

Program Collaboration and Service Integration:

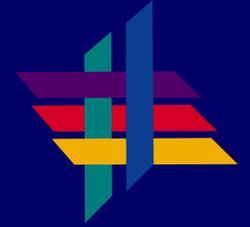
Welcome, vision, meeting objectives

Kevin Fenton, M.D., Ph.D., F.F.P.H.

Director

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

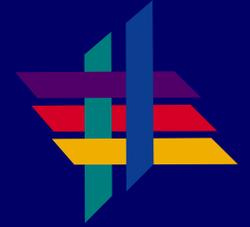
August 21, 2007



Overview

- NCHHSTP overview
- Surveillance data on coinfections
- What is PCSI?
- Integration as a Center priority
- PCSI Consultation





NCHHSTP Mission

Maximize public health and safety nationally and internationally through the elimination, prevention, and control of disease, disability, and death caused by

HIV/AIDS

Non-HIV Retroviruses

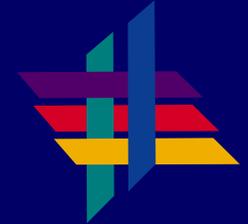
Viral Hepatitis

Other Sexually Transmitted Diseases

Tuberculosis

Non-Tuberculosis Mycobacteria

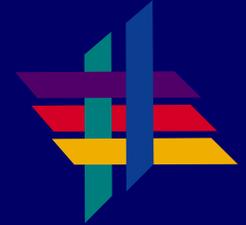




About NCHHSTP

- National Center for HIV, STD, and TB Prevention established in FY 1995
 - Brought together CDC's HIV, STD and TB prevention activities
- Viral hepatitis prevention activities added to mission in 2006, awaiting final approval
- Center supports both domestic and global activities
- Size: 1,500+ FTE and non-FTE staff
 - 15% of CDC workforce
 - Diverse staff





Burden of disease

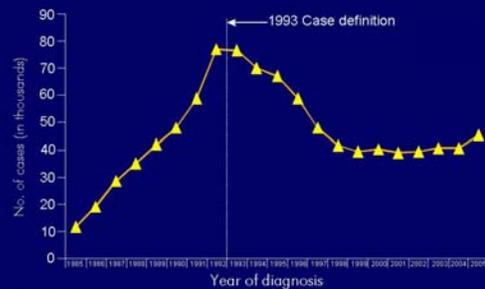
- Estimated 1 million Americans infected with HIV
 - One fourth are unaware of their infection
- Chronic liver disease is the 10th leading cause of death in U.S.
 - More than half of these deaths due to viral hepatitis
 - Hep C is most common blood-borne disease in U.S.
- Estimated 18.9 million cases of non-HIV STDs occur each year in U.S.
 - Chlamydia and gonorrhea are most commonly reported infectious diseases
- Estimated 10 million to 15 million in U.S. have latent TB infection
 - 13,767 had TB disease in 2006





Heterogeneity in National Epidemics of HIV/AIDS, Hepatitis B, TB, and Selected STDs

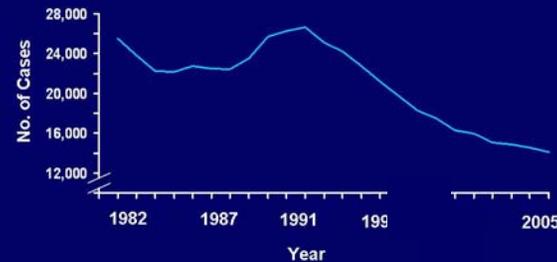
Estimated Number of AIDS Cases among Adults and Adolescents with AIDS, 1985–2005—United States



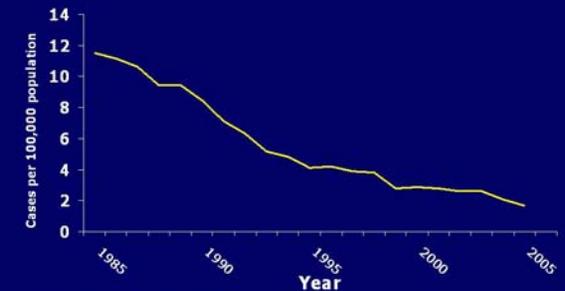
Note: Data have been adjusted for reporting delays.



Reported TB Cases United States, 1982–2005

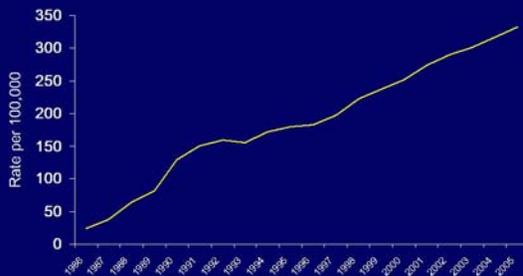


Reported Cases Acute Hepatitis B United States, 1985–2005



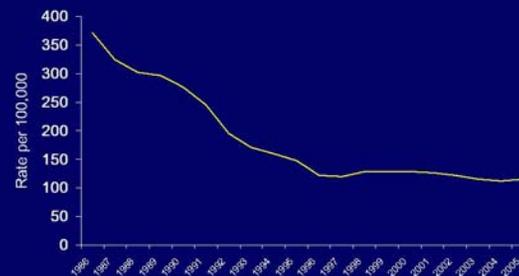
Source: National Notifiable Diseases Surveillance System (NNDSS)

US Chlamydia rate, 1986–2005

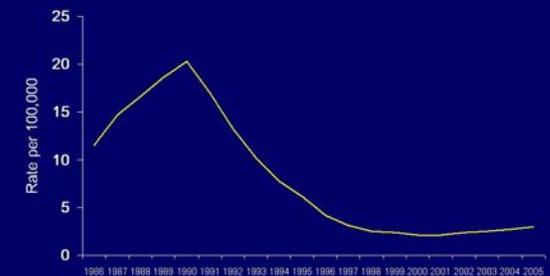


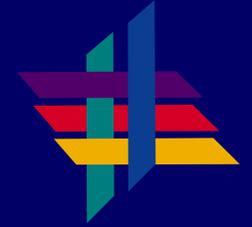
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

US Gonorrhea rate, 1986–2005



US P&S Syphilis rate, 1986–2005





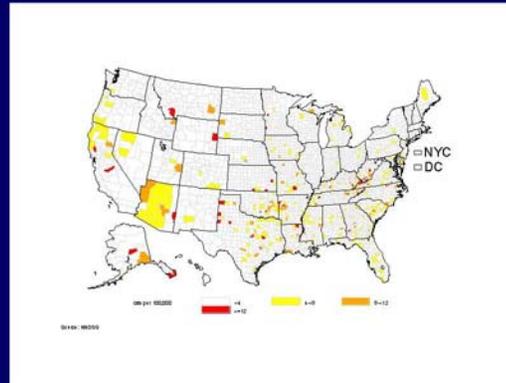
Geographic heterogeneity in epidemics of HIV/AIDS, Hepatitis B, TB, and Selected STDs

Estimated Diagnosis Rates of HIV/AIDS for Adults and Adolescents, 2005—33 States

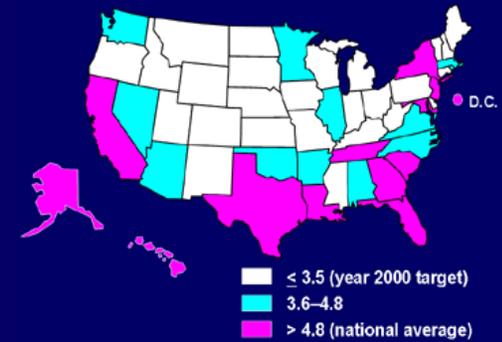


Note: Data include persons with a diagnosis of HIV infection regardless of AIDS status or diagnosis. Data from 33 states with confidential name-based HIV infection reporting since at least 2001. Data have been adjusted for reporting delays.

Incidence of Acute Hepatitis B, by County, United States, 2005



TB Case Rates,* United States, 2005

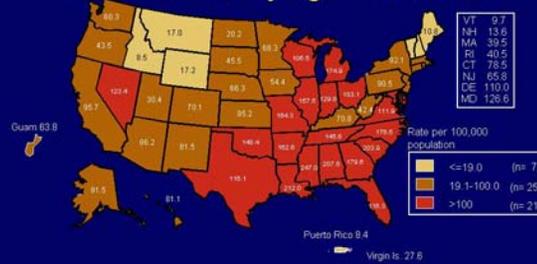


Chlamydia — Rates by state: United States and outlying areas, 2005



Note: The total rate of chlamydia for the United States and outlying areas (Guam, Puerto Rico and Virgin Islands) was 329.5 per 100,000 population.

Gonorrhea — Rates by state: United States and outlying areas, 2005

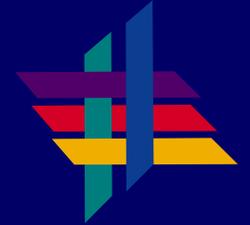


Note: The total rate of gonorrhea for the United States and outlying areas (Guam, Puerto Rico and Virgin Islands) was 114.2 per 100,000 population.

Primary and secondary syphilis — Rates by state: United States and outlying areas, 2005



Note: The total rate of P&S syphilis for the United States and outlying areas (Guam, Puerto Rico and Virgin Islands) was 3.0 per 100,000 population.

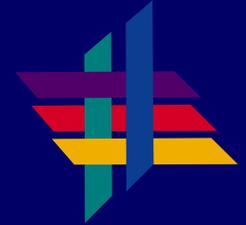


HIV/AIDS, Hepatitis, STD and TB

Common determinants

- Similar or overlapping at-risk populations
- Disease interactions
 - Common transmission for HIV, hepatitis and STDs
 - STDs increase risk of HIV infection
 - 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





NCHHSTP Programs

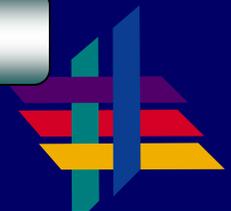
Common Purposes and Strategies

- Eliminating health disparities, especially in sub-populations with disproportionate burden of disease
- Managing and reducing stigma and the resulting consequences in accessing and providing services
- Preventing disease among at-risk/un-infected persons
- Increasing access to high quality, culturally competent services for marginalized, under and uninsured
- Interrupting transmission of infection using similar methods of partner counseling, elicitation, referral, and contact investigations
- Diagnosing disease and providing expeditious treatment and/or referral for care
- Maintaining systems that assure confidentiality
- Monitoring infections in the population (i.e., case surveillance)



CDC Goals and Strategic Imperatives

Shared Leadership Values



Drug Users

MSM

Corrections

Global Antenatal

National HIV/AIDS, Viral Hepatitis

Maximizing Global Synergies

Program Integration

Associate Director for Communications (Acting)
Niki Keiser

Director Kevin Fenton
Deputy Director

Associate Director for Program Integration (Acting)
Susan DeLisle

Associate Director for Health Disparities (Acting)
Raul Romagosa

Associate Director for Science (Acting)
Semaan

Associate Director for Planning & Coordination
Eva Margones

Associate Director for Laboratory Sciences (Acting)
Hsi Liu

Divisions

Reducing Health Disparities

Tuberculosis Elimination
Director
Kenneth G. Castro

Global AIDS Program
Director
Deborah Birx

Surveillance/Strategic Information

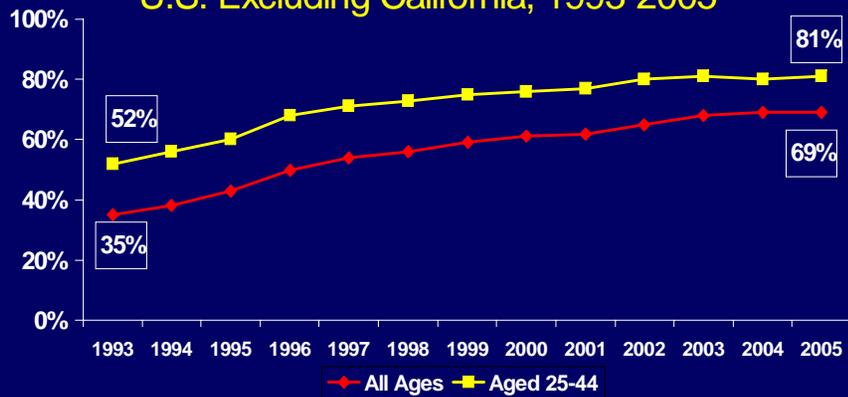
Health Disparities

Program Integration

Modeling/Health Results Measures

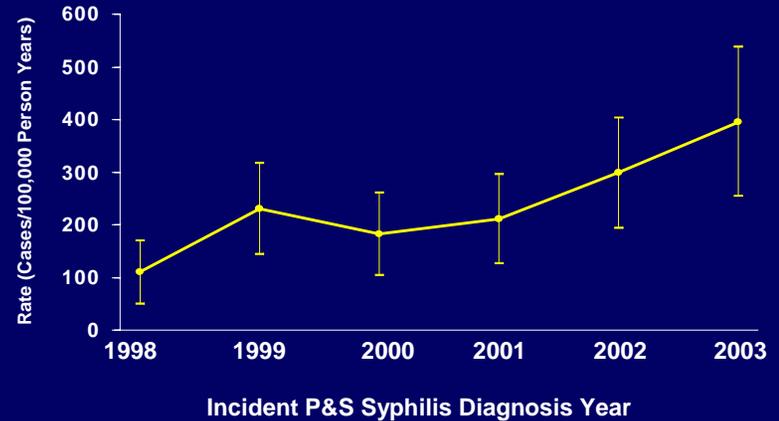


Percentage of TB Patients Having Known HIV Status, U.S. Excluding California, 1993-2005



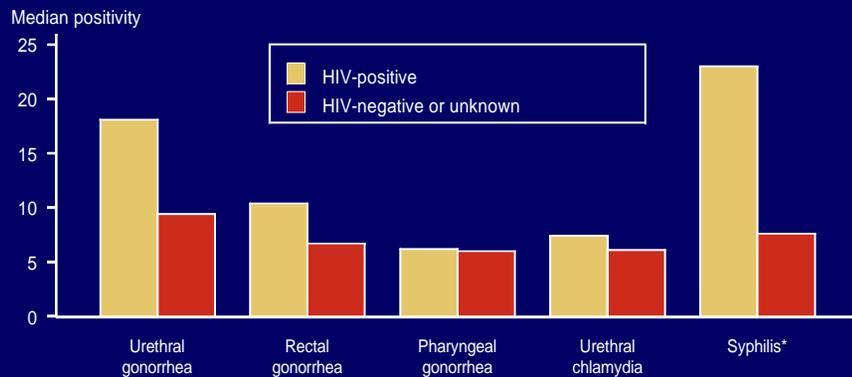
National TB surveillance system, unpublished data, accessed in April 2007

ASD P&S Syphilis Incidence Rates: HIV-infected patients, 1998-2003



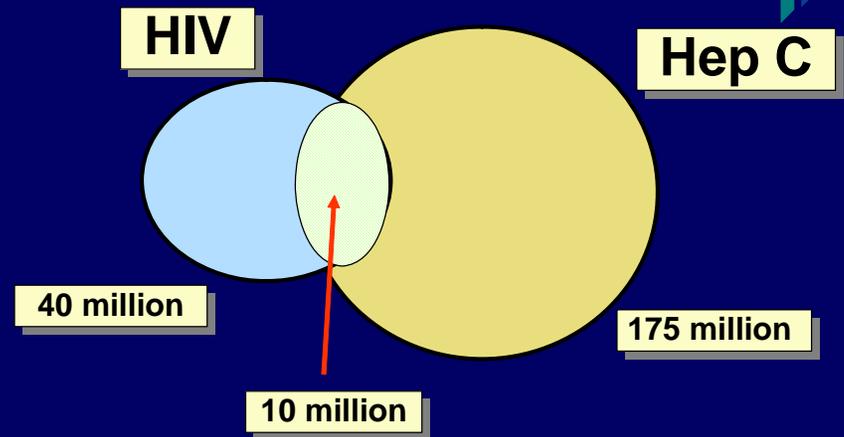
Source: AIDS Surveillance Data, 1998-2003

Test Positivity for Gonorrhea, Chlamydia, & Syphilis Seroreactivity among MSM, by HIV status: STD clinics 2005

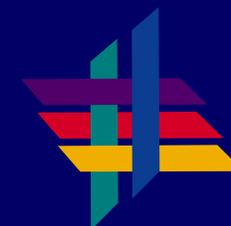


Source: MSM Prevalence Monitoring Project

Overlapping HIV & HCV Epidemics



Estimated 300,000 HIV/HCV-coinfected individuals in the United States



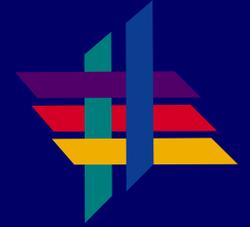
Program Collaboration and Service Integration (PCSI)

- Operating Definition:
 - A mechanism of organizing and blending inter-related health issues, separate activities, and services in order to maximize public health impact through new and established linkages between programs to facilitate the delivery of services
- Integration should be focused at the field or client level where the interface between the system and the consumer takes place.



Integration results in more holistic services for clients, regardless of the agency structure.

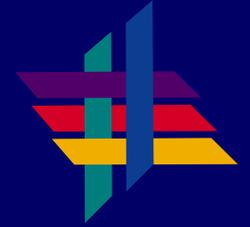




Program Collaboration and Service Integration (PCSI)

- Goal:
 - Provide prevention services that are holistic, science based, comprehensive, and high quality to appropriate populations at every interaction with the health care system.
- Vision:
 - Remove barriers to and facilitate adoption of service delivery integration at the client level by aligning NCHHSTP activities, systems, and policies with this goal.

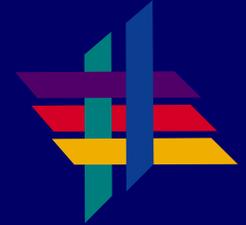




What Are the Potential Benefits of PCSI?

- Increased efficiency and reduced redundancy
- Increased flexibility by enabling partners to adapt, implement, and modify integrated services to increase responsiveness to evolving epidemics or changing contexts
- Increased control over operations, using local information from surveillance and key performance indicators

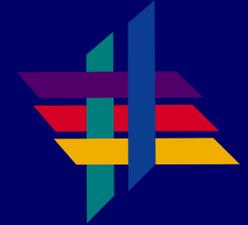




What Are Current Barriers to PCSI?

- Lack of national guidelines
- Administrative requirements
- Data collection and surveillance systems unintegrated
- Insufficient support for cross training, evaluation and dissemination of best practices
- Uncertainty about available funding
- Programmatic concerns
 - Loss of program identity, focus and expertise
 - Mixing of prevention models
 - Loss of control

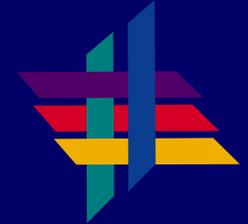




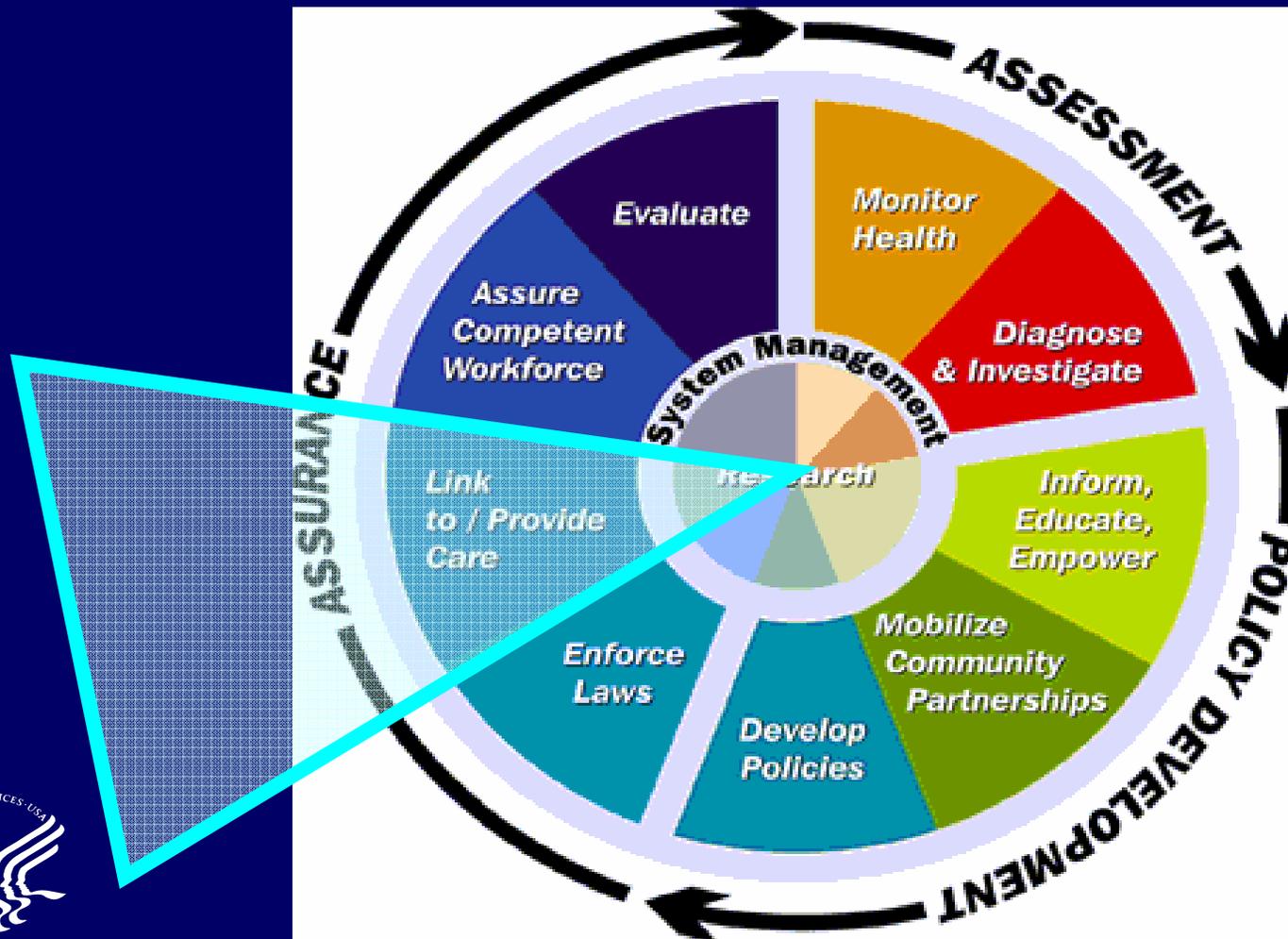
Principles of Effective PCSI

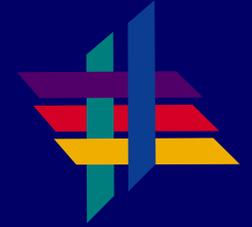
- Appropriateness
- Effectiveness
- Flexibility
- Accountability
- Acceptability





Essential Public Health Functions



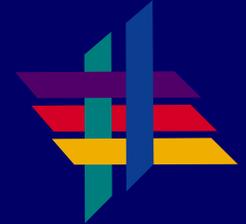


CDC Consultation on Program Collaboration and Service Integration

August 21-22, 2007

Atlanta, GA.



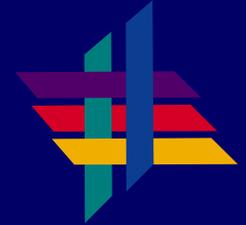


CDC Consultation on PCSI

Overall meeting objectives

1. To advise NCHHSTP on the development of Program Collaboration and Service Integration (PCSI) activities over the next five years
2. Assist in establishing priorities for PCSI; short term and longer term
3. Identify what CDC can do to assist local PCSI efforts
4. Identify what CDC can do to improve its own efforts toward PCSI





CDC Consultation on PCSI

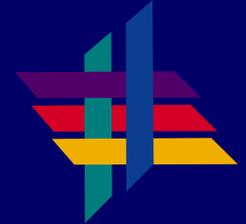
Process for Identifying PCSI Participants

- Planning Committee of national organizations
 - NCSD, NASTAD, NTCA, Hep. C Coord., UCHAPS, CSTE, NNPTC
- Non-CDC members of the Consultation Planning Committee developed peer selection process
- Selection was made with aim toward diversity on these factors:
 - Large and small size programs (both in funding and population)
 - Integrated and non-integrated programs (structurally and service delivery)
 - Urban and rural states; High morbidity and lower morbidity states/cities
 - Equality across diseases (HIV, TB, STD, viral hepatitis)
- Five CBO's were nominated by DHAP with diverse focus (LGBT, corrections, substance abuse, AF/AM women)



NCHHSTP Divisions nominated surveillance breakout session participants



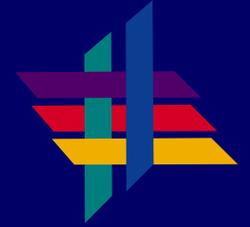


CDC Consultation on PCSI

Attendees

- Broad range of external and internal stakeholders (approx.100)
 - Grantees – 7 from each program, 5 CBO's
 - NNPTC, RTMCC, AETC
 - CSTE and 3-4 state surveillance coordinators from each program
 - CHAC, ACET representation
 - Representatives from each NCHHSTP Division
 - Other federal agencies (e.g. HHS,HRSA, SAMSHA, OPA,)
 - Non federal partners (e.g. ASTHO, NACCHO, ASHA)
- 40 Project areas represented



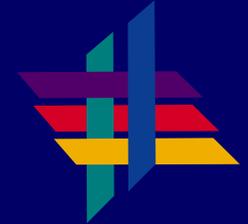


CDC Consultation on PCSI

NCHHSTP Participation

- Division Directors selected staff to participate
- Number of staff determined by size of Division
 - HIV: 9
 - STD: 6
 - TB: 5
 - Viral Hepatitis: 4
- Program & Leadership (management & policy)

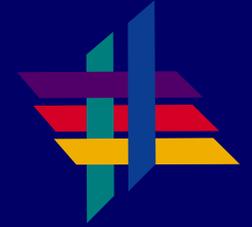




Summary

- Welcome to Atlanta!
- Program Collaboration and Service Integration is a major strategic priority for NCHHSTP
- Surveillance and strategic information are important tools for successful implementation, monitoring and evaluation of PCSI efforts
- Today's pre-meeting aims to provide time and space to discuss challenges and opportunities for PCSI development and support by CDC and our partners





Levels of Integration of clinical preventive services in health care settings

- Limited integration
 - HIV testing
 - Some integration of health information
- Expanded
 - Service integration across programs funded by CDC based on risk assessment
- Comprehensive
 - Service integration across systems of care (CDC or other) based on risk assessment

