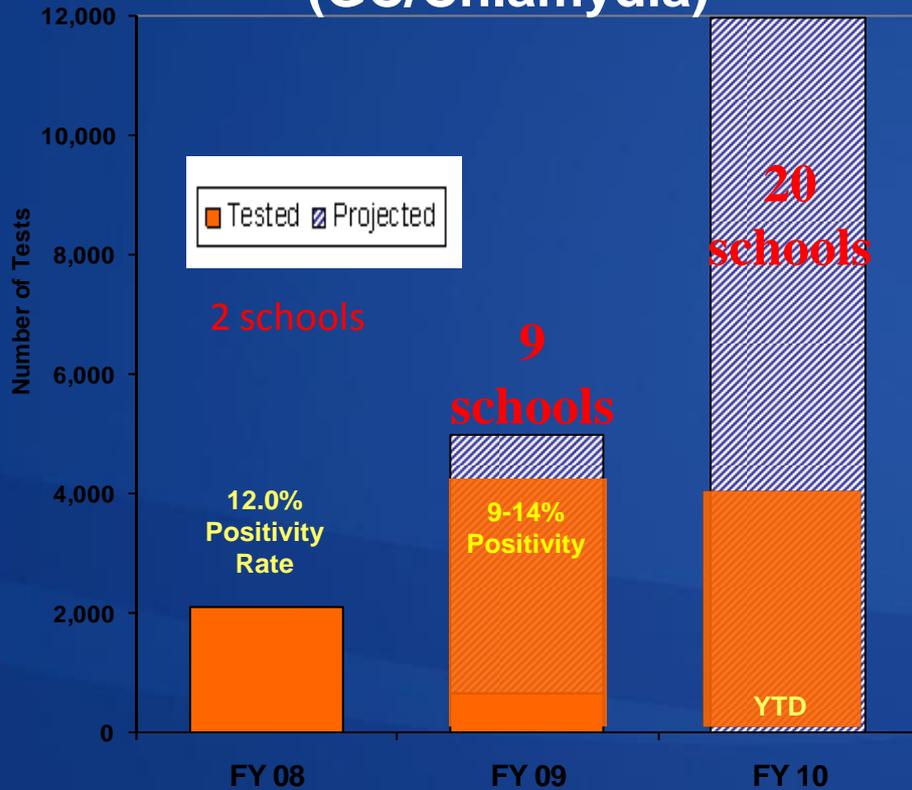
You didn't know before you found out. Your partner probably doesn't know either. Partner services help you and your partners stay healthy.

For more information, call 800-458-5231 or www.doh.dc.gov/hiv



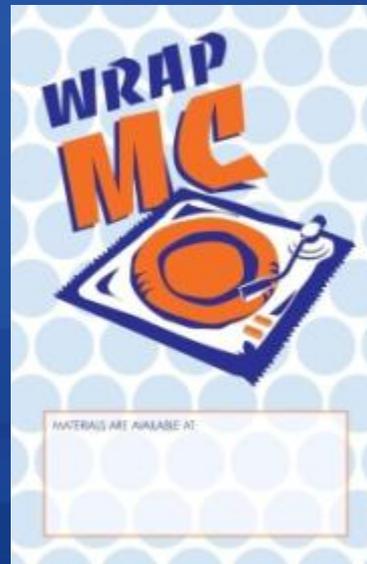
Youth STD Outreach Testing, Condom Distribution, Master of Condoms (MC)

Numbers of Youth Tested (GC/Chlamydia)

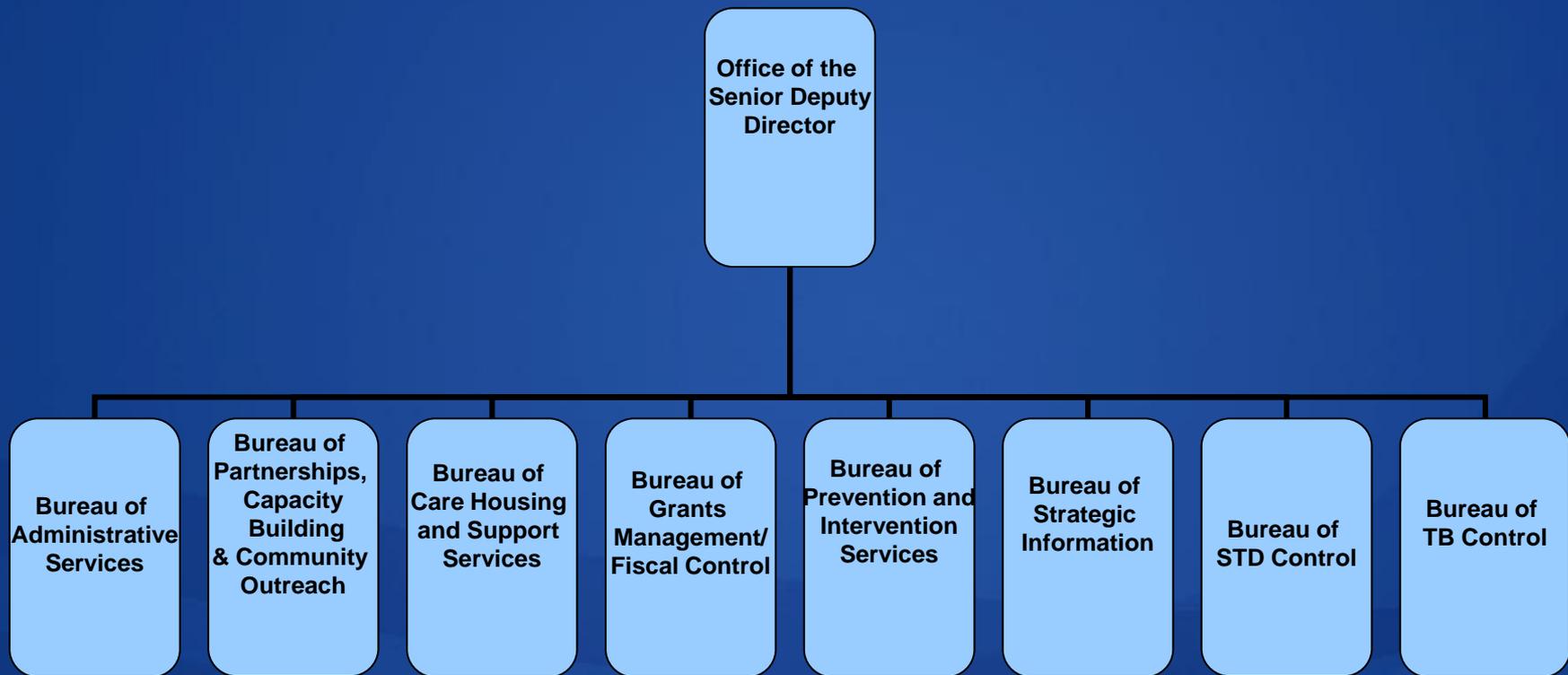


District Condom Program

- 3.2 million distributed FY09
- Expanded school availability
- Wrap MC Web Training



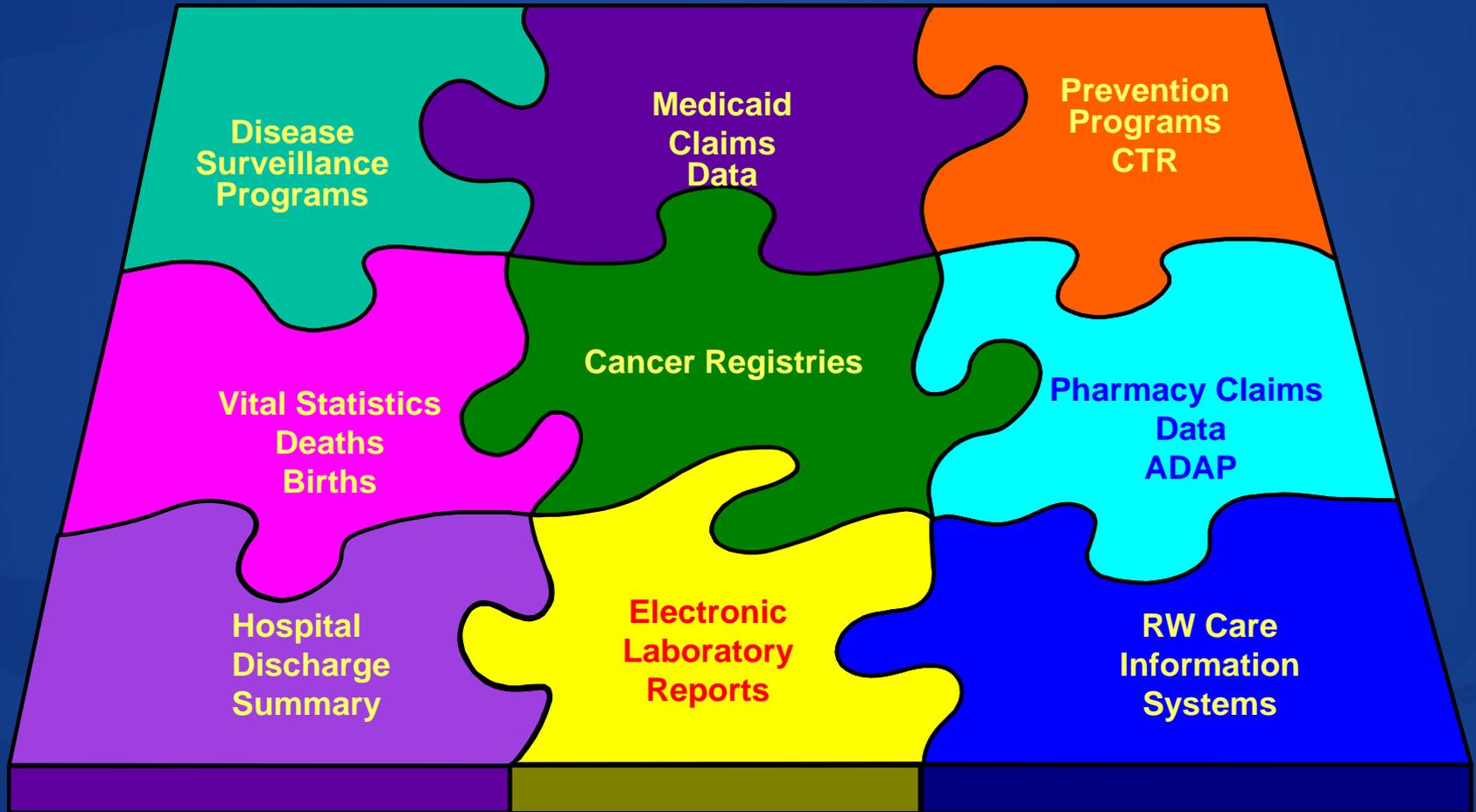
Implementation in D.C. HIV/AIDS, Hepatitis, STD and TB Administration



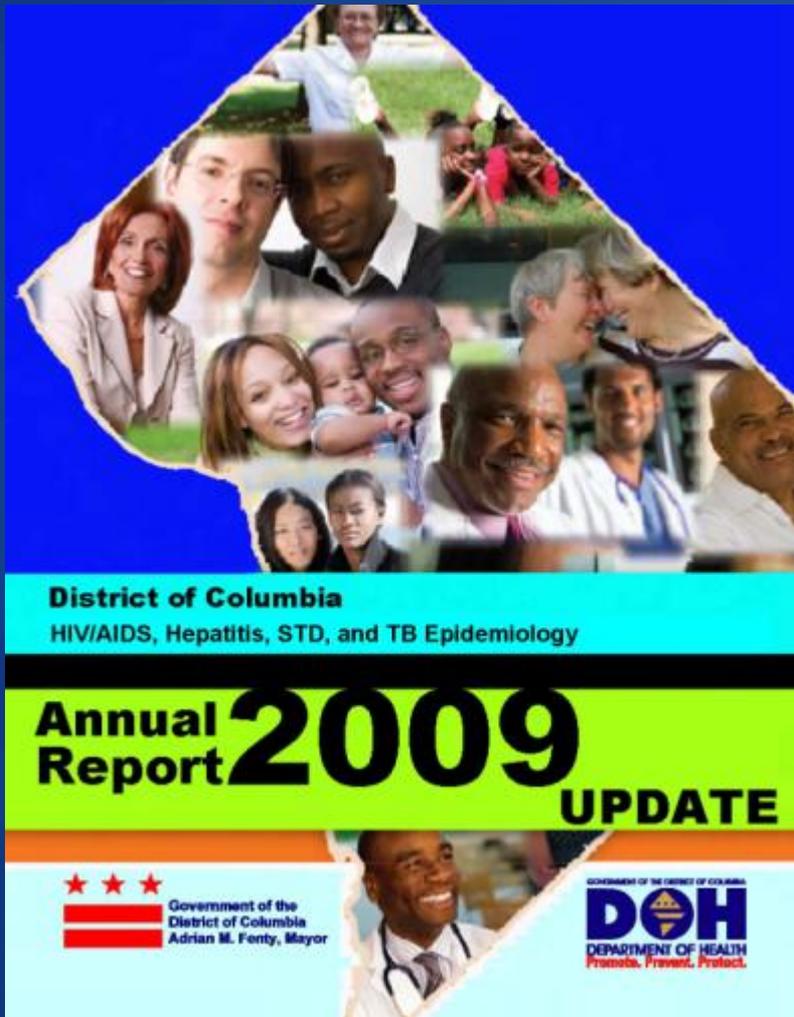
Internal Collaboration & Integration



Data Sharing Partners



Benefits of Local Implementation



- *Innovation*
- *Improvement*
- *Impact*



Summary

- Evolving syndemics of HIV, STD, viral hepatitis and TB epidemics in the United States.
- Small changes in the way services are delivered have the potential to maximize prevention opportunities.
- Modernizing our public health response based on best practices of what and how services are delivered
- Facilitating ongoing effectiveness and efficiency of services
- Implementing best and promising practices, and a commitment to evaluation, based on core PCSI principles



“Given the complexity of the problems and the need for innovation, it is not possible to achieve goals without collaboration.”

President Barack Obama





Program Collaboration and Service Integration

<http://blogs.cdc.gov/healthprotectionperspectives/>

