# Integrated HIV Prevention and Care Plan

**For the Commonwealth of Pennsylvania Department of Health, Division of HIV Disease**

**2022-2026**

**October 2022**

pennsylvania
DEPARTMENT OF HEALTH

This publication of the Pennsylvania Department of Health Integrated Prevention and Care Plan was submitted jointly to the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) on or before December 9, 2022. With sustained community input, this plan was created by the Division of HIV Disease and the Bureau of Epidemiology in the Pa. Department of Health, the HIV Prevention and Care Project at the University of Pittsburgh (PIs Friedman, Givens, and Krier), and the members of the HIV Planning Group, which represent impacted communities and stakeholder organizations from across the state. The publication may be cited as:

Pa. Department of Health, University of Pittsburgh HIV Prevention and Care Project, Pa. HIV Planning Group. (2022). The Pennsylvania Integrated HIV Prevention and Care Plan 2022-2026. *Pennsylvania Department of Health*.

The HIV Planning Group's (HPG) efforts during the past five-year planning cycle have made this plan possible through both their dedication to the planning process and their work improving the HIV Continuum throughout the commonwealth.

# Contents

## Section I: Introduction and Executive Summary

### 1a. Integrated HIV Prevention & Care Plan General Summary

The purpose of the Integrated HIV Prevention and Care Plan (IHPCP) is to provide a roadmap to how the Pennsylvania (Pa.) Department of Health (DOH) Division of HIV Disease (Division) is addressing HIV in the commonwealth. The IHPCP focuses on the status of HIV in Pa. and what will be done to prevent HIV, help people living with HIV (PLWH) get and stay in care, address emerging trends, and respond in ways to help HIV prevention and care efforts succeed.

The IHPCP was developed through gathering information from a variety of sources and stakeholders, including data from the DOH, HIV providers for prevention and care services, partnering agencies, and people at risk for or living with HIV. The IHPCP brings together this information and how the information will be used to address HIV in this state.

The IHPCP is a Pa.-specific plan, but it is aligned with the Center for Disease Control and Prevention (CDC) and the Health Resources & Services Administration (HRSA) grant requirements, and the Ending the HIV Epidemic (EHE) plan's four pillars: Prevent, Diagnose, Treat, and Respond. The Division has also added a fifth pillar to demonstrate additional supports believed to be necessary to best accomplish the goals, strategies and activities of the first four pillars. The IHPCP compliments both the EHE and the National HIV/AIDS Strategy (NHAS), to ensure everything that is being accomplished in Pa. to address HIV is meeting the expectations of federal funders.

The IHPCP incorporates all the Division's HIV prevention and care activities within the four EHE pillars as well as the additional fifth pillar. It not only lays the groundwork for what the Division is doing, and will be doing, but it demonstrates how each activity plays a vital role in accomplishing the mission of the Division, federal funders, while also showing a powerful partnering with every other state/territory in the United States in a combined strategy to address HIV.

The authors would like to thank you for your interest in supporting the health of people at-risk for, and people living with, HIV in Pa. For questions or to become more involved with HIV planning or the HIV Planning Group (HPG), please visit www.stophiv.org or email stakeholders@stophiv.com.

### 1b. IHPCP Executive Summary

The Division, University of Pittsburgh HIV Prevention and Care Project (HPCP), and the statewide HPG have been developing structure and content for the 2022-2026 IHPCP since 2019. The following document is the sum of those efforts, which provides the direction, goals, and processes that form the jurisdiction's IHPCP for 2022-2026. The IHPCP is built on the needs established in Sections II and III. Section II outlines the HPG's recommendations from 2017 through early 2022 regarding both the 2017-2021 IHPCP activities and their expertise assessing the state of the epidemic, as well as all other qualitative data gathered from stakeholders, especially PLWH, during this period. This is equally weighted with the state of the epidemic and indicated needs identified by the Pa. Bureau of Epidemiology's epidemiological data in Section III. Section IV combine these needs and data to formulate the strategies that will be used to maintain and improve the entire HIV continuum of care

throughout the commonwealth. Section V lists the activities the Division and its partners will take in order to prevent, diagnose, treat, respond to HIV, and the necessary supports to accomplish this effort. Section VI describes how both the state and the HPG will monitor the activities in the IHPCP, and Section VII certifies that the HPG has been a collaborating partner throughout this process and approves of this IHPCP.

### A. Approach

The approach for this plan was to create an entirely new document based on the joint federal guidance for integrated planning published in 2021, aligned with the EHE pillars; Prevent, Diagnose, Treat and Respond. Two exceptions in the current plan that were retained from the 2017-2021 IHPCP are the retention of the IHPCP's accessible (Flesch-Kincaid 12$^{th}$ grade reading level) introductory summary above and the basic structure of the IHPCP activities table (with several improvements) in Section V.

Federal guidance recommends that to the greatest extent possible planning should be an integrated and collaborative effort with metropolitan jurisdictions within Pa. Philadelphia is categorized by the CDC as an Eligible Metropolitan Area (EMA). In accordance with this guidance, a representative from the Division actively participates in the Philadelphia EMA planning process, while two appointed representatives from the Philadelphia EMA, as well as multiple community members, participate in the HPG. The Pa. IHPCP is a state jurisdictional plan, which covers the entire Commonwealth of Pa. However, the Philadelphia EMA, has also written a localized integrated prevention and care plan for their specific EMA/Ryan White Part A region, which consists of the five southeast counties in the greater Philadelphia area. Both the commonwealth's and Philadelphia's plans provide for ongoing coordination and future collaboration; this IHPCP is also harmonious with the city of Pittsburgh's Getting to Zero HIV Initiative.

### B. Documents

The IHPCP and its contents represent a unique effort by dedicated parties from across the state. The planning process and content that forms the basis of the IHPCP – that is, the assessments, reports, and recommendations – were developed over the course of five years through the joint efforts of the Division, various supporting DOH departments such as the Bureau of Epidemiology, and the members of the HPG, the official planning advisory body for the Division. This body meets all federal guidelines for representativeness, inclusion, and parity among members, including representatives from community stakeholders (high-risk groups, health professionals and providers, relevant state agency representatives, etc.), Ryan White (RW) Parts A-F, PLWH, and others. The efforts of all involved, analyses, reports, and recommendations, which over those years have involved the time and expertise of more than four dozen stakeholders, PLWH, and professionals, are integrated into every section of this document.

Other documents or parts of documents contributing to the development of the IHPCP include the Statewide Coordinated Statement of Need (SCSN) and needs assessments, as well as the DOH's annual epidemiological profile report from the Bureau of Epidemiology. These comprise

parts of Section II and all of Section III. Other materials utilized include recommendations and assessments from the HPG, required annual Division reports to HRSA and the CDC, as well as the updated/retained elements from the 2017-2021 IHPCP noted above. The 2022-2026 IHPCP, particularly those sections detailing the collaborative work of the HPG and the Division, has been compiled, drafted, edited, and reviewed by Division staff, Bureau of Epidemiology, partnering agencies, the HPG, and the HPCP. Many of its materials are a result of input and recommendations by the aforementioned partners. The HPG, has also received regular updates on activities and progress throughout this years-long process, to monitor activity for the very purpose of providing feedback to the Division.

## Section II Community Engagement and Planning Process

Section II outlines the many ways that stakeholders, impacted and at-risk communities, and PLWH have contributed to this 2022-2026 IHPCP. Specifically, this section details the diverse, ongoing efforts for stakeholder engagement along with the work of the HPG and involvement of other groups, including RW Parts A-F, County, and Municipal Health Departments (CMHDs), community-based providers and PLWH. The conclusion of this section further summarizes these collective findings as well. Please note throughout the descriptions in this section that COVID-19 emerged as an ongoing barrier and confounding variable that impacted numerous community engagement activities during the latter third of this planning cycle.

### 1. Jurisdiction Planning Process

The planning and engagement work for assessing both the state of HIV in the jurisdiction and the effectiveness of the IHPCP began in 2017 when the 2017-2021 IHPCP took effect. The Division has worked closely with the HPG and numerous partners to define and enact a robust planning process that centers around people at risk for or living with HIV. This includes state agency partners, grantees, and organizations representing every stage of the HIV care continuum and every demographic and geographic group impacted by HIV. The HPG-approved stakeholder engagement plans particularly center and prioritize engagement with Pa.'s priority populations, most notably men who have sex with men (MSM) and trans women, African American communities, youth and youth of color, and people who inject drugs (PWID). The five years of community input, organizational reporting, and resulting HPG recommendations are summarized in this section, culminating in stakeholder and consumer priorities referenced directly by the IHPCP activities for 2022-2026 in Section V.

#### A. Entities involved in process

The Division, in partnership with the HPG and members of the HPCP, have successfully engaged diverse key constituents throughout the five-year planning period. These stakeholders include: DOH staff; community-based organizations serving populations affected by HIV; HIV services providers; PLWH; PLWH who are dual diagnosed with hepatitis B or C; populations at risk from HIV; behavioral and social scientists; epidemiologists; HIV clinical care providers including RW Part C and D; Sexually Transmitted Disease (STD) clinics and programs; community leaders; community health care center representatives from Federally Qualified Health Centers (FQHC's); substance use treatment providers; hospital planning representatives; the Mid-Atlantic AIDS Education & Training Center (MAAETC); academic institutions; mental health providers; PLWH who have experienced incarceration; correctional facility representatives; social services providers and housing services representatives; and Medicaid/Medicare partners. In addition to the work of the HPG, which is outlined in part C below, diverse strategies/activities were employed to connect with these key groups, as prescribed by the HPG's yearly Stakeholder Engagement Plan (facilitated and executed by the HPCP).

a. Pa. Townhalls: In 2019, the HPCP facilitated two in-person regional townhall meetings on behalf of the HPG. These meetings contained presentations by the Division, a panel of HPG members

and a spotlight on a local provider in each region. Most importantly, they featured an open forum section for participants to share their concerns and experiences in direct conversation with HPG and Division members.

April 2019's townhall meeting, held in Pittsburgh was attended by 76 individuals. Attendees included those representing PLWH, MSM, all age groups (over the age of 13), and Latinx communities. Confidentially self-identified PLWH attendees matched the proportion of PLWH in the southwest Pa region. Individuals from the 30-39-year-old age group, African American/black communities, and transgender communities were underrepresented in the meeting relative to the region. Stakeholders discussed topics related to HIV and housing, disability and aging, mental health, incarceration, underrepresented communities (especially communities of color), and HIV education.

July 2019's townhall meeting in State College was attended by 77 individuals. Attendees representing the 40–49-year-old age group matched the rate of that age group in the North Central region. Attendees representing PLWH were overrepresented in our meeting, compared to the rate of PLWH in north central Pa. Individuals from other age groups, African American/black communities, Latinx communities, transgender communities, and those at risk for HIV were present but proportionally underrepresented in this meeting. Attendees at the State College townhall meeting discussed mental health, Preexposure Prophylaxis (PrEP), HIV stigma, and disability as important topics. Based on feedback from the Pittsburgh townhall meeting, this meeting was further enhanced by extending time for discussion, supplying "to-go" containers for the provided meal, and offering online participation options and remote watch parties in safe community spaces/organizations (to address transportation and stigma barriers) for this meeting. Dinner was provided for all guests at the event *and* for all those in the designated remote watch parties.

As part of the Townhall Stakeholder Engagement sessions, the 'host' Ryan White Part B (RWPB) regional grantee was asked to help the HPG invite specific community subrecipient organizations to spotlight. This methodological enhancement to the traditional townhall structure offers powerful and productive learning and listening opportunities. Specifically, this approach allowed HPG members and Division leaders and staff to converse directly with community groups working on the ground in the region. In turn, the groups' representatives presented not only their efforts highlighting what was working well in their specific field, and what the existing needs and gaps are, but they could also both learn about and contribute to HIV Planning. In the April 2019 townhall in Pittsburgh, the featured group was AIDS-Free Pittsburgh, which led to robust discussions on their work and advances enhancing the HIV care continuum, and to ongoing health and racial inequalities in the city. The August 2019 townhall organizations for the North Central region were the Caring Communities and the AIDS Resources community groups. These two organizations' work highlighted and stimulated an evening of discussion that covered 22 topics.

The needs and gaps the community organizations identified and discussed with the HPG and Division, along with *all* community members feedback, are recorded and summarized after each townhall. These summary reports were presented to the HPG, the Division, the regional grantee, and was also made available to all attendees who requested follow-up communication. This summary feedback is reflected in the recommendations developed by the HPG and listed in subsection F below.

b. Online/digital outreach: HPCP established and continues to maintain a digital presence to be current with evolving communication and networking sources, to best ensure the ability to share relevant HIV and HPG updates. This includes 294 stakeholders across Pa using Emma email software, an additional 44 followers on Twitter, and access to HPCP's stakeholder-facing website and blog. Content shared in these mediums includes emerging health information, testing resources, HPG announcements, ongoing projects, relevant health information, partner events, and CDC and Pa. DOH public health campaigns, including anti-stigma campaigns. The postings also summarize and distribute key points and announcements from each HPG meeting.

c. COVID-19 and PLWH Listening Posts: In 2020 as the COVID-19 pandemic prompted a public health emergency and shelter-in-place actions began, access to services and daily routines were adversely impacted. At this same time the HPCP was conducting a survey to assess experiences of HIV-related stigma in health care settings for PLWH on behalf of an HPG sub-committee. As a result of spontaneous comments being submitted through the survey detailing fears of the impact of COVID-19 on HIV-related care, the HPG requested listening session events be held to address those fears and provide updates regarding services and on the pandemic. The HPCP hosted two regionally focused virtual listening sessions in October 2020, with guided discussion. A combined total of 35 people virtually attended these two sessions. Participants shared concerns around isolation, keeping active, finding meeting space outside of the home as public places remain closed, especially as winter was approaching, limited transportation options, and the intersections of the pandemic and HIV-care as they relate to people with disabilities. Providers expressed that staff's mental health has been affected, due to the difficulty maintaining a work-life balance during the pandemic. Providers also reported lower than normal numbers of HIV tests being given, difficulty contacting clients, especially as drop-in centers were closed, and the fear of putting clients at risk by seeing them in-person.

   Both sessions had a large focus on telehealth as an emergent tool. Some said that telehealth has made it easier to see clients, particularly in rural areas and for mental health visits. Others reported that not all clients were comfortable with the medium, noting a learning curve. However, participants would like to see telehealth continue as an option alongside traditional in-person visits. Those using telehealth emphasized the need for reliable technological support staff. Many participants also noted some positive changes during the pandemic, including shorter wait times at appointments and a greater ability to provide personalized care because of less crowded schedules.

d. HPG Community networks: The HPG, as the representative advisory body to the Division, is charged with sharing information gathered and discussed by the HPG to the communities they represent, as well as collecting and reporting concerns, issues, and potential emerging needs from those stakeholders across the state. To accomplish this, the HPG's membership has been defined (by the HPG itself) in the HPG Protocols to include specific stakeholders from across the continuum of care positioned to accomplish this responsibility. To that end, the HPG recruited members who work in or otherwise represent HIV prevention activities, RW Parts A-D services, HIV community organizations/RWPB sub-recipients, CMHD representatives, and most importantly, PLWH. The input and activities of these and all HPG members, informed in part by their community and professional networks, are detailed in the next section below.

e. Community Assessments and Surveys: At the request of the Division, HPCP conducted two needs assessments of training needs for state-funded agencies providing HIV-related services. This data assists in planning statewide capacity building trainings, making sure that course offerings match the training needs of providers. The two waves of the survey in 2017 and 2020 garnered a total of 90 provider/provider agency responses. The methods and results of the two needs assessments are discussed in Section III.

   The other major survey conducted during this period was around RWPB priority setting. Regional grantees were contacted in November 2019 to plan in-person priority setting sessions in their respective regions. With their support, a schedule of in-person priority setting sessions was developed and planned to take place across Pa. from April through early fall of 2020. Community-based locations were suggested by Regional Grantees because of their accessibility and comfort for participants in the region. Proposed local priority setting sessions were designed to include discussion of the priority setting process, explanation of how participant data is used, a presentation on definitions of all services, participant ranking (on paper, with staff assistance as needed), an open forum for concerns, and feedback on the process.

   As the COVID-19 pandemic spread through Pa., local priority sessions were replaced with an online Qualtrics survey. Survey language was approved by the Pa. DOH, and the survey was assigned an official survey number. The online survey remained anonymous, but demographic data was collected from participants. The survey was available in both English and Spanish. To allow for greater access to the survey, regional grantees, providers, and the HPCP were all able to accommodate participants requests for a paper copy of all materials to be mailed to them.

   A flyer with a URL link was shared on social media platforms, and survey information was distributed through HPCP email contacts, with the request that recipients share with their networks. After two survey rounds of collecting priority setting responses (October to November 2020 and May through November 2021) a total of 148 responses were collected during both iterations of the survey.

### B. Role of the RWHAP Part A Planning Council

This element is not required for state-only plans.

### C. Role of Planning Bodies and Other Entities

1. Summary of HPG membership, structure, and activities: The HPG is charged with representing the many diverse voices and communities impacted by HIV in Pa. They facilitate robust and representative planning, monitoring, and evaluation for the IHPCP and other HIV-related needs/issues throughout the jurisdiction. Through this planning period, the HPG has been comprised of a range of between 16 and 32 community members as well as 18 non-voting planning partner positions. Key community member demographic data can be found below. To reflect the epidemic, the HPG also tracks age and regional geographic affiliation; 2019 pre-pandemic group membership was 50 percent under the age of 39, seven percent of the members identified as transgender, and members proportionally represented Pa.'s geographic regions (southwest, northwest, north central, south central, northeast, and the southeast/Philadelphia region.). Additionally, a slight majority (~55 percent) of members lived in either rural or urban settings as opposed to suburbs or small-medium size cities.

   The COVID-19 pandemic hampered both 2021 and 2022 HPG recruitment and membership efforts in line with the disproportionate impacts that the crisis has had on marginalized communities in Pa. and nationwide. Many of the same communities hit hardest by COVID-19 are the same ones at risk and most often impacted by HIV. Despite adapting outreach and recruitment efforts, this significant overlap outweighed recruitment efforts from its onset through 2022.

**Figure 1: HPG Membership Race and Ethnicity**

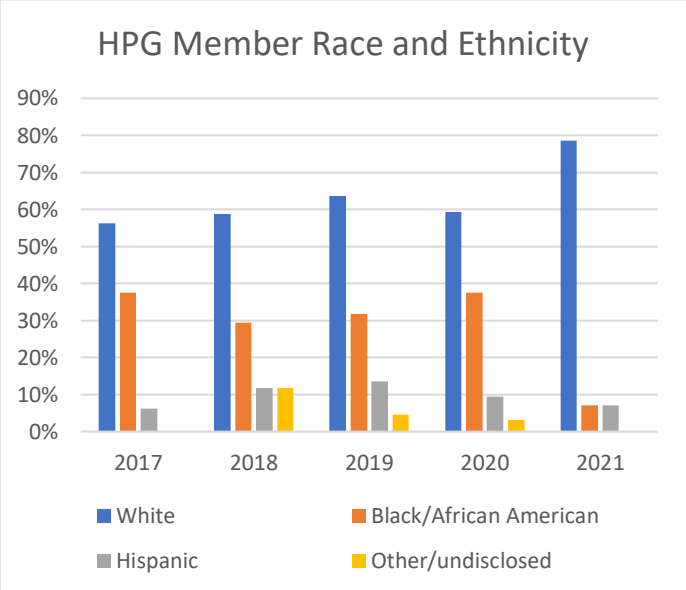
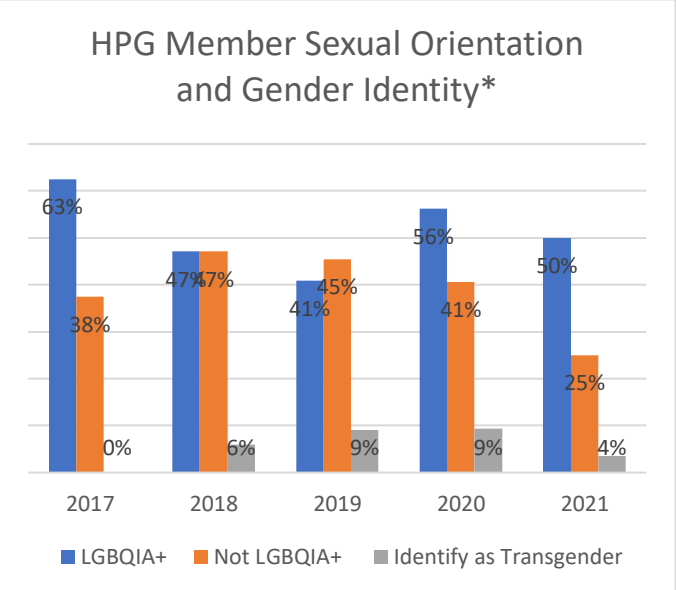


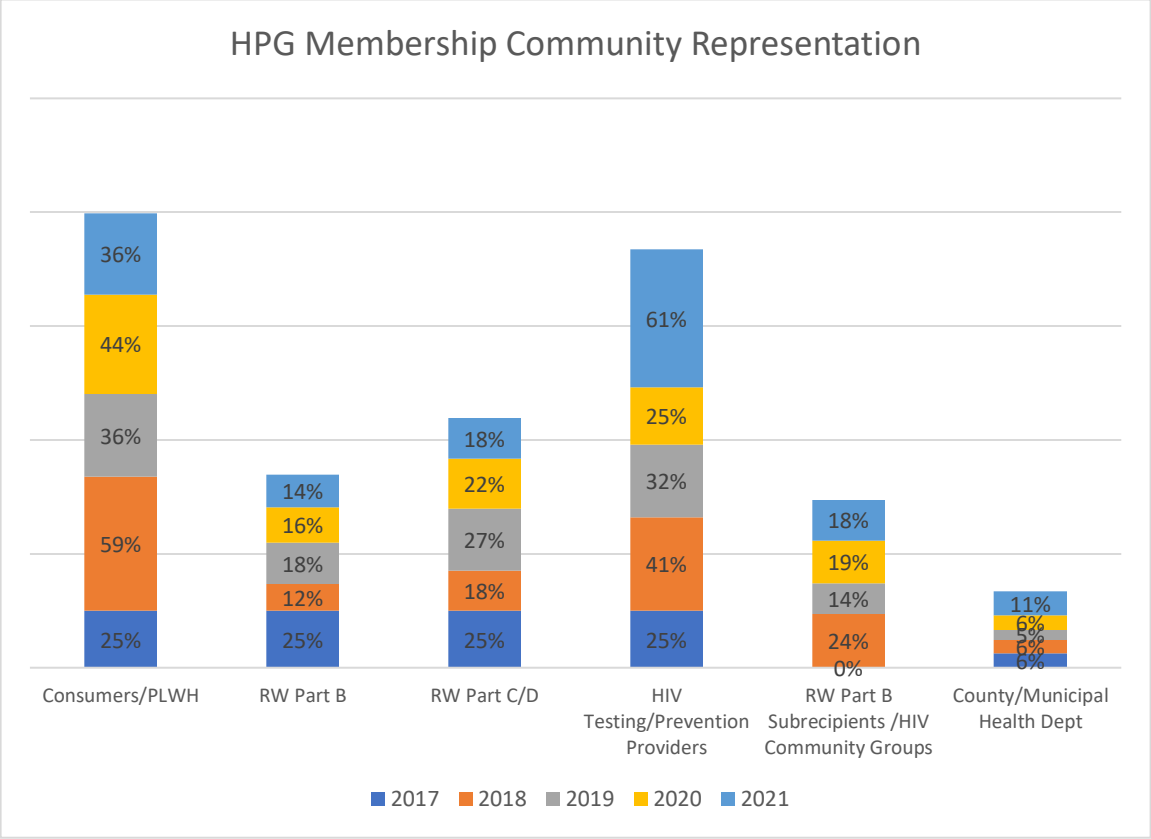

**Figure 2: HPG Member Sexual Orientation & Gender ID**




*Race, ethnicity, sexual orientation, and gender identity are voluntarily self-reported, and some members choose not to share some or all of this information. Neither race and ethnicity, nor sexual orientation and gender identity are

interchangable/equivilent aspects of identity, and are represented together in these charts only to more succinctly highlight the HPG's recruitment of minority communities who have been disproportionately impacted by HIV.

**Figure 3: HPG Community Representation**




Note: Each HPG Member may denote up to *two* representative communities

A unique element of Pa.'s HPG membership is the role of Planning Partners. These nonvoting members represent agencies whose work overlaps or offers synchronism with Pa. communities impacted by HIV. These Planning Partners include[1]: DOH STD Program; DOH Tuberculosis (TB) Program; DOH Viral Hepatitis Program; DOH HIV Epidemiology; DOH Office of Health Equity; Housing Opportunities for People With AIDS (HOPWA); MAAETC; Pa Office of Medical Assistance Programs (Medicaid); Office of Mental Health and Substance Abuse Services (OMHSAS); Pa. Association of FQHCs; Pa. Department of Drug & Alcohol Programs (DDAP); Pa. Department of Education; Pa. Department of Corrections; Pa. Department of Aging (PDA); Philadelphia Dept. of Health (Philadelphia RW Part A HRSA Grantee); Philadelphia Office of HIV Planning; Special Pharmaceutical Benefits Program (SPBP) Advisory Council; and a statewide agency representing people with disabilities[2]. As discussed further in this section, many of these partner agencies have worked with the full HPG and the Division (above and

[1] The HPG has also pre-approved a slot for a statewide "AIDS Free Pa" representative should such an entity be created in the future.
[2] As of time of publication, no agency is assigned to or currently filling this slot.

beyond their roles in HPG operations and advisement) in investigating and addressing specific intersectional issues between their agencies' service communities and communities impacted by HIV.

The roles of the HPG are threefold. The HPG is tasked by the Division, in line with federal guidance, to evaluate and monitor the previous IHPCP for progress and provide input for updates, assess the current status of the epidemic in Pa. for ongoing and emerging needs or issues, and provide feedback and perspectives, as guidance for consideration by the Division. The HPG accomplishes these three objectives—which all tie into the maintenance of the previous IHPCP and the development of the new IHPCP—through its Evaluation subcommittee, Assessment subcommittee, and two intersectional HIV ad hoc workgroups. For more information about the Pa. HPG, including its membership composition goals and mission, please visit https://stophiv.com/hpg-documents/.

2. Evaluation Subcommittee recommendations: The Evaluation subcommittee (comprised of both community and planning HPG members) met during every HPG meeting from 2017 – 2022 (an average of eight meeting days a year, even during the pandemic) to review progress on the then current IHPCP's activities. In 2017, the subcommittee developed and approved a standardized reporting sheet that all responsible parties for any activity in the IHPCP used to report their progress in meeting the goals or targets of the specific activity in question. Once the subcommittee selected an activity or series of related activities for review, they submitted a request for information and reporting from the DOH or the other responsible parties for said activity(s). They would then receive reports and/or presentations at the next subcommittee meeting, where the members reviewed the report(s) and any other related data, and then crafted findings or recommendations. This process then repeated with new selected activities or clusters of related activities. Pa.'s 2017-2021 IHPCP had 42 activities; several were reviewed by this group more than once based on initial findings, further updates, or concerns about progress. In 2019 the Division accepted and included 23 of the subcommittee's recommendations into the 2017-2021 IHPCP. The subcommittee has summarized their remaining and further recommendations since 2019 into the following categories:
    - Support existing programs:
        - Partnership/support for Department of Education training and technical assistance for school-based HIV/STD prevention
        - Latinx and Spanish language outreach, plus any emerging popular languages in Pa for HIV/Hepatitis C Virus (HCV)/Sexually Transmitted Infections (STI) information
        - Best practices around HIV opt-out language
        - Add state/local corrections as responsible parties
    - Increase provider, subrecipient, and community groups' capacity
        - Explore developing statewide medical case management trainings
        - Develop capacity around clinical/insurance coding for HIV tests

    - Assess what non-conventional locations might benefit from HIV testing
    - Assess knowledge & awareness of PrEP from DDAP providers
    - Increase the number of DDAP providers who can provide PrEP referrals
    - Add anti-racism lens to trainings
    - Consider offering organizational equity assessments, either as a part of or in addition to trainings
    - Encourage holding organizations accountable for testing and other measurable results
- Improve DOH definitions
    - Define Target Audiences for trainings and RW Capacity Building (CB)
    - Incorporate education around limitations of PrEP
    - Identify reason(s) why insurance premium payments require a contract in place
    - Clarify epidemiologic data to better reflect health disparities impacting black/Latinx communities
    - Improve data collection for accurate activity evaluations
    - Can CD4 count be a measurement for retention in care?
    - Look into offering Continuing Education Credits (CECs) as a way to increase training attendance
- Improve community outreach
    - HPCP should continue to develop new methods for informing stakeholders about its resources & outreach
    - Explore expanding outreach/support to collaborate with county-level health departments
    - Engage faith-based community organizations around HIV testing, and develop a survey or other methods for outreach to black churches specifically
    - Ensure Division website is accessible and user-friendly
    - Revamp list of available testing locations in Pennsylvania
    - Include all local and county Health Departments when sending out Health Alerts
    - Utilize HPG as an advocacy group when needed to advance policy-related activities
    - Increase outreach by Division for routine testing by medical providers
    - Include community voices in development of community projects
    - Develop outreach to organizations doing syringe work
- Support Innovative Pilot programs/interventions
    - Examine/pilot methods for identifying repeat testers
    - Consider non-conventional HIV testing locations and/or outreach
    - Support the PLWH employment workgroup
    - Develop an action plan for improving syringe access and services for PWID populations (so that the department and its partners are prepared should decriminalization of syringe services occur)

3. Assessment subcommittee findings/recommendations: The Assessment subcommittee is also comprised of both HPG community members and planning partners. This group had two primary roles. The subcommittee investigated emerging issues in the state related to HIV, including intersectional issues where HIV overlapped with Planning Partners' priorities and communities. It also reviewed, finalized, and presented to the HPG for final voting, all HPG recommendations leading up to the 2019 revision to the IHPCP.

   Intersectional HIV work for HPG ran from 2017 through 2021. During that time, the HPG and all members of the Assessment subcommittee identified and investigated issues impacting the HIV Care Continuum. Examples of topics proposed by HPG members during this period included: Aging; Cluster Detection (Data monitoring); Disabilities; Racial Disparities; Corrections; DDAP; Education; Injection Drug Use (IDU), Viral Hepatitis; Mental Health; Rural health and FQHCs; STI, TB, and COVID-19. Topics also chosen and researched by the HPG included housing for PLWH (HOPWA), racial health disparities (Pa Office of Health Equity), transportation for PLWH (regional grantees), Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, plus (LGBTQIA+) stigma (HPCP, 2017), HIV-related stigma (HPCP, 2020-22) and COVID-19's impact on PLWH. Some of this work, including partner presentations, was conducted with the full HPG, but the Assessment subcommittee continued and refined the conversations and crafted the specific recommendations with the HPG planning partners and regional grantees. The cumulative subcommittee recommendations that came from this intersectional work are: set goals or secondary goals/measures related to improving HIV-related comorbidities (for example, STIs, Hep C, cancers, syphilis, etc.); support transportation options/funding for PLWH and/or novel communications mechanisms for PLWH (like telehealth); more explicitly incorporate racial health disparities awareness into planning and outcomes as well as improve the emphasis on racism and racial disparities in one or more required state trainings; measure and reduce HIV-related stigma in multiple communities across Pa.; establish a comprehensive system to help case managers, PLWH or others, identify and utilize all housing opportunities PLWH may also qualify for. These recommendations are also included in the summary table in subsection F below.

   The Assessment subcommittee was also responsible for reviewing, finalizing, and presenting to the HPG for final voting all HPG recommendations leading up to the 2019 revision to the IHPCP. From 2017 through 2019, the Assessment subcommittee recommended, and the HPG completed: improving/expanding stakeholder engagement (2017, completed 2019); supporting programs/interventions to reduce LGBTQIA+ stigma (2017-2018, completed 2018-2019); and establishing an HPG ad hoc Employment workgroup to further investigate and support employment opportunities for PLWH (proposed and enacted in 2019).

4. Ad hoc workgroups: Employment & Clinical Quality Management (CQM): Since its formation in September of 2019, the Employment Working Group has met regularly. For this IHPCP the Employment workgroup has recommended:

- Increase capacity and implementation of vocational development and employment services and evaluation of these services on HIV health and prevention outcomes
    - Identify the employment needs of people living with or with greater vulnerability to HIV in Pa.
    - Increase involvement and collaboration with the Pa. Department of Labor and other chronic illness/ disability rights groups addressing employment needs to inform planning, implementation, and evaluation of vocational development and employment services
    - Provide training to case managers, HIV service providers, and Department of Labor staff

The HPG adopted this recommendation at the November 2021 meeting. Following this decision, the Employment Working Group is gathering necessary data to measure this activity including assessing employment needs of PLWH in the Northeast region through surveys distributed at the Wright Center in Scranton, collaboration with Pa. State Office of Vocational Rehabilitation to offer Skill-up information to case managers and other staff at the Wright Center and seeking external funding to meet these goals and gather more information.

The CQM workgroup is a key component of the HPG as well. As part of integrated federal guidance for HIV Planning, HRSA requires a RWPB CQM plan to have an oversight body that is comprised of a broad array of representation reflective of HIV service providers, related partners, and PLWH receiving services. This oversight body guides the CQM team's efforts and makes recommendations based on the analysis of CQM data results for identified goals. In Pa., the HPG voted to assume this role and incorporated the CQM process into its operations, thereby providing the federally required oversight with the required representation. This ensures an accurate reflection of the diversity of communities impacted by HIV in Pa., while also keeping the statewide planning advisory group fully informed of the CQM activities and outcomes for their use in their role as a statewide advisory group to the Division.

The Division and HPG are aware that not all RWPB services are utilized to their maximum potential in all regions of the state. To address this issue, the CQM workgroup utilizes a wide array of available data sets such as service utilization data and the Priority Setting activity results (discussed in both subsections A and E). The CQM workgroup operates to viably track improvement progress, update the HPG on service needs and improvements, and provide valuable input to the Division on its overall efforts and outcomes. For 2021 (prior to the completion of the Priority Setting process), the CQM workgroup has identified and focused on improving viral load and suppression numbers for clients receiving case management.

### D. Collaboration with RWHAP Parts

RW Parts A-F and their subrecipients are important partners in the HIV Planning process. From 2017-2022, these RW Parts A-F and their representatives have been integrally involved as HPG

community members or Planning Partners, as responsible parties in the 2017-2021 IHPCP, and as members of the HPG's CQM workgroup.

1. On the HPG: As noted in the HPG membership section and graphs above, the HPG strives to represent all impacted stakeholders. RWPB (i.e., regional grantees), as well as RW Parts A, C and D organizations, are encouraged to have representatives/employees apply to serve as community members on the HPG. In this way, their perspectives and contributions are reflected in all the HPG stakeholder engagement narratives outlined above. Additionally, the MAAETC is a RW Part F recipient and is based in Pa. This organization serves as a permanent Planning Partner member, consistently offering valuable perspectives and resources to the HPG with both its Pittsburgh and Philadelphia staff.

2. In the IHPCP: RW Parts A-F are also key contributors to the planning process as named responsible parties in many aspects of the 2017-2021 IHPCP. As such, the organizations have, at the HPG's request, offered numerous reports over the year to the Evaluation subcommittee, as well as providing data that the Division has presented on their behalf. In the Revised 2017-2021 IHPCP, RW Parts A-F are cumulatively listed as collaborative partners for eight of the 42 activities.

3. With the CQM: RW Parts' A-F members have been extended special invitation to participate in the HPG's ad hoc CQM workgroup, given the outsized role such organizations play in clinical care for PLWH. Accordingly, this workgroup also includes RW Part A-F representatives who are not HPG members. 81 percent of the 2021 CQM group represent a RW Part A-F.

### E. Engagement of people living with HIV

Finally, the most critical stakeholders included in HIV Planning are PLWH. Subsections A-C above outline the many ways that PLWH are the primary voices engaged in HIV Planning processes. For example, PLWH are the primary community members recruited for HPG membership, and (except for the pandemic-impacted recruitment of 2021) have the greatest representation on the HPG. Additionally, the Priority Setting survey process and COVID Listening Posts for PLWH (outlined in subsection A) are two recent examples of the active engagement posture of the HPG and Division; even in the face of an unprecedented pandemic lockdown, digital survey methodologies and digital community meeting rooms were used to foster feedback and preserve outreach to our communities. These examples are all parts (adapted for the pandemic) of the larger comprehensive Stakeholder Engagement Plan the HPG approved in 2017 and reviews annually to ensure that PLWH are always at the forefront of HIV Planning in Pa.

No activity better exemplifies the overlapping ways community and PLWH voices are included in these processes than the HPG's Priority Setting Process. HRSA requires a Priority Setting activity for RWPB services to be completed to help inform the Division's Care section's

allocation process for the distribution of funds for RWPB services. This activity is to include input from recipients of RWPB services—that is, PLWH—and from the HPG regarding the specific needs identified in Pa.

To complete the 2020-21 Priority Setting process, the HPG approved the planning for the Priority Setting survey process described in subsection A to engage PLWH and record their priorities for services. Additionally, over the course of a year of meetings the HPG reviewed a full range of Priority Setting applicable data on RWPB services, including utilization data, specific program requirements, linkage to care data, etc. so as to be fully informed about RWPB services and how and where they are used in Pa. Leading up to the November 2021 HPG meeting, members were encouraged to review all data presentations and accompanying documents, including the definitions of services, and cast a preliminary vote to develop a starting point for group discussion. HPG members discussed the results of their preliminary votes, paying special attention to places where they were surprised, and making cases for their individual priorities. After one clarifying round of discussion, HPG members conducted another round of live voting, followed by another clarifying discussion period and a final round of voting.

HPG members were then presented with their weighted priorities as well as their priorities based on number of votes. The HPG agreed to adopt the priorities as decided by the overall number of votes per priority because of the skew of a weighted vote. By choosing this option, the priorities captured more general agreement, as some of the highest priorities in a weighted vote only had a few HPG members in support of them. The HPG further agreed that the top 10 priorities should be ranked, with all others counting equally as a second tier. HPG members reached this conclusion in part because the Division explained that in Pa., as a result of rebates generated through SPBP drug purchases, there is enough available funding for all allowable services-meaning that none of the lower ranked services would go without funding. The HPG's finalized top priorities are: 1. SPBP (aka Pa.'s AIDS Drug Assistance Program (ADAP)); 2. Housing; 3. Medical Case Management (MCM); 4. Early Intervention Services (EIS); 5. Outpatient/Ambulatory Care; 6. Emergency Financial Assistance (EFA); 7. Health Insurance Premiums; 8. Outreach Services; 9. Home and Community Based Health Services (HCBHS); 10. Oral Health Care.

These most prioritized services represent the HPG's metrics including utilization, impact on the HIV Care Continuum, and how consumers experience and are impacted by said services. This prioritization guides not only IHPCP priorities but also impacts the CQM improvement and monitoring process as well. That is, the Priority Setting process assist in directing the activities/goals of the IHPCP workplan and informing the focus of how funds and initiatives are allocated in the Division Care section for RWPB services. It also works in tandem with RWPB service utilization data to help that workgroup identify which services in the CQM plan would be best to assess, monitor, and improve in addition to the required services enumerated through HRSA's processes (should they differ).

## F. Priorities

The following list was generated by the HPG as a result of the subcommittees fulfilling their roles, and then reinforced by the priority setting process. The following recommendations carefully consider the outcomes from the previous IHPCP, in relation to the priorities identified through the priority setting process, and the representation brought to the process by the Townhall participants, partnering DOH agencies and programs, Division data, and members of the HPG. The following recommendations were submitted to the Division for consideration in the development of the 2022-2026 IHPCP.

**Table 1: Summary of all Stakeholder Feedback and Recommendations for the IHPCP**

| Ref # | Priority/need/gap | Data source |
|---|---|---|
| 1 | Increase outreach to, and services in, underrepresented communities: African Americans, at-risk folk younger than 39, people who identify as transgender, and Latinx communities | HPG Membership and recruitment workgroup; Pa Townhall participants; Intersectional HIV Investigations (Health Equity); HPG Evaluation subcommittee; Priority Setting process |
| 2 | Increase support for/access to rural transportation and/or telehealth options for PLWH | Pa Townhall participants; PLWH COVID-19 Listening Post participants; HPG Assessment subcommittee |
| 3 | Support/fund RW Services for 1) housing 2) general HIV education | Pa Townhall participants; Intersectional HIV Investigations (HOPWA); HPG Assessment subcommittee; Priority Setting process |
| 4 | Develop new systems, services, or interventions to engage/support under-resourced/under-engaged at-risk communities: aging PLWH, people with disabilities (PWD), people recently incarcerated, and those with mental health needs | Pa Townhall participants; Intersectional HIV Investigations (Health Equity); PLWH COVID-19 Listening Post participants; HPG Evaluation subcommittee |
| 5 | Identify, measure, and reduce HIV-related stigma | Pa Townhall participants; Intersectional HIV Investigations; HPG Assessment Subcommittee |

| | | |
|---|---|---|
| 6 | Identify and address unmet needs around transportation and services supporting mental health | PLWH COVID-19 Listening Post participants; Pa Townhall participants |
| 7 | Support and engage existing partnerships such as the Dept. of Education, Dept. of Corrections, Dept. of Labor | HPG Evaluation subcommittee; HPG Employment Workgroup |
| 8 | Increase provider, subrecipient, and community groups' capacity in response to community need, including employment needs | CB training survey; HPG Evaluation subcommittee; HPG Employment Workgroup |
| 9 | Improve and clarify DOH and Division terminology/definitions | HPG Evaluation subcommittee |
| 10 | Improve community outreach | HPG Evaluation subcommittee |
| 11 | Develop/Support innovative pilot programs/interventions for groups/communities such as repeat testers, PLWH employment, PWID communities | Pa Townhall participants; HPG Evaluation subcommittee |
| 12 | Set secondary goals or measures for HIV-related comorbidities | HPG Assessment subcommittee |
| 13 | Incorporate racial health disparities into IHPCP outcomes as applicable | HPG Assessment subcommittee |
| 14 | Track and improve the emphasis on racism and racial disparities in one or more required state trainings | HPG Assessment subcommittee |
| 15 | Establish a comprehensive system to help case managers, PLWH, or others identify and utilize all housing opportunities PLWH may also qualify for | HPG Assessment subcommittee; Priority Setting process |
| 16 | Increase capacity and implementation of vocational development and employment services and evaluation of these services on HIV health and prevention outcomes through:<br>Identifying employment needs of people living with or with greater vulnerability to HIV in Pa.;<br>Increasing involvement and collaboration with the Pa. Department of Labor and other chronic illness/ disability rights groups addressing employment needs to inform planning, implementation, and evaluation of vocational development and employment services | HPG Employment Workgroup |
| 17 | Prioritize services: SPBP; Housing; MCM; EIS; Outpatient/Ambulatory Care; EFA; Health Insurance Premiums; Outreach Services; HCBS; Oral Health Care | Statewide HPG Priority Setting Process |

## G. Updates to Other Strategic Plans

This element is not applicable to this plan.

## Section III: Contributing Data Sets and Assessments

The purpose of this section is to describe and analyze available jurisdictional data demonstrating how HIV impacts Pennsylvanians. These data sets (combined with the qualitative data from Section II) also indicate services needed by individuals to access and maintain HIV prevention, care and treatment services, barriers that exist in accessing those services, and gaps in the service delivery system.

### 1. Available Data (including sharing and use)

The Division utilizes data in every aspect of the planning, implementation, monitoring, and evaluation of its work. The qualitative and quantitative data sets included in the development and implementation of this IHPCP include the comprehensive and ongoing stakeholder input from the past five years described in Section II, the quantitative data explicated below from Pa's HIV Epidemiological Profile, needs assessments, and care and prevention data sets from CAREWare, Evaluation Web, and the Pa. National Electronic Disease Surveillance System (PA-NEDSS) systems, respectively. Each of these are described in greater detail in the subsections below.

For enhanced and more efficient access to data, the Division has more recently commenced a major centralization process for CAREWare data for providers funded through RWPB. Prior to this effort, RWPB providers would have to submit monthly data file uploads to a secure site, and the data was then compiled by the Division data team. Prevention data collection has a well-established process and utilizes Evaluation Web and the PA-NEDSS data system.

The Division also recognizes the significance of not only access to data, but also the integrity of any data collected and utilized. To that end, substantial efforts and resources are dedicated to the enhancement and expansion of data collection, access, and repository capabilities, as well as ensuring the integrity of the data itself. However, it is not an undertaking without challenges, and while great strides have been made, work remains to be done to ensure optimal data access, and integrity. As systems and programmatic needs evolve and expand, it is a never-ending effort to obtain and remain efficient and effective with the data generated through and relevant to the Division.

The Division has made strides in securing access to data from other programs within the state such as the STD and TB programs, for example. However, an established data sharing agreement with the state Medicaid program has remained an unfulfilled challenge. The DOH, Bureau of Epidemiology has made several attempts to obtain Medicaid data from the Pa. Department of Human Services (DHS). A Memorandum of Understanding (MOU) for data sharing was submitted for consideration and the legal team was in communication with the DHS, however, as of the time of publication this remains outstanding.

### 2. Epidemiologic Snapshot

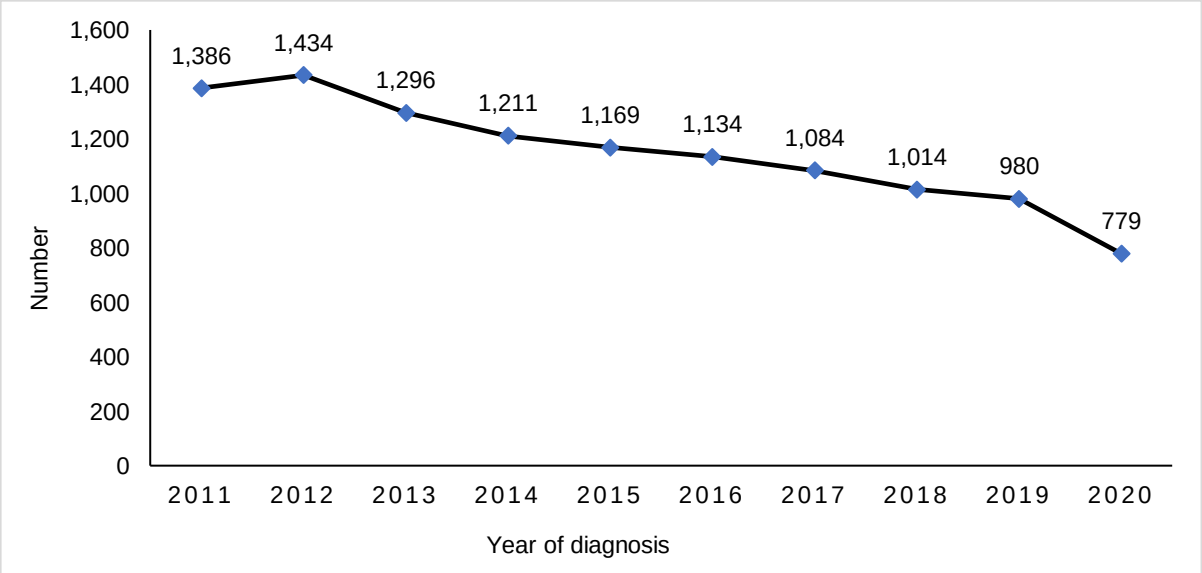
This snapshot is a summary of the most current epidemiologic profile and provides information on individuals newly diagnosed with HIV, PLWH, the HIV care continuum, and persons at risk for HIV. This information is based on available data at time of publication; however, this will be updated each

year as part of the annual IHPCP updates. For this section, the data year refers to the end of the year when the dataset was frozen. All analyses are reported up to the year 2020 except for the section on the HIV care continuum which is based on 2019 data. Data for the year 2020 should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing, care-related services, and case surveillance activities in state/local jurisdictions. As the COVID-19 pandemic is still ongoing, more time and data will further illuminate COVID-19's impact on communities and the HIV continuum in Pa.

Since the inception of the HIV epidemic through the end of the year 2020, a total of 63,204 individuals have been diagnosed with HIV in the Commonwealth of Pa. An estimated 39,909 PLWH were residing in Pa. at year-end 2020. The number of PLWH increased from 39,402 at year-end 2016 to 39,909 at year-end 2020 (Table 2). The number of PLWH continues to increase in part because more people are living longer with advances in diagnosis, linkage to care, medical treatment and pharmacotherapeutics, and increased access to, and retention in care.

On the other hand, the number of individuals newly diagnosed with HIV is declining. In 2011, 1,386 individuals were newly diagnosed compared to 779 individuals in 2020 (Figure 4). This represents a 43.8 percent decline in new diagnoses. However, the year 2020 data should be interpreted with caution because of the impact of the COVID-19 pandemic.

**Figure 4: Trend in the number of individuals newly diagnosed with HIV, 2011-2020*, Pa.**




Data source: Pa. HIV surveillance
* Count may be incomplete due to lag in reporting.

HIV affects people of different ages, sex, race, and ethnicity. However, disparities were observed in the newly diagnosed HIV rate by sex and race/ethnicity. In 2020, the rate of individuals newly diagnosed with HIV in Pa. was 6.1 per 100,000 population overall, but the rate for males (9.8 per 100,000 male population) was almost four times the rate for females (2.5 per 100,000 female population). Also, HIV

diagnosis rates were highest among black/African American males (42.7 per 100,000 black/African American male population) and black/African American females (12.6 per 100,000 black/African American female population). Among males, the rate of individuals newly diagnosed with HIV for black/African American males was ten times (42.7 per 100,000 black/African American male population) more than the rates for white men (4.3 per 100,000 white male population). Likewise, black/African American females had rates that were approximately 16 times (12.6 per 100,000 black/African American female population) that of white females (0.8 per 100,000 white female population). The overall rate of newly diagnosed HIV in blacks/African Americans (27.1 per 100,000 population) was approximately 11 times the rate for whites (2.5 per 100,000 population) and more than twice the rate (12.9 per 100,000) for Hispanics/Latinos (Table 3).

In comparing numbers of individuals newly diagnosed with HIV with the sociodemographic of the state, the HIV epidemic disproportionately impacts blacks/African Americans and Hispanics/Latinos. Blacks/African Americans accounted for almost half (378/779) of all new HIV diagnoses in the year 2020, but 12 percent of the general population of Pa. Hispanics/Latinos/Latinx accounted for 16.6 percent (129/779) of individuals newly diagnosed with HIV and 7.8 percent of the general population of Pa. Comparatively, whites accounted for 81.6 percent of the general population of Pa. and 31.2 percent (243/779) of individuals newly diagnosed with HIV in the year 2020. In total, 65.1 percent (507/779) of all individuals newly diagnosed with HIV in 2020 were among blacks/African Americans and Hispanics. While these health disparities have long been noted, greater attention needs to be placed on addressing the disparities and social determinants of health that might influence these disparities with subsequent implementation of practical interventions and prevention strategies. Therefore, concerted joint efforts by all stakeholders are necessary to end the epidemic in Pa.

Despite the decrease in the annual number of new individuals newly diagnosed with HIV, those aged 25 to 34 and MSM are at a higher risk of acquiring HIV. MSM comprised over half (52.2 percent or 407/779) of all newly diagnosed individuals in in the year 2020 and 52 percent (2,593/4,991) from the year 2016 to the year 2020. Among males, MSM accounted for 66 percent (2,593/3,890) of all new individuals diagnosed with HIV from the year 2016 to 2020 with black/African American MSM accounting for 46.2 percent (1,197/2,593) of the total number of new individuals diagnosed compared to 18.2 percent (473/2,593) for Hispanic/Latino MSM or 30.6 percent (794/2,593) for white MSM. Individuals aged 25 to 34 accounted for 36.3 percent (283/779) of new individuals diagnosed with HIV in the year 2020, and the five-year period from 2016 to 2020, individuals who were in this age group at the time of diagnosis accounted for 34.5 percent (1,724/4,991) of all new individuals diagnosed with HIV. This age group accounted for the highest proportion of individuals newly diagnosed with HIV in all transmission categories. This age group accounted for 39 percent of those newly diagnosed with HIV among MSM. Among heterosexual contact, this age group accounted for 26.8 percent, and among PWID, 49.3 percent.

The estimates for PLWH in the Commonwealth of Pa. are based on the last known address reported in the surveillance system. This method provides the best possible estimate when accounting for migration

in and out of Pa. By gender identity, a total of 28,745 (72 percent) were males, 10,714 (26.8 percent) were females and 450 (1.1 percent) identify as transgender. By race/ethnicity, individuals who identified as black/African Americans are often disproportionately impacted by HIV. A total of 18,660 (46.8 percent) PLWH at year-end 2020 were black/African Americans compared to individuals who identified as white (11,963 or 30 percent) or Hispanics/Latinos (7,147 or 17.9 percent). By current age at year-end 2020, individuals aged 45 to 64 accounted for 54 percent (21,567) PLWH at year-end 2020. A total of 5,347 (13.4 percent) PLWH were 65 years or older. Among PLWH, MSM account for the highest number of cases. A total of 16,405 (41.1 percent) of PLWH who are alive at year-end 2020 identify as MSM compared to 12,051 (30.2 percent) whose transmission mode were through heterosexual contact, 6,832 (17.1 percent) through IDU or 1,806 (4.5 percent) who were MSM and PWID. PLWH with all other modes of transmission totaled 2,798 (seven percent) (Table 2).

**Table 2: Persons living with diagnosed HIV, 2016-2020, Pa.**

| | **Year** | | | | | |
|---|---|---|---|---|---|---|
| | **2016** | **2017** | **2018** | **2019** | **2020** | |
| **Selected characteristics** | **No.** | **No.** | **No.** | **No.** | **No.** | **%** |
| **Total** | **39,402** | **39,963** | **39,832** | **39,921** | **39,909** | **100** |
| **Sex/Gender** | | | | | | |
| Female | 10,675 | 10,753 | 10,729 | 10,731 | 10,714 | 26.8 |
| Male | 28,321 | 28,779 | 28,652 | 28,737 | 28,745 | 72.0 |
| Transgender | 406 | 431 | 451 | 453 | 450 | 1.1 |
| **Age at year-end (years)** | | | | | | |
| ≤12 | - | - | - | - | - | - |
| 13-14 | - | - | - | - | - | - |
| 15-24 | 978 | 963 | 939 | 872 | 764 | 1.9 |
| 25-34 | 5,322 | 5,408 | 5,453 | 5,482 | 5,341 | 13.4 |
| 35-44 | 7,025 | 7,066 | 6,964 | 6,928 | 6,887 | 17.3 |
| 45-54 | 13,042 | 12,346 | 11,442 | 10,561 | 9,876 | 24.7 |
| 55-64 | 9,819 | 10,476 | 10,852 | 11,345 | 11,691 | 29.3 |
| ≥65 | 3,214 | 3,701 | 4,179 | 4,729 | 5,347 | 13.4 |
| **Race/ethnicity** | | | | | | |
| American Indian/Alaska Native | 47 | 50 | 51 | 50 | 54 | 0.1 |
| Asian | 321 | 331 | 346 | 352 | 363 | 0.9 |
| Black/African American | 18,453 | 18,706 | 18,623 | 18,694 | 18,660 | 46.8 |
| Hispanic/Latino[+] | 6,755 | 6,909 | 7,003 | 7,090 | 7,147 | 17.9 |
| Native Hawaiian/Other Pacific Islander | 24 | 25 | 26 | 22 | 25 | 0.1 |
| White | 12,049 | 12,176 | 12,053 | 11,997 | 11,963 | 30.0 |
| Multiple races | 1,752 | 1,765 | 1,729 | 1,715 | 1,696 | 4.2 |
| Unknown | - | - | - | - | - | - |
| **Transmission category** | | | | | | |
| Male-to-male sexual (MSM) contact | 16,144 | 16,679 | 16,752 | 16,996 | 16,405 | 41.1 |
| Injection drug use (IDU) | 7,961 | 7,844 | 7,644 | 7,488 | 6,832 | 17.1 |
| --*Male* | 5,080 | 4,980 | 4,841 | 4,723 | 4,385 | 11.0 |
| --*Female* | 2,881 | 2,864 | 2,802 | 2,764 | 2,447 | 6.1 |
| MSM and IDU | 1,944 | 1,943 | 1,913 | 1,902 | 1,806 | 4.5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Heterosexual contact | 13,247 | 13,390 | 13,421 | 13,434 | 12,051 | 30.2 |
| --*Male* | 5,448 | 5,497 | 5,490 | 5,464 | 5,069 | 12.7 |
| --*Female* | 7,799 | 7,893 | 7,931 | 7,970 | 6,982 | 17.5 |
| Pediatric mode* | 19 | 20 | 18 | 19 | 17 | 0.0 |
| Other** | x | x | x | x | 2,798 | 7.0 |

Data source: Pa. HIV surveillance

* Pediatric mode included perinatal exposure, risk not reported, no risk identified risk, and received transfusion/transplant/clotting factor.

** Other transmission category included risk not reported, no risk identified risk, and received transfusion/transplant/clotting factor in adults only.

[+] Hispanic/Latino persons can be of any race.

- Dash indicates cell size of ≤5.

**Table 3: The Number and Rate of Individuals Newly Diagnosed with HIV by Sex and Race/Ethnicity, 2020*, Pa.**

| | Sex at birth | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Female | | | Male | | | Total* | | |
| **Race/Ethnicity** | **No.** | **%** | **Rate** | **No.** | **%** | **Rate** | **No.** | **%** | **Rate** |
| AI/AN[+] | - | - | - | - | - | - | - | - | - |
| Asian | - | - | - | 7 | 1.1 | 3.1 | 7 | 0.9 | 1.5 |
| Black or African American | 91 | 56.5 | 12.6 | 287 | 46.4 | 42.7 | 378 | 48.5 | 27.1 |
| Hispanic/Latino | 26 | 16.1 | 5.3 | 103 | 16.7 | 20.3 | 129 | 16.6 | 12.9 |
| Multiple races | - | - | - | - | - | - | 17 | 2.2 | 7.8 |
| NHPI[++] | - | - | - | - | - | - | - | - | - |
| White | 41 | 25.5 | 0.8 | 202 | 32.7 | 4.3 | 243 | 31.2 | 2.5 |
| Total | 161 | 100 | 2.5 | 618 | 100 | 9.8 | 779 | 100 | 6.1 |

Data source: Pa. HIV surveillance

Population by sex and race retrieved from

United States Census Bureaus (2021). State Population by Characteristics: 2010-2019.

https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html. Accessed July 20, 2021

[+]AI/AN=American Indian/Alaska Native.

[++]NHPI=Native Hawaiian and Other Pacific Islander.

Rates are per 100,000 population.

Reported numbers less than 12, as well as estimated numbers (and accompanying rates and trends) based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30 percent and are considered unreliable.

* Count may be incomplete due to lag in reporting.

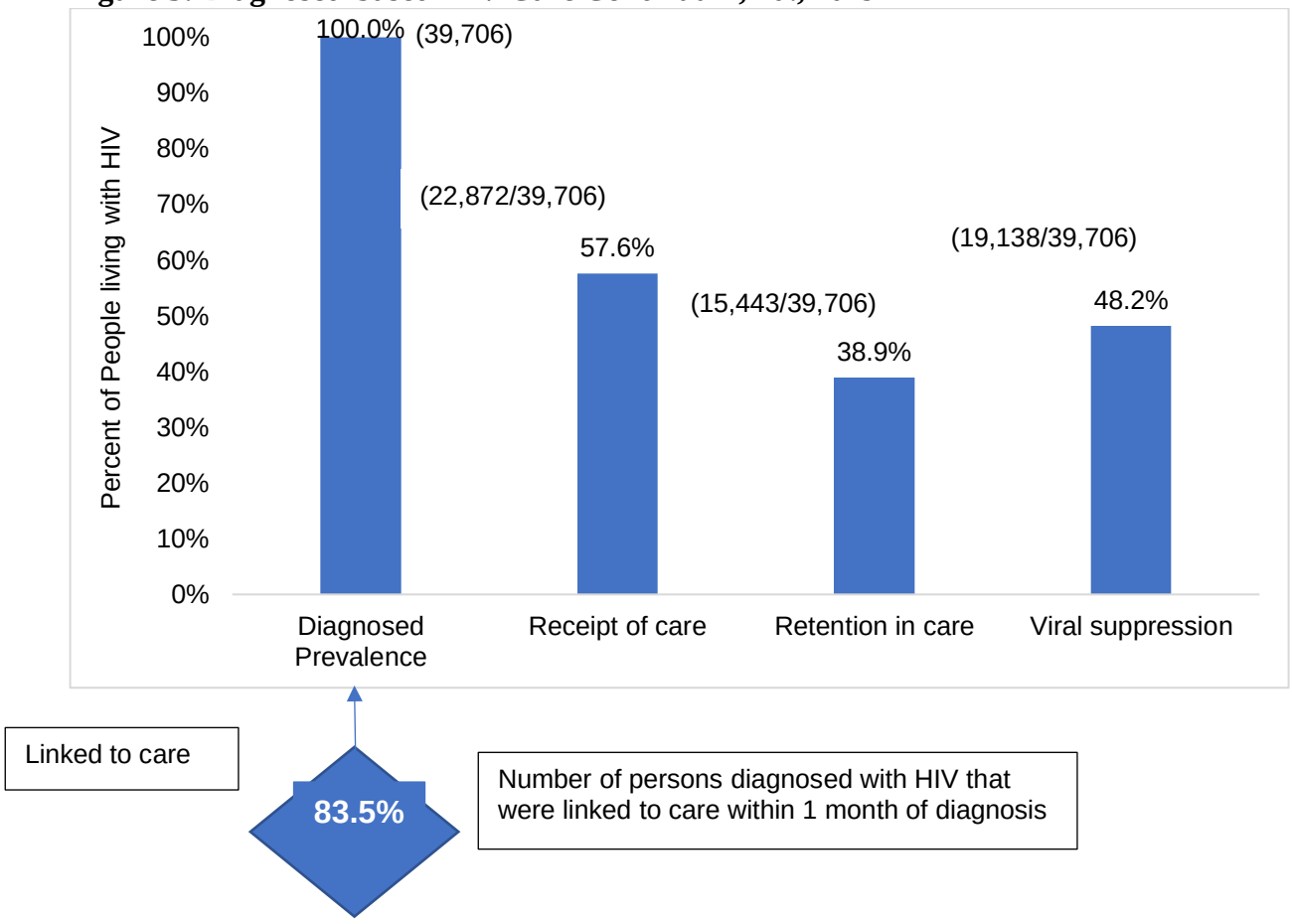
Count may be incomplete due to lag in reporting.

-Dash indicates cell size of ≤5.

DOH HIV Surveillance assessment of the HIV care continuum used data through year-end 2019 with data updated at year-end 2021. A total of 989 individuals were newly diagnosed with HIV in 2019, and 83.5 percent (826/989) were linked to care within one month after diagnosis. In the HIV care continuum, an estimated 39,706 individuals were diagnosed up to 2018 and were alive at year-end 2019 in Pa. Out of these, an estimated 57.6 percent were in receipt of care, 38.9 percent were retained in care, and 48.2 percent were virally suppressed (Figure 5). Prior to October 31, 2020, the Pa. HIV regulation required reporting of only detectable viral load (VL) tests and CD4 results that are below 200 cells/ul or 14 percent. This regulation made it less likely to receive CD4 and VL test results outside these limits. The excluded test results were necessary for assessing HIV care continuum. Therefore, the data provided for the HIV care continuum demonstrates a minimum estimate of the HIV care continuum for PLWH in Pa. during the analysis period.

The Pa. DOH started implementing HIV Cluster detection and response activities at the end of year 2018. The types of HIV clusters being monitored in Pa. are molecular cluster and Time-Space cluster. A molecular cluster is of national interest if at least five cases were diagnosed in the most recent 12-month period at a genetic distance threshold of 0.5 percent, and a time-space cluster is of interest if the number of cases is above what would be expected or there is a significant increase of cases in vulnerable populations such as PWID, women of childbearing age, homeless individuals, or individuals also concurrently diagnosed with an STD. A total of 20 HIV transmission clusters were identified between the year 2018 and the year 2021. There were eight molecular and 12 time-space clusters of interest. The Division also participated in the investigation of two CDC national molecular clusters. The locations of these clusters varied geographically in the state, and a total of 441 individuals were identified as members of these clusters. Males represented 87.5 percent of the cases. MSM was the most predominant mode of HIV transmission, accounting for 65.5 percent of the clusters. Individuals aged 25-34 years in HIV transmission cluster were 47.4 percent of the clusters and 52.6 percent identified as white.

**Figure 5: Diagnosed-based HIV Care Continuum, Pa., 2019**




Data source: Pa. HIV surveillance data
Note: Estimates were derived from using CDC's monitoring HIV care outcomes using HIV surveillance data

This assessment of the epidemiology of HIV in Pa., which is part of the comprehensive HIV epidemiologic profile, is an integral part of HIV prevention and care programs in the commonwealth.

As summarized here, it provides information to guide prevention and care activities effectively. We hope that it will assist numerous organizations in planning HIV-related programs, resource allocation for prevention and care activities, and education for PLWH, their caregivers, lawmakers, and the public. For a more comprehensive epidemiology profile of HIV in Pa., please access the Epidemiology of HIV in the Commonwealth of Pa. published annually by the DOH, Bureau of Epidemiology found at this link: https://www.health.pa.gov/topics/programs/HIV/Pages/Integrated-Epidemiologic-Profile.aspx

Organizations and agencies providing HIV care and prevention services in the jurisdiction: The following resource map has been created by HIV Surveillance and the Division to support the identification and resource mapping of all HIV providers across the state: The resource map can be found at this link: https://arcg.is/1OC8vH0 .

## 3. HIV Prevention, Care and Treatment Resource Inventory

### A. The HIV Prevention, Care, and Treatment Resource Inventory listing and description

a. HRSA (including all RWHAP parts) and CDC funding sources

| Funding type, Year | Funding detail/amount |
|---|---|
| CDC (Federal), Calendar Year (CY) 2022 | Prevention: $5,522,846<br>Surveillance: $1,016,645 |
| HRSA RWPB (federal), CY 2022 | Formula: $10,864,163<br>ADAP: $26,071,417<br>MAI: $352,538<br>EC: $272,978<br>Rebates (anticipated): $81,970,000 |
| State funding, CY 2022 | $9,638,177 |
| Pa HOPWA funding, CY 2021 | $3,163,713 |
| Philadelphia HOPWA funding, CY 2021 | $8,327,150 |
| Pittsburgh HOPWA funding, CY 2021 | $1,202,295 |

b. Leveraged public and private funding sources: The IHPCP collectively utilizes available resources in the design and implementation of a comprehensive approach to positively impact the HIV Continuum of Care for the commonwealth. As demonstrated by the relatively unique approach of the Division to utilize all RWPB ADAP and formula funds for the provision of drug formulary medications provided through the SPBP, and then utilizing the rebates generated from that service to fund all other RWPB allowable services.

   The development of options to coordinate HOPWA housing funds with RW housing resources and EIS services to enhance prevention funded activities and services, and the utilization of State Opioid Response (SOR) funding for ensuring the collaboration of prevention activities for

individuals at risk for HIV and other related health concerns are prime examples of how funds are leveraged within the Division and across other funding sources. The Division continuously seeks opportunities for collaboration with any potential resource to best maximize funds and efforts to ensure the ability to reach as broad a base and implement a cohesive approach to addressing HIV, as demonstrated by the collaboration through the SOR grant.

Finally, the purposeful inclusion of planning partners in the HPG process provides the opportunity for the leveraging of the resources represented by those respective partners. These partnerships provide intersecting opportunities for the Division to provide a focus on HIV prevention and/or care into the work of the respective planning partners. At the same time, these partners can incorporate their respective work/resources into the work of the Division and the HPG. In this way, the HPG's planning partner structure maximizes not only opportunity and diverse professional perspectives, but potential access to services and resources available through the collaborating partners as well.

This comprehensive approach to maximizing the funds/resources available, either directly or indirectly, to the Division proves to ensure a multi-pronged approach to not only "meet individuals where they are", but to make apparent the awareness of all information and supports available to them in the effort to remain HIV free or obtain and sustain viral suppression.

c. Jurisdictional strategy for coordinating substance use prevention and treatment services with HIV prevention and care services: Activities that contribute to the identification of PLWH include coordinating with HIV prevention and testing sites to connect with newly diagnosed individuals, accepting referrals from the emergency room and inpatient units for at-risk individuals, and identifying individuals who may have been previously engaged but are lost-to-care. Outreach workers often represent the communities they serve and can conduct culturally appropriate outreach and health education services to individuals in need. Several organizations focus on reaching priority populations, including adolescents, PWID, and those who have experienced incarceration. Service providers are required to obtain documentation for each individual's participation in care. Case management and referrals to other support services can help to alleviate individual and systemic barriers to care that contribute to rates of unmet need.

Status neutral navigation and linkage program is a case-management style intervention based on best practices that acts as a referral source for individuals at risk for, or currently living with HIV to prevention and care services.

Core services are available throughout the state service delivery system. The RWPB regional structure is designed to ensure access to the most needed services within each region of the state, making service need a primary determining factor. The established regional structure provides the necessary flexibility to adapt to identified emerging populations and focus on pressing needs based on local needs assessment processes, particularly PWID. It allows for the development of

relationships between funders and providers, and providers to providers, at a more localized level in the coordination and collaboration of services and funding streams, resulting in a more concerted response and tailored to the regional needs. The funded services are intended to reduce the impact of life conditions that can impede or adversely impact access to medical care and treatment adherence, such as unstable housing, lack of transportation, and psychosocial support.

Funding for specialized media campaigns is also being utilized in specific areas focusing on targeted populations. The campaigns are being developed and implemented to raise both awareness to the need, as well as how to access the resources to assist individuals to remain HIV free.

Finally, HIV and viral hepatitis coinfection are considered a public health crisis and has been exacerbated by the opioid epidemic. The CDC has determined that at least three counties in the state of Pa. (Luzerne, Cambria, and Crawford) are at high risk for an HIV outbreak as a direct result of the opioid crisis. Similarly, thirteen counties contain Hepatitis C hotspots, and ten (mostly the same) counties contain overdose death hotspots according to the 2019 PADOH In-State Vulnerability Assessment. In response, the Division is partnering with the SOR Grant project. SOR is the Pa. DOH Bureau of Epidemiology and the Pa. DDAP project for the integration of Hepatitis/HIV and substance use disorder treatment. The development of this program is to aid addiction treatment providers in the ability to integrate HIV/viral hepatitis services within current program infrastructures and sustain capacity over time. The project goal is to increase awareness of, and expand access to HIV and viral hepatitis testing, and provide education and prevention services in facilities treating persons with substance use disorder.

d. Describe how services will maximize the quality of health and support services available to people at-risk for or living with HIV: Various mechanisms are enumerated above for ensuring clinical quality, supportive services, and feedback techniques regarding those services and experiences. Many of these are built into the HPG, including the CQM workgroup and CQM Plan, stakeholder feedback, and regular needs assessments. Other service maximization and efficiency methods include routine site visit monitoring for Participating Provider Agreements (PPA's), CMHDs and Regional grantees, the CQM Workgroup, staff reporting, and service utilization reporting.

### B. Strengths and gaps

The Commonwealth of Pa. is a large state geographically (46,000 square miles) and is also one of the most populous states in the country. Pa. has an estimated total population of just over 13 million people and is made up of 67 counties. Forty-eight (48) of its 67 counties are designated rural counties and the remaining 19 are designated urban counties; this makes Pa. a state with vast rural areas and a comparatively large rural population.

This geography and demography impact HIV services in specific ways. As a result of being a

large state with a large rural area, issues with distance from RW providers may negatively impact the provision of RWPB services. Rural areas have fewer providers and even fewer specialized providers with experience in treating HIV compared to urban areas. Additionally, only eleven of Pennsylvania's 67 counties have county or municipal health departments. This may contribute to services being siloed or under-resourced in areas without a health department.

Efforts to address and improve these challenges are in constant evolution. When a specific challenge for an individual receiving RW services is identified, efforts are made to eradicate the challenge and barriers to ensure access to services for that individual. Regardless, some persistent challenges in the most rural areas may continually resurface, such as transportation. Resolutions are not always consistent or sustained but are constantly reevaluated and addressed. The COVID-19 pandemic and resulting increased use of Tele-Health services, have positively impacted some of the unique challenges for some around access to health care providers, and transportation needs in those rural areas have been lessened. Other barriers such as stigma and discrimination remain in many of these areas, however, and the Division and its partners continue to develop and support efforts to address these as well, including in this IHPCP.

HIV Prevention data is also used to address gaps in high impact prevention services including testing, partner services (PS), and linkage to HIV medical care. HIV testing data through Evaluation Web, specific to publicly funded testing providers, is also used to consider effective engagement of priority populations to assure that the individuals who most need to be tested for HIV are being effectively engaged. PS activities are analyzed to assure that individuals who are newly identified as living with HIV are offered all services they may need. Interviewing these individuals to elicit partners is a priority for the department. Linking individuals who are newly identified as living with HIV to care within 30 days of their initial diagnosis is also a priority. Review of PS data to make sure these activities are being completed within an appropriate timeframe helps us to know whether we need to address gaps in certain areas of the commonwealth. Additionally, the review of HIV surveillance data helps in the identification and response to potential time space and molecular clusters, in order to prevent the continued spread of HIV in a geographic area of concern.

While strengths are continually evaluated and assessments for improvement are ongoing, known areas for improvement as indicated by data and assessments in this section include:

- Technical Assistance (TA) for field staff,
- TA for CMHDs,
- TA on the Department's Cluster Detection and Response Plan.
- Increase awareness and uptake of PrEP among priority populations including Women (specifically black/African American women) and black and Hispanic MSM.
- Improve testing/PrEP use in rural areas
- Routinize testing in private providers/emergency departments/urgent care sites

### C. Approaches and partnerships

This inventory and the Division take a data driven approach to resource allocation and utilization. In compiling this inventory, the Division has relied primarily on the many qualitative and quantitative data sources identified above, on staff and partner expertise such as from CMHDs, Regional Grantees, and on the assistance of the HPCP at the University of Pittsburgh. Note, that the data sets used here also include those previously described in Section II, which help inform needs, priorities, and areas for improvement. New resource inventory partners include the SOR grant partners in the DOH, Drug and Alcohol Single County Authorities (SCAs), and ongoing communications and collaboration with Philadelphia as a RW Part A recipient, United States Department of Housing and Urban Development (HUD) as the federal funder of the HOPWA program, Medicaid, and other partners represented on the HPG.

## 4. Needs Assessment

As noted in Section II A, the Division had two needs assessments conducted during this planning period for key stakeholder groups. The results of both assessments are described in this section, informing work such as the Strengths and Gaps narrative above. For complete details of the methods and inclusionary criteria for these assessments, please see Section II 1:A.

1. Services people need to access HIV testing, including status neutral services needed after testing:
    - Pennsylvania Expanded HIV Testing Initiative (PEHTI): works to expand resources and training to/for entities that work with populations at risk for HIV.
    - HIV Self-Test (HST): This program has demonstrated success in reaching populations who may not have access to HIV testing and other prevention services and/or who have an aversion to testing in traditional HIV testing venues.
    - Rapid linkage to Anti-Retroviral Treatment (ART) or PrEP is that "real time" response that keeps HIV treatment or prevention relevant.
    - Quickly starting ART or PrEP also links people to actual health care in real time so they are able to take control of their overall health and stay in care or remain HIV negative.
    - Other innovative approaches are utilized in the jurisdiction as well, including replication and support of projects such as Project Silk, which started out as a demonstration project with CDC funding in Pittsburgh designed to engage young African American and Latino MSM and transgender individuals into a recreation-based HIV prevention intervention. The project demonstrated success in engaging this population and positive outcomes regarding testing, linkage and re-engagement into care and has been recognized nationally. This intervention has since been replicated in two other areas of the state.

        a. Services people at-risk for HIV need to stay HIV negative:

        - SOR grant: the education and resources for providers working with a population at risk for HIV to ensure access to testing.
        - Innovative approaches through Pa.'s Early Identification of Individuals with HIV/AIDS (EIIHA) Plan address barriers to testing. These include the utilization

of data to identify needs and initiate EIIHA activities, including: the use of epidemiological data to identify priority areas for non-clinical testing activities; the use of surveillance data to drive PS; and the use of STD data to identify individuals who may be at increased risk for acquiring HIV.

- Status neutral navigation services to ensure access to PrEP, harm reduction, and periodic re-testing services as necessary.

b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis:

- Funding for specialized media campaigns is being utilized in specific areas focusing on targeted populations. The campaigns are being developed and implemented to raise both awareness to the need, as well as how to access the resources to assist individuals to remain HIV free.
- STD Data to PrEP: working in tandem with the STD program provides referrals to PrEP for individuals at increased risk for acquiring HIV due to repeated diagnosis of STDs.
- Outreach and harm reduction services to provide education and information to ensure individuals know how to keep themselves HIV free, and how to access the necessary resources to do so.
- Condom distribution: to ensure access to condoms to aid in the prevention of the spread of HIV.

2. <u>Services that PLWH need to stay in HIV care and treatment and achieve viral suppression</u>:
   - Status neutral navigation services to ensure linkage to medical services to obtain an undetectable viral load
   - MCM services to ensure access to all the necessary supports to sustain medical treatment and an undetectable viral load.
   - Innovative approaches through Pa.'s EIIHA Plan also include the utilization of data to identify needs and initiate EIIHA activities, including the use of surveillance data to drive PS and linkage/re-engagement to care activities, and use of the Divisions Data to Care (D2C) program.
   - D2C is a public health initiative that uses HIV surveillance and other data to identify PLWH lost to HIV medical care. The primary goals of D2C are to facilitate HIV care engagement for PLWH and to increase the number of PLWH who are virally suppressed.
   - The Division, through its providers, offers all RWPB funded services to ensure the ability of PLWH receiving services to achieve and sustain an undetectable viral load. All allowable RWPB services are required to be made available to individuals as needed. If an individual needs a particular service not typically available through the provider, the provider is required to assist the individual to access the service, either by connecting the individual to another provider for that service or providing it on an emergency basis.

- There is an extensive and comprehensive ADAP drug formulary offered, and a medication adherence project utilizing SPBP claims data to identify individuals at risk for a compromised medication regimen.
- Minority AIDS Initiative (MAI) funds are also received and dedicated to reaching/reengaging PLWH who identify with minority populations. The MAI program adds critical steps towards greater equity and successful engagement along the care continuum, particularly in retention and reengagement in care for black/African American communities.
- The HIV care continuum is a series of care engagement steps from the time an individual is diagnosed with HIV up to the point of successful treatment with medications, which results in viral suppression or undetectable VL. The HIV care continuum helps identify any gap(s) in medical care that can be addressed through improved medical service delivery and policy changes that will influence how the service(s) is/are delivered, with the goal of achieving optimal patient outcome.
- The root of stigma is fear. If rapid ART is provided, along with education on Undetectable=Untransmittable (U=U), that fear for their own health, and the fear they will harm a loved, one is diminished.

3. Barriers to accessing existing HIV testing including state laws and regulations and accessibility of both HIV prevention services and HIV care and treatment services.

Accessibility, both in terms of geographic proximity/transportation and barriers to entry/engagement for PLWH has consistently been identified by stakeholders as key issues hampering both testing and other HIV services. As mentioned in the Strengths and Gaps section, continuous efforts to address these issues are on-going, but resolution is not always consistent due to the varying resources available in the regions, nor is it always sustainable as due to changes in those localized resources.

Currently, one state law providing a challenge to prevention activities is in the state "contraband" law which makes conducting syringe service programs (SSPs) illegal within the commonwealth. However, there are areas of exceptions (specifically, Philadelphia and Pittsburgh), in which local governing entities have declared public health emergencies, superseding state law, and those services are being provided in those specific areas. Additionally, both the HPG and the CDC have identified statutes in Pa law that provide specific sentencing enhancements for people living with HIV; these most directly impact people who are prisoners and those engaged in sex work. It is widely accepted in medical and public health practice that such laws have the effect of increasing stigma and marginalization for PLWH, especially and disproportionally among already marginalized communities.

### A. Priorities

The HPG conducted significant work (see Section II 1: C) regarding needs within the jurisdiction. The Assessment subcommittee identified numerous barriers and opportunities to improve long-term outcomes for PLWH and communities at-risk for HIV. Their recommendations are: to set

goals or secondary goals/measures related to improving HIV-related comorbidities (for example, STDs, Hep C, cancers, syphilis, etc.); support transportation options/funding for PLWH and/or novel communications mechanisms for PLWH (like telehealth); more explicitly incorporate racial health disparities into planning and outcomes, as well as improve the emphasis on racism and racial disparities in one or more required state trainings; measure and reduce HIV-related stigma in multiple communities across Pa; establish a comprehensive system to help case managers, PLWH, or others identify and utilize all housing opportunities for which PLWH may also qualify.

The Stigma assessment is a prime example of the HPG's assessment work and contributions to this IHPCP. Reducing stigma and eliminating discrimination associated with HIV status is a key strategy in the IHPCP, and the HPG identified stigma as one of the main threats to the provision of effective HIV prevention and care in the commonwealth. In collaboration with the HPG, HPCP developed and administered a state-wide electronic survey among PLWH in Pa. to better understand experiences of intersectional stigma in health care settings and its impact on health outcomes.

Participants were recruited to complete the survey via a mailed letter by SPBP between February-May 2020. Recruitment letters specifically targeting those living in Philadelphia were distributed between September – November 2020. Individuals were eligible to complete the survey if they were clients of Pa.'s SPBP and 18 years of age or older. The anonymous, electronic survey took 20-30 minutes to complete, was available in English or Spanish, and participants were given a $20 electronic gift card as a thank you for their time.

A total of 1421 PLWH from all seven RW regions of Pa. completed the SPBP stigma survey. Average age was 51.8 years (range: 19-86 years); 15.3 percent identified as Hispanic/Latinx ethnicity. 57.0 percent of respondents were white; 23.4 percent were Black; 15.3 percent were multiracial; 1.1 percent were Asian; 0.3 percent were Native American. 76.2 percent of respondents identified as male; 22.8 percent as female; and 0.3 percent as transgender.

Participants were asked about their experiences with stigma within health care settings across five professional types. Stigma was defined in the survey as being made to feel less than or inferior, being treated negatively or poorly, and/or being treated differently than others due to characteristics or circumstances in a person's life. Participants disclosed being stigmatized at least once by various health care staff including non-HIV doctors (33 percent of participants), front desk staff (26 percent of participants), medical care team (25 percent of participants), case managers (20 percent of participants), and HIV doctors (14 percent of participants). Participants shared that they felt they were stigmatized within health care settings most often because of their HIV status, sexual orientation, race/ethnicity, and sexual behavior. When asked about the stigma that respondents expected to experience in future visits, participants felt that they were likely to be treated poorly by health care staff in the next year, most often by non-HIV doctors (11 percent

of participants), followed by medical care team (8 percent of participants), front desk staff (7 percent of participants), case managers (7 percent of participants), and HIV doctors (3 percent of participants).

When examining predictors of experienced stigma, bisexual and other-identified respondents reported higher stigma levels compared with heterosexual-identified respondents; respondents of minority race/ethnicity reported higher stigma levels compared with white, non-Latinx respondents, and; low-income participants reported higher levels of stigma compared with higher-income participants. Furthermore, stigma was found to be a significant predictor of self-reported detectable viral load and not being retained in HIV care.

Four open-text questions asked about concerns and preferences for future health care engagement, including where PLWH feel the most comfortable and least stigmatized when seeking health care. Responses were classified by broad thematic codes and recurring sub-themes. Key themes include concerns and worries about: the ability to obtain health care services and coverage for medications; the negative impact of COVID-19 on health and access to health care services; experiences and anticipation of HIV-related and intersectional stigma within health care settings; insufficient employment; the ability to travel to a health care facility, and; insufficient or unstable housing. Participants identified HIV doctors/clinics, infectious disease specialists and Primary Care Physicians (PCP)s as the provider types and settings where they feel most comfortable and least stigmatized when engaging in health care. Other characteristics of a preferred health care setting include: efficiency, privacy, HIV expertise, consistency, patient-centered care, reputation and trust.

Results from this project contribute critical insight into how stigma impacts health care experiences and health outcomes of people living with and at risk for HIV. Findings will inform the development of interventions and social marketing campaigns to reduce HIV-related stigma and improve HIV prevention and care outcomes in Pa.

Collectively, the HPG completed a priority setting assessment as well indicating prioritization based on need, consumer input, service utilization and other guiding principles outlined in HRSA and TargetHIV 2019 guidance. This process identified the SPBP, which is Pa.'s ADAP, Housing, MCM, EIS, Outpatient/Ambulatory Care, EFA, Health Insurance Premiums, Outreach Services, HCBHS, and Oral Health Care as top priorities for the Division and this IHPCP.

Additional Priorities identified through the activities of the HPG (separate from those noted in Section II):

- Reduce late diagnoses: an estimated 227 (22.9 percent) individuals newly diagnosed with HIV in 2019 were late diagnoses. (This means about 1 in 4 newly diagnosed individuals had a documentation of an AIDS-defining condition or CD4 test result of less than 200 cells/mL or CD4 percentage of total lymphocytes of less than 14 percent within 3 months of diagnosis.)

- Address unmet needs: an estimated 34 percent (13,209/38,874) of PLWH have unmet service needs
- Improve viral suppression: 17.8 percent (4,575/25,665) of PLWH were in care but not virally suppressed
- Include determinants of health: homelessness/unstable housing, stigma, transportation
- Expand non-traditional testing locations
- Continue primary activities/systems level interventions: including routine HIV testing in clinical settings, HIV testing in non-clinical settings, HST, systematic referral and linkage to PS for individuals who are newly diagnosed and their partners; referral and linkage to PS for PLWH; referral and linkage to PrEP for individuals at increased risk for HIV; timely linkage to HIV medical care, and re-engagement to HIV medical care for PLWH
- Continue testing strategies to reach individuals at increased risk for acquiring HIV and those disproportionately impacted by HIV who may be unaware of their status in non-clinical, non-traditional venues and HST
- Expansion of case management services

### B. Actions Taken

Key activities are underway by the Division to address needs and barriers identified during the needs and priority assessment processes. These include the following:

- Update the Fee-for-Service HIV Testing agreements to focus on priority populations over positivity rate
- Increase routine HIV testing in clinical settings
- Increase HST efforts to reach individuals who may not have access to, or may have an aversion to seeking HIV testing elsewhere.

Based on the data outlined in this section, the following steps will ensure that the goals of the HIV care continuum are being met:

- Reduction in barriers to access to care such as transportation, homelessness/housing, and stigma
- Expansion of HIV testing among close contacts of PLWH
- Ensuring that all PLWH have access to ART and are engaged in care
- Ensuring that those retained or engaged in care have access to services that will help alleviate other challenges that might otherwise become barriers to accessing care such as transportation, housing, and food
- Enhancement of case management services through trainings, service standards updates, and communications.

### C. Approach

This needs assessment process is the culmination of all sections and partners' efforts during the planning cycle. This has included:

a) The Division's HIV Prevention Program leading implementation of the EIIHA Plan with several major collaborators

b) The HIV Surveillance Program in the Bureau of Epidemiology documenting and reporting data regarding all PLWH
c) The HIV Care Program overseeing the RWPB initiative
d) The STD Program working with HIV Prevention to implement routine, clinical HIV testing and non-clinical HIV/Syphilis outreach
e) PEHTI at Penn State University engaging with health care providers to promote routine HIV testing and integrated HCV testing. They also collaborate on the HST initiative
f) HPCP at the University of Pittsburgh assisting with the HPG and various anti-stigma, social media, and innovative pilot initiatives. They also collaborate on the HST initiative
g) Local health departments operating STD clinics and conducting PS for individuals within their jurisdiction
h) Regional Sub-recipients administering the RWPB program in their region
i) Numerous provider agencies throughout the state serving as frontline testers and client services organizations
j) The Division receiving significant input from the HPG into evaluation and assessment activities and specific advising needs
k) Viral Hepatitis Program partnering through participation on the HPG.

## Section IV: Situational Analysis

This section summarizes the community engagement and planning processes in Section II and the data sets and assessments in Section III to provide an overview of strengths, challenges, and identified needs with respect to HIV prevention and care. This analysis lays the groundwork for the strategies and specific activities in Section V below.

### 1. Situational Analysis

To summarize the Epidemiological Snapshot, the estimated number of PLWH in Pa. at year-end 2019 was 39,921 compared to 39,832 at year end 2018. This represents a 0.2 percent increase in the number of PLWH in Pa. These numbers therefore suggest a relative stability in HIV prevalence in Pa. The data can reveal some groups to prioritize for testing or HIV services:

- All genders exhibit needs. An estimated 72 percent of PLWH in Pa. were males, 26.9 percent were females and 1.1 percent identify as transgender.
- Individuals aged 55 and above accounted for 40.2 percent of PLWH at year end 2019.
- Blacks/African Americans accounted for 46.8 percent of the PLWH.
- The predominant mode of transmission was MSM contact, accounting for 40.8 percent of acquisition among PLWH.
- PLWH (not diagnosed with AIDS) accounted for 44.6 percent (17,797/39,921) of PLWH compared to 55.4 percent (22,124/39,921) of individuals living with a diagnosis of AIDS only.
- Pa. has 19 urban counties and 48 rural counties. An estimated 86.5 percent (34,533/39,921) of all PLWH resided in the urban counties. An estimated 53.3 percent. (18,413/34,533) of those residing in the urban counties were in Philadelphia County.
- HIV prevalence rate in 2019 was 312 per 100,000 population.

The estimated number of individuals newly diagnosed in Pa. in 2018 was 1,006 compared to 989 individuals in 2019. This represents a 1.7 percent decrease in new HIV diagnoses.

- In 2019, 751 (76 percent) newly diagnosed persons were males, 227 (23 percent) were females and 11(1.1 percent) identified as transgender
- Individuals in the age group 25 to 34 accounted for the highest percentage of individuals newly diagnosed with HIV at 36.7 percent (363/989)
- Blacks/African Americans accounted for 47.3 percent (468/989) of all individuals newly diagnosed with HIV
- The predominant mode of transmission was MSM contact accounting for 52.8 percent of all individuals newly diagnosed with HIV
- The rate of new HIV diagnoses in 2019 in Pa. was 7.7 per 100,000 population
- In 2018, a total of 215 (21.4 percent) individuals were diagnosed at stage 3 (AIDS stage) of HIV compared to 227 (23 percent) individuals in 2019. This means that in both 2018 and 2019 an estimated 1 in 4 individuals newly diagnosed with HIV was made at stage 3 of the disease progression. This is the late stage of HIV which has a range of implications in the approach to

care of persons diagnosed with AIDS. Therefore, more focus should be placed on early diagnosis and linkage to HIV care of all persons diagnosed and living with HIV.

While data over a two-year period to determine the trend of HIV prevalence and number of individuals newly diagnosed in Pa. is not ideal, this data indicates a decrease in the number of new HIV diagnoses from 1,496 individuals in 2010 to 989 individuals in 2019. Also, the number of PLWH has increased from an estimated 33,963 individuals in 2010 to 39,921 individuals in 2019. Beyond these data trends, the IHPCP can summarize the qualitative and quantitative sections above to specifically speak to the stages of the care continuum and goals of the EHE:

### A. Diagnose all PLWH as early as possible

As Pa. data demonstrates that one in four newly diagnosed cases are made in the late stage of disease progression, the Division has a targeted focus to "find individuals where they are" to test and diagnose individuals to ultimately limit the progression of HIV to the greatest extent possible. Specific activities centered on increased testing in non-clinical/non-traditional sites have been implemented. This includes the expansion of HST. Efforts to identify and provide CB opportunities for both health care and non-health care providers who have recently reported identifying new individuals with a diagnosis of HIV within their respective service populations. Greater efforts for identifying individuals at risk through PS and participation in the SOR grant are enhancing efforts to address this concern.

The Division is also working to expand a more coordinated use of EIS services to maximize funding and ensure coordination of both prevention and care programmatic efforts. EIS and the provision of support services serve to engage and retain individuals who meet unmet need criteria along the continuum of care. Epidemiological data assists in identifying potential high prevalence areas for unmet need.

Additionally, funding for specialized media campaigns is being utilized in specific areas focusing on targeted populations. The campaigns are being developed and implemented to raise both awareness to the need, as well as how to access the resources to assist individuals to remain HIV free.

### B. Treat individuals with HIV rapidly and effectively to reach sustained viral suppression

The initiation of ART is paramount in the treatment of HIV to ensure optimal health for PLWH. As the suppression of the viral load ensures the inability to transmit the virus, it also minimizes the opportunity for adverse effects of the virus for PLWH. The current RWPB CQM plan, which is a subset of the larger IHPCP workplan, focuses on monitoring the efficacy of RWPB services as demonstrated by successful viral suppression rates for PLWH who are currently receiving services. The SPBP Medication Adherence program is another approach to ensuring effective treatment. The efforts of the MAI are specific to relocating individuals who identify with a minority population and have fallen from treatment. Especially working for reengagement to

services and access to medications to ensure optimal health for those who may have encountered barriers to care due to language, cultural, or other factors related to their race or ethnicity.

### C. Prevent new HIV transmissions by using proven interventions

A total of 3911 PrEP visits (including laboratory services) were supported in FY20-21 through the PPA, indicating those served were uninsured. Federal Affordable Care Act (ACA) guidance released in July 2021 directed private insurers and market plans to pay for PrEP without any deductibles, co-pays or co-insurance costs falling on the consumer. (Laboratory/medical visit related costs will still apply).

Beyond insurance and SPBP rebates, the Division seeks to directly impact HIV prevention through innovative approaches. Examples can be found in the EIIHA Plan to address barriers to testing and treatment including the utilization of data to identify needs and initiate EIIHA activities. Some examples include the use of epidemiological data to identify priority areas for non-clinical testing activities; the use of surveillance data to drive PS and linkage/re-engagement to care activities; use of our D2C program to identify individuals no longer in care and conduct outreach to re-engage them to care; and the use of STD data to identify individuals who may be at increased risk for acquiring HIV. Another approach is through the replication of innovative projects such as Project Silk, previously described in Section III, subsection 4, 1 as well as the implementation of HST and its continued expansion.

### D. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to individuals who need them

The Pa. HIV Cluster and Outbreak Detection and Response Plan (PAHCODRP) is designed to provide a strategic framework for the Pa. DOH and its partners in responding to and containing HIV transmission clusters and outbreaks.

The PAHCODRP plan is designed as a 5-phased approach with specific actions for the HIV cluster and outbreak management team. Each phase is cumulative, meaning the activities of the previous phase continue and new activities are added with the trigger of a new phase. The phases are:

- Monitoring
- Cluster/outbreak investigation/declaration
- Cluster/outbreak response
- End of cluster/outbreak declaration
- Training and evaluation

The management of clusters is executed by the HIV Cluster Investigation Team (HCIT) which is an expansion of the HIV Cluster Plan Team (HCPT). The original HCPT was expanded to include more staff, local health departments, care providers, and community-based organizations (CBOs) of the areas affected by the clusters. The composition of the HCIT members will change slightly depending on a given cluster situation and location.

Having a process in place will help facilitate rapid public health action when an outbreak or cluster is identified to quickly contain and minimize the impact. The DOH identified and investigated 11 time-space and four molecular HIV clusters in 2020-2021.

## 2. Priority Populations

As a result of the epidemiological HIV data for the commonwealth, the Division recognizes concerns for specific populations including women (specifically black/African American women), youth of color, and black and Hispanic MSM. Concerted efforts have been defined within Section V resulting in strategies and activities to better address those concerns. Continuous monitoring and evaluation of the activities and the data will either ensure progress or guide the future direction of the workplan, so progress is ultimately realized.

## Section V: 2022-2026 Goals and Objectives

This section enumerates the goals, strategies, and specific activities detailing how the jurisdiction will diagnose, treat, prevent, respond to HIV, and do so in a way that also deepens collaboration and advances health equity. To be compatible with SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) formatting, these activities include time expectations, the need, gap, or barrier they address, the responsible party(s), priority populations, data baselines and target figures, and references to the original data from Sections II and III that inform each strategy. No notable portions of other strategic plans were used to satisfy this requirement, though the Division of HIV Disease (Division) and HIV Prevention and Care Project (HPCP) did consult with Philadelphia for planning synergy.

### 1. Goals. Strategies, and Activities

All activities have a completion date of 2026 unless otherwise specified in the activity description. References to "Stakeholder Data" that are included at the end of each strategy section refer to the table of consumer and stakeholder feedback recommendations which is summarized at the end of Section II.

| **Ending the HIV Epidemic Pillar: Prevent** | | | | | |
|---|---|---|---|---|---|
| *Goal:* Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs). | | | | | |
| **#** | **Activity** | **Need/Gap/Barrier and/or Priority Population** | **Responsible Party & Partnerships** | **Data Baseline** | **Target Goals/ Outcomes** |
| **Strategy 1A: Implement Data-to-Care (D2C) approaches to reengage People Living With HIV (PLWH) into care** | | | | | |
| 1 | Identify persons with previously diagnosed HIV who are not in care. | *Gap:* All people living with HIV (PLWH) not in care/lost to care<br>*Priority:* black, Indigenous and People of Color (BIPOC) and Sexual & Gender Minorities (SGM) communities | Division;<br>*Partner*: HIV Surveillance | An estimated 105 PLWH identified as not in care by nine providers | Implement Central Output Model to engage individuals statewide in D2C<br><br>Increase # identified as not in care to include entire state |
| 2 | Provide linkage to, re-engagement in, and retention in HIV medical care services for persons with previously diagnosed HIV who are not in care. | *Gap:* All PLWH not in care/lost to care<br>*Priority Pop:* BIPOC and SGM communities | Division;<br>*Partner*: HIV Surveillance | Number of PLWH linked to care, re-engaged and/or retained in care as a result of D2C | 25% increase in number of PLWH linked to care, reengaged and/or retained in care as a result of D2C |

| | | | | | |
|---|---|---|---|---|---|
| 3 | Expand D2C process across the state to include all regional jurisdictions. | *Gap:* All PLWH not in care/lost to care<br>*Priority Pop:* BIPOC and SGM communities | Division;<br>*Partners*: County Municipal Health Departments (CMHD) | 9 (# of 2021 D2C sites) | 11 CMHD and 6 Districts |
| Strategy 1A: Data Sets informing this objective: Stakeholder Input Data # 11, 13; Epidemiological data | | | Key Disparity metrics: testing and linkage outcomes by race, ethnicity, and SGM status | | |
| **Strategy 1B: Expand status neutral capacity across the commonwealth** | | | | | |
| 4 | Develop and implement status neutral navigation and linkage services (SNNLS) that Promote Risk Reduction measures, including incorporating risk reduction into capacity building (CB). | *Need*: CB recipients<br>*Priority pop*: CB recipient agencies/trainees | Division;<br>*Partners*: HPCP, testing agencies | Completion of SNNLS<br><br>6 HPCP CB trainings, with an average of 25 per year, that include Risk Reduction | Any increase in number of partnering agencies offering SNNLS based on morbidity data |
| 5 | Equip all CMHDs to provide status neutral linkage services/interventions. | *Priority pop:* CMHDs | Division, HPCP;<br>Partner: CMHDs | 0% of 2021 CMHD staff trained in SNNLS | 100% of previous year CMDH staff |
| 6 | Develop status-neutral training, education, or guidance based on pending CDC guidance. | | Division<br>*Partners:* Centers for Disease Control & Prevention | n/a | Implement/Disseminate status-neutral training/education/guidance |

| | | | | | |
|---|---|---|---|---|---|
| | | | (CDC), Mid-Atlantic AIDS Education & Training Center (MAAETC) | | |
| Strategy 1B: Data Sets informing this objective: CB Needs Assessment survey; Epidemiological data | | | Key Disparity metrics: Linkage to Care (LtC) among marginalized communities, retention in care among marginalized communities; equitable diffusion of Risk Reduction and SNNLS trainings | | |
| **Strategy 1C: Support and expand PrEP screenings and services** | | | | | |
| 7 | Increase number of Participating Provider Agreements (PPAs) providers prescribing PrEP. | *Need/Gap:* Clinical capacity; *Priority pop:* PPA providers | Division, PPAs; *Partners*: CMHD | 48 PrEP PPA providers in 2021 | 5% increase |
| 8 | Promote and increase access to new PrEP medications as they become available. | *Need/Gap*: PrEP uptake | Division, PrEP Providers | 2879 PrEP visits supported by Division | 15% increase in number of PrEP visits supported by Division annually |
| 9 | Ensure linkage to and retention in PrEP services for clients by the CMHD's and relevant providers throughout the grant cycle. | *Need/Gap*: PrEP uptake | Division, CMHDs | 1850 PrEP linkages reported by CMHDs and relevant providers | 50% increase in PrEP linkages reported by CMHDs and relevant providers |
| 10 | Develop collaborations with Department of Drug & Alcohol Programs (DDAP) | *Gap*: DDAP providers | Division; *Partners*: Department | 30 Single county authorities | 10% in overall HIV testing in health care |

| | | | | | |
|---|---|---|---|---|---|
| | providers to expand PrEP screening to people who inject drugs (PWID). | *Priority pop:* PWID | of DDAP, DDAP providers | (SCAs) and 4 provider collaborations in 2021 | settings 15% increase in number of DDAP provider collaborations |
| 11 | Support research into expanding PrEP access and uptake among underserved populations, including women of color. | *Need/Gap:* culturally specific messaging for women esp. women of color | Division; *Partner*: HPCP | Research supported/ underway in 2022 | Report on research findings/ successes |
| Strategy 1C: Data Sets informing this objective: Stakeholder Input Data # 1, 8, 10, 11; Contract Laboratory and Provider Reporting | | | Key Disparity metrics: PrEP uptake among minority communities, SGM communities, women of color and other underserved/underutilizing groups | | |
| **Strategy 1D: Expand sexually transmitted diseases (STD) Data-to-PrEP Initiative** | | | | | |
| 12 | Enhance current use of STD Data-to-PrEP to identify clients for PrEP referrals. | *Need/Barrier*: linking repeat STD testers to PrEP; *Priority pop*: people frequenting STD testing | Division; *Partner:* Division of STD | 555 individuals or 32% of those identified through STD Data to PrEP frequency of successful program connection to PrEP in 2021 | 25% increase in individuals identified through STD Data to PrEP that are successfully linked to PrEP |

| | | | | | |
|---|---|---|---|---|---|
| Strategy 1D: Data Sets informing this objective: Epidemiological data, STD Data,<br>Stakeholder Input Data #8 | | | Key Disparity metrics: ensuring STD Data-to-PrEP is equitably implemented in marginalized communities, esp. BIPOC communities and among SGM | | |
| **Strategy 1E: Continue and enhance condom distribution** | | | | | |
| 13 | Facilitate purchase of specialty condoms with federal funding. | *Need:* specialty condoms to promote uptake | Division; *Partner*: CMHDs | 90,000 number of specialty condoms purchased in 2021 by the Division | 10 % increase |
| 14 | Continue and enhance distribution of condoms in priority/high incidence areas. | *Need*: increased condom distribution; *Priority pop*: geographic communities experiencing high HIV and/or STD incidence; communities experiencing or at risk for HIV cluster outbreaks | Division; *Partner*: CMHDs, HIV testing sites, PPAs, priority community partners | 467,950 number of condoms distributed in 2021 | 25 % increase |
| 15 | Continue and enhance distribution of condoms to priority populations. | *Need*: increased condom distribution; *Priority pop*: BIPOC communities, SGM communities, | Division; *Partner*: CMHDs, HIV testing sites, PPAs, priority community partners | Ensure 80% of condoms distributed are to | Ensure 80% of condoms distributed are |

| | | | | | |
|---|---|---|---|---|---|
| | | under-resourced groups such as people with disabilities (PWD), youth, older Pennsylvanians | | priority populations | to priority populations |
| 16 | Ensure that CMHDs maintain robust condom distribution programs to ensure the effective distribution of condoms within their individual communities across the commonwealth. | *Need:* continued CMHD condoms distribution | Division; *Partner*: CMHDs | 15,173 number of CMHDs condoms distributed in 2021 | 50 % increase |
| Strategy 1E: Data Sets informing this objective: Epidemiological data, Stakeholder Input Data #1, 4, 8 | | | Key Disparity metrics: Condom distribution among BIPOC communities, SGM, People who inject drugs (PWID), youth, and older Pennsylvanians | | |
| **Strategy 1F: Support Social Media Campaigns that advance prevention efforts** | | | | | |
| 17 | Identify campaigns for appropriate dual messaging around HIV, STD & Hepatitis C Virus (HCV). | *Barrier*: HCV comorbidity | Division; *Partner*: Division of HCV | Zero campaigns currently identified/in use | 2-3# campaigns identified/in use per year |
| 18 | Expand PrEP education campaigns across the state. | *Need:* greater PrEP uptake; *Barrier*: PrEP community awareness; *Priority pop*: communities most underutilizing PrEP—BIPOC communities, black women, and SGM | Division; *Partner*: Division of HCV | Zero campaigns currently identified/in use | 1-2 # campaigns identified/in use per year |

| | | | | | |
|---|---|---|---|---|---|
| 19 | Identify with HPCP a minimum of one other social marketing campaign opportunity related to HIV and stigma and/or other intersectional issues or social determinants. | *Need*: additional community awareness around social determinants associated with HIV risk | Division, HPCP; *Partners*: HIV Planning Group (HPG), CDC, Health Resources & Services Administration (HRSA), AIDS.gov, community partners, social media groups | One campaign promoted as of 2021 | Yearly documentation of, and engagement results from, yearly campaign(s) |
| 20 | Support regional grantee media campaigns to educate and engage regionally prioritized populations. | *Need*: additional community awareness around regional needs and HIV risks | Division, regional grantees; Partners: community groups | 3 campaigns promoted as of 2021 | Yearly documentation of, and engagement results from, yearly campaign(s) |
| Strategy 1F: Data Sets informing this objective: Surveillance/HCV data, Stakeholder Input Data #1, 3, 4, 10, 12 | | | Key Disparity metrics: the percentage of messaging engaging BIPOC, SGM and regionally prioritized communities | | |
| **Strategy 1G: Continue Post Exposure Prophylaxis (PEP) activities** | | | | | |
| 21 | Conduct a needs assessment for PEP. | *Need*: additional data around needs/gaps for PEP, including regional needs | Division | n/a | 1 successful Needs Assessment, with report to the HPG, by 2024 |

| | | | | | |
|---|---|---|---|---|---|
| | | *Priority Pop:* individuals exposed to HIV | | | |
| 22 | Develop an initiative to address gaps in the provision of PEP including capacity, education, and resources. | *Need*: additional data around needs/gaps for PEP, including regional needs and priority populations | Division; *Partners:* HPCP, MAAETC, and/or regional grantees | n/a | 1 successful intervention underway, with annal reporting to the HPG, by 2025 |
| Strategy 1G: Data Sets informing this objective: Epidemiological data Stakeholder Input Data # 1, 4, 11, | | | Key Disparity metrics: Those most at risk for not receiving or having access to PEP services, including BIPOC, SGM, aging, disability, and rural communities | | |
| **Strategy 1H: Support Perinatal Prevention Services** | | | | | |
| 23 | Conduct site and telehealth/remote visits to birthing facilities to improve the disease reporting ability of local clinicians. | *Need*: improve perinatal disease reporting | Division staff [Disease Infection Specialists (DIS)] *Partners*: hospitals and clinicians, Pa. Perinatal Quality Collaborative | 36 site visits conducted in 2021 | 100 % |
| 24 | Conduct case surveillance for people who are pregnant and diagnosed with HIV and/or syphilis, and their infants after birth. | *Need*: improve perinatal diagnosis and outcomes *Priority pop*: people who are | HIV and STD Surveillance staff *Partners*: Division, | 82 people who were pregnant | 100% |

| | | | | | |
|---|---|---|---|---|---|
| | | pregnant (pre-and post-partum) and diagnosed with HIV, and their infants | hospitals and clinicians | | |
| 25 | Conduct perinatal exposure reporting for HIV and congenital syphilis. | *Barrier*: quality of perinatal data | HIV and STD Surveillance staff<br>*Partners*: Division, hospitals and clinicians | 8 (2 HIV and 6 congenital syphilis) cases in 2021 | 100% |
| Strategy 1H: Data Sets informing this objective: Epidemiological data, Pennsylvania's (Pa.) data in the National Electronic Disease Surveillance System (PA-NEDSS) | | | Key Disparity metrics:<br>Equitable successful case surveillance among BIPOC people who are pregnant | | |
| **Ending the HIV Epidemic Pillar: Diagnose** | | | | | |
| *Goal*: Diagnose all people living with HIV as early as possible | | | | | |
| **#** | **Activity** | **Need/Gap/Barrier & Priority Population** | **Responsible Party & Partnerships** | **Data Baseline** | **Target Goals/ Outcomes** |
| **Strategy 2A: Continue and expand HIV Testing** | | | | | |
| 26 | Increase efforts to support private providers conducting HIV testing. | *Need*: increased testing among priority populations, esp. BIPOC and SGM communities and youth | Division;<br>*Partners*: testing providers, Pa. Expanded HIV Testing Initiative (PEHTI), MAAETC, HPCP | 45 private providers in 2021 | 25 % increase |

| | | | | | |
|---|---|---|---|---|---|
| 27 | Provide/facilitate capacity building for clinical testing. | *Need*: ongoing training needs for clinicians | Division, HPCP, MAAETC; PEHTI *Partners*: hospitals/ clinicians | 0 of clinicians & clinician staff trained in 2022 | 10 % increase per year |
| 28 | Identify and support health care and non-health care providers that have diagnosed individuals with HIV. | *Gap*: Providers testing and linking clients to care | Division; CMHD, *Partners*: testing providers | Identify private providers that diagnosed individuals with HIV | Conduct outreach to private providers that diagnosed individuals with HIV |
| 29 | Increase HIV testing with priority populations. | *Need/Priority pop*: increased testing among BIPOC and SGM communities and youth | Division Prevention program staff, CMHD, testing providers | 28,852 (56% of all individuals tested) | 75% of all people tested identify with priority populations |
| Strategy 2A: Data Sets informing this objective: Epidemiological data, PA-NEDSS<br>Stakeholder Input Data # 1, 8 | | | Key Disparity metrics:<br>HIV testing rates for, and provider engagement among, BIPOC, SGM and disability communities, as well as youth | | |
| **Strategy 2B: Continue Novel HIV Testing Initiatives** | | | | | |
| 30 | Continue to support efforts to identify new partners to promote routine HIV testing, including assessing feasibility of Urgent Care Centers. | *Need*: new partners for HIV testing | Division, PEHTI *Partners*: routine care centers, urgent care centers | 13 successful engagements, 2021 | 15 % increase |

| | | | | | |
|---|---|---|---|---|---|
| 31 | Assess feasibility of incorporating Viral Hepatitis testing/education with routine HIV testing. | *Need/Gap:* Hepatitis awareness & testing | *Partner*: Division of Viral Hepatitis | n/a | Feasibility report and/or pilot results |
| 32 | Continue to promote and fund HIV Self Testing (HST) activities and online promotion throughout the commonwealth, in coordination with Philadelphia's self-testing program. | *Need/Gap*: HIV testing in private or home settings<br>*Barrier*: access to testing<br>*Priority pop*: rural communities, individuals experiencing stigma | Division, HPCP, PEHTI | 1,030 HST orders placed in 2021 | 1,200 HST orders per year |
| 33 | Promote and support HIV testing in non-clinical settings, including in bars, community centers, and other priority community resources. | *Need/Gap*: HIV testing in private or home settings<br>*Barrier*: access to testing, HIV stigma<br>*Priority pop*: BIPOC, SGM, PWID, people experiencing housing instability | Division, HPCP, Participating Providers, CMHD<br>*Partners*: bars, community centers, syringe services programs (SSPs), other community resources | 4443 Tests in non-clinical settings in 2021 | 10% Increase in testing of priority populations in non-clinical settings |
| 34 | Gather baseline data on the number of HIV providers across the state who are also offering Hepatitis testing services. This info to be used to inform Activity # 34. | *Need:* Data on HCV service colocation | Division, Viral Hepatitis Division | n/a | 1 report on statewide HCV testing colocation |

| | | | | | |
|---|---|---|---|---|---|
| 35 | Increase outreach to HIV providers to provide education and technical assistance to expand on-site Hepatitis testing initiatives. | *Need:* Data on HCV comorbidity and existing services | Division, PEHTI *Partners:* Viral Hepatitis Division | n/a | 50% of HIV providers offered TA per year |
| Strategy 2B: Data Sets informing this objective: PA-NEDSS Stakeholder Input Data # 2, 5, 11 | | | Key Disparity metrics: % of BIPOC and SGM utilization of HST compared to total participants | | |
| **Strategy 2C: Continue PPAs** | | | | | |
| 36 | Assess the feasibility to add "early initiation of Anti-Retroviral Treatment (ART) and PrEP" language to the PPA to enhance efficacy among HIV testing providers. | *Gap*: requiring ART in PPAs | Division; *Partners*: Participating providers | n/a | Successfully updating and approving language |
| 37 | Continue to support and monitor PPA agreements throughout the commonwealth | *Need*: need for participating provider services *Priority pop*: participating providers engaging BIPOC and SGM communities | *Partners*: Participating providers | 47 PPAs with 0.27% overall positivity | Baseline 0.3% Target=0.4% |
| 38 | Collaborate with Division of Immunizations to enhance outreach and education for public health emergencies that impact communities impacted by HIV. | *Need: enhanced collaboration and utilization of resources to ensure optimal health* | *Partners*: Department of Health (DOH) Division of Immunizations | | Report yearly to the HPG on all coordinated efforts of outreach and education for public health emergencies |
| Strategy 2C: Data Sets informing this objective: Epidemiological data, PPA reporting, PA-NEDSS, Stakeholder Input Data # 8 | | | Key Disparity metrics: | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | participating providers engagement in BIPOC and SGM communities and/or other key populations | | |
| **Strategy 2D: Continue and enhance Partner Services (PS)** | | | | | |
| 39 | Increase partner elicitation among newly identified/diagnosed individuals with HIV. | Testing capacity gap/need; prioritizes partner notification services | Field Staff, CMHD and other HIV testing providers | 87 % of PLWH newly diagnosed in 2021 interviewed for PS | 100% of PS for PLWH, newly diagnosed offered PS |
| 40 | Increase the number of partners identified with an unknown HIV status. | *Need/priority*: key communities, esp. BIPOC and SGM communities | Field Staff, CMHD and other HIV testing providers | 198 partners elicited | 100% of named partners with unknown status referred for HIV testing |
| 41 | Refer 100% of individuals in priority populations who test positive for HIV to PS. | *Need*: connect newly diagnosed individuals to PS<br>*Priority pop*: BIPOC, youth, SGM, PWID | Field Staff, CMHD and other HIV testing providers | 87 % of PLWH, newly diagnosed in 2021 interviewed for PS | 100% of PLWH referred to PS |
| Strategy 2D: Data Sets informing this objective: Stakeholder Input Data # 1, 4, 10; PA-NEDSS | | | Key Disparity metrics: PS linkage/engagement among BIPOC, SGM, youth and PWID who test positive | | |
| **Strategy 2E: Implement State Opioid Response (SOR) Grant, HIV/Viral Hepatitis Service Integration Project** | | | | | |
| 42 | Increase awareness of, and expand access to, HIV and viral hepatitis testing, education, and prevention services in facilities treating persons with substance use disorder. | *Need*: Hepatitis C Virus (HCV)-HIV comorbidities<br>*Priority pop*: PWID | Division, Division of Viral Hepatitis | n/a | Completed SOR grant |

| | | | | | |
|---|---|---|---|---|---|
| Strategy 2E: Data Sets informing this objective: Epidemiological data, HCV incidence data, Stakeholder Input Data # 4, 11 | | | Key Disparity metrics: HIV and HCV testing and education PWID | | |
| **Ending the HIV Epidemic Pillar: Treat** | | | | | |
| *Goal*: Treat people with HIV rapidly and effectively to reach sustained viral suppression | | | | | |
| **#** | **Activity** | **Need/Gap/Barrier & Priority Population** | **Responsible Party & Partnerships** | **Data Baseline** | **Target Goals/ Outcomes** |
| **Strategy 3A: Continue and enhance the Ryan White (RW) Clinical Quality Management (CQM) Plan** | | | | | |
| 43 | Improve viral load (VL) suppression. | *Need*: improve VL suppression<br>*Priority pop*: PLWH | Division field staff, SPBP staff;<br>*Partners*: Ryan White Part B (RWPB) Grantees, RW Parts C-D, RW subrecipients | See current approved CQM plan for detailed measurements recent HIV viral load test | Baseline- 93%<br>Benchmark- 90% |
| 44 | Improve annual retention in support services. | *Need*: improve retention in care/support services<br>*Priority pop*: PLWH | Division field staff, RWPB Grantees, RW Parts C-D, RW subrecipients | See current CQM plan for detailed measurement | Baseline- 63%<br>Benchmark- 90% |
| 45 | Annual retention in core services. | *Need*: improve retention in core RW services<br>*Priority pop*: PLWH | Division field staff, medical case managers, RWPB Grantees, RW Parts C-D, | See current CQM plan for detailed measurement | Baseline- 80%<br>Benchmark- 90% |

| | | | | | |
|---|---|---|---|---|---|
| | | | RW subrecipients | | |
| 46 | Improve linkage to RWPB Services within 30 days of diagnosis. | *Need*: improve linkage to RW services<br>*Priority pop*: PLWH, esp. BIPOC communities | Division field staff, RWPB Grantees, *Partners*: RW subrecipients | See current CQM plan for detailed measurement | Baseline- 53%<br>Benchmark- 85% |
| Strategy 3A: Data Sets informing this objective: PA-NEDDS, CAREWare, Special Pharmaceutical Benefits Program (SPBP) data, Epidemiological data,<br>Stakeholder Input Data #1 | | | Key Disparity metrics:<br>Rates of linkage to care and retention in care among BIPOC and SGM | | |
| **Strategy 3B: Continue the SPBP Medication Adherence Program** | | | | | |
| 47 | Identify SPBP clients who need additional support to become adherent to HIV medication treatment regimens. | *Need:* improve adherence to medications<br>*Priority pop*: PLWH | Division staff/SPBP staff | In 2021, a six-month pilot program was conducted to identify clients that were unable to remain adherent to HIV treatment medications. | Identification of clients that are unable to remain-adherent to HIV treatment medications will be conducted at least quarterly. |

| | | | | | |
|---|---|---|---|---|---|
| 48 | Provide clinical consultation to clients and their providers to ensure optimal adherence with HIV medication treatment regimens. | *Barrier*: client medication regimen non-adherence<br>*Priority pop*: PLWH (SPBP clients) | Division staff/SPBP staff, medical case managers (MCMs);<br>*Partners:* SPBP clients | 64% of identified clients adherent to HIV treatment medications post intervention in the six-month pilot program in 2021 | 90% of identified clients adherent to HIV treatment medications post intervention |
| 49 | Increase HIV viral suppression among SPBP clients. | *Need*: increased rates of viral suppression among clients<br>*Priority pop*: PLWH (SPBP clients) | Division staff/SPBP staff, MCMs;<br>*Partners:* SPBP clients | 95% of SPBP clients with a viral load less than 200 copies/ml at the most recent HIV viral load test | 90% of SPBP clients with a viral load less than 200 copies/ml at the most recent HIV viral load test |
| Strategy 3B: Data Sets informing this objective: PA-NEDDS, CAREWare, SPBP client data | | | Key Disparity metrics: viral suppression among BIPOC SPBP clients | | |
| **Strategy 3C: Continue the Minority AIDS Initiative (MAI)** | | | | | |
| 50 | Re-Engage PLWH who are lost to care back into treatment & access to medications. | *Gap*: reengaging PLWH lost to care; | MAI Recipients | 1) 76% of BIPOC individuals | 1) 80% of individuals who received |

| | | | | | |
|---|---|---|---|---|---|
| | | *Priority pop*: BIPOC PLWH | | receiving MAI outreach services linked to medical care (i.e., attended their first medical appointment after being identified as lost-to-care/high risk) within the fiscal grant year (July 2021 – June 2022) | Encounter Outreach Services will be linked to medical care within the measurement year;<br>2) 80% of individuals who received Referral Outreach Services will keep their first medical appointment within the measurement year |
| 51 | Increase the participation numbers of BIPOC PLWH populations in AIDS Drug Assistance Program (ADAP)/SPBP and other medication assistance programs. | *Priority pop*: BIPOC PLWH | MAI Recipients; *Partners*: Regional Grantees, RW subrecipients | 48% of BIPOC clients eligible for SPBP were enrolled in SPBP within the fiscal grant year (July | [baseline data 41 desired 10% increase] |

| | | | | | |
|---|---|---|---|---|---|
| | | | | 2021 – June 2022) | |
| Strategy 3C: Data Sets informing this objective: Epidemiological data, Stakeholder Input Data # 1, 10 | | | Key Disparity metrics<br>BIPOC SPBP members reengaged and retained in care | | |
| **Strategy 3D: Support RW Regional Grantees** | | | | | |
| 52 | Develop a state RWPB Handbook. | *Need*: for internal RWPB resources | Division; *Partners*: RW Part B grantees | n/a | Completion of handbook |
| 53 | Develop Frequently Asked Questions (FAQ) for Regional Grantees. | *Need*: for internal RWPB resources | Division; *Partners*: RWPB grantees | n/a | Completion of FAQ |
| 54 | Hold Quarterly meetings with Regional Grantees. | *Need*: for internal RWPB resources | Division; *Partners*: RWPB grantees | n/a | Initiating and sustaining quarterly meetings (each year) |
| 55 | Develop and distribute a toolkit to HIV providers focused on integrating Hepatitis testing and treatment into their settings | | Bureau of Epidemiology Viral Hepatitis staff, Division staff | n/a | Completion and dissemination of toolkit |
| Strategy 3D: Data Sets informing this objective: Needs Assessments, Stakeholder Input Data # 3, 15 | | | Key Disparity metrics<br>All regions are engaged equitably | | |
| **Strategy 3E: Develop and support a Case Management (CM) Workgroup** | | | | | |
| 56 | Review the RW Program Standards annually and update as necessary. | *Need*: improved case management resources | Division, and HPG CQM Workgroup | n/a | Successfully completed annual review and update |

| | | | | | |
|---|---|---|---|---|---|
| 57 | Complete a Case Management Standards Update annually. | *Need*: improved case management resources | Division | n/a | Successfully completed annual review and update |
| Strategy 3E: Data Sets informing this objective: Needs Assessments, Stakeholder Input Data # 9 | | | Key Disparity metrics none | | |
| **Strategy 3F: Enhance the SPBP Customer Service Line (CSL)** | | | | | |
| 58 | Develop call standards for the CSL. | *Need*: to ensure consistency and efficacy in all calls addressed through the CSL | Division staff/SPBP staff | | Successfully completed set of call standards |
| Strategy 3F: Data Sets informing this objective: Needs Assessments | | | Key Disparity metrics<br>BIPOC and SGM callers/clients enrolled in SPBP | | |
| **Ending the HIV Epidemic Pillar: Respond** | | | | | |
| *Goal*: Monitor HIV incidence and respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them | | | | | |
| **#** | **Activity** | **Need/Gap/Barrier & Priority Population** | **Responsible Party & Partnerships** | **Data Baseline** | **Target Goals/ Outcomes** |
| **Strategy 4A: Maintain the Pa. Cluster Detection and Response (CDR) Plan** | | | | | |
| 59 | Initiate an Outbreak Response Plan (ORP) within 72 Hours of an outbreak declaration. | *Need*: Maintain ORP readiness<br>*Priority pop*: PLWH, people who | HIV Epidemiology, Division staff | 0 detected outbreaks as of 2021 | 95% of identified outbreaks have an ORP initiated within 72 hours of the |

| | | | | | |
|---|---|---|---|---|---|
| | | don't know their status | | | outbreak declaration |
| 60 | Enact continuous evaluation of the ORP throughout the course of a determined outbreak. | *Need*: Maintain ORP readiness *Priority pop*: PLWH, people who don't know their status | HIV Epidemiology, Division staff | 0% of disease investigation specialists who received training in CDR operations in 2022 | At least 85% of disease investigation specialists have received training in CDR operation per year |
| 61 | Conduct an overall evaluation of the activities of the ORP once a determined outbreak has been contained. | *Need*: Maintain ORP readiness | HIV Epidemiology, Division staff | N/A | 100% of outbreaks receive a documented evaluation per year |
| 62 | Develop a final report to summarize the activities of the ORP for a determined outbreak once the outbreak has been contained and evaluated. | *Need*: Maintain ORP readiness | HIV Epidemiology, Division staff | N/A | 100% of identified outbreaks have a written summary report within 6 months of being contained and closed |
| 63 | Ensure that all CMHDs have a CDR Plan as required through the HIV Prevention grant. | Maintain CDR readiness | CMHD and Division staff | n/a | Final summary reports submitted to Division |
| Strategy 4A: Data Sets informing this objective: ORP, Epidemiological monitoring | | | Key Disparity metrics: unique to each case. Monitoring will be required to ensure that no | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | correlative patterns of plan failure emerge relative to any outbreaks in marginalized communities | | |
| **Strategy 4B: Facilitate monitoring by statewide stakeholder bodies** | | | | | |
| 64 | Convene and support the HIV Planning Group to monitor and evaluate the progress of the Integrated HIV Prevention & Care Plan (IHPCP) narrative, data, and activities. | *Need*: for stakeholder oversight of HIV and IHPCP activities; *Priority pop*: PLWH and representative community stakeholders | Division, HPG, HPCP; *Partners*: Impacted communities, PLWH | The HPG held quarterly meetings throughout the past calendar year and generated a summary of recommendations for the IHPCP and assessed progress on its activities | The HPG will hold at least quarterly meetings throughout a calendar year and generate a yearly summary of recommendations for the IHPCP and an assessment of progress on its activities |
| 65 | Convene and support SPBP Advisory Council to review and update the SPBP formulary. | *Need*: for stakeholder involvement in SPBP activities; *Priority pop*: PLWH | Division and SPBP staff, SPBP Advisory Council members, regional grantees, HPCP; *Partners*: Impacted communities, providers, PLWH | New medications were reviewed and either approved or denied for inclusion in the SPBP formulary quarterly in 2021 | New medications are to be reviewed and either approved or denied for inclusion in the SPBP formulary at least quarterly per calendar year |

| | | | | | |
|---|---|---|---|---|---|
| Strategy 4B: Data Sets informing this objective: Federal guidelines, Stakeholder Input Data # 1, 10 | | | Key Disparity metrics:<br>Percentage of PLWH, BIPOC, SGM and HIV stakeholder involvement on advisory bodies | | |
| **Strategy 4C: Continue and enhance HIV Surveillance** | | | | | |
| 66 | Ensure completeness of laboratory data including CD4+ T-lymphocyte (CD4) and VL results that will be used to determine linkage to care for persons newly diagnosed with HIV. | *Need:* accurate and timely HIV lab reporting | HIV Surveillance, disease investigators | 85% of people who had one or more documented CD4 or viral load reactive tests will receive a diagnosis of HIV within 30 days (1 month) in 2021. | Per calendar year, at least 85% of people who had one or more documented CD4 or viral load reactive tests will receive a diagnosis of HIV within 30 days (1 month). |
| 67 | Maintain structural strategies to ensure data security and confidentiality in the collection, review, and use of all data managed by the DOH. | *Need:* ensuring secure data | Division and HIV Surveillance staff; *Partners*: DOH Information Technicians (IT) Staff | 100% completion of annual security and confidentiality training by all disease investigators working with PA-NEDSS data in 2021 | 100% completion of annual security and confidentiality training by all disease investigators working with PA-NEDSS data by January 1 of each reporting year |

| | | | | | |
|---|---|---|---|---|---|
| 68 | Enhance geocoding and data linkage capacity to enhance knowledge of the influence of social determinants on risk for disease and continuum of care outcomes. | *Need:* accurate and timely geocoding and data linkage | HIV Surveillance, disease investigators | 99.1% of newly diagnosed HIV and prevalence were geocoded in 2021 | At least 90% of newly diagnosed HIV and prevalence are geocoded |
| 69 | Finalize CAREWare Centralization Project for data completeness and security. | *Need:* accurate and complete HIV data and reporting | Division; *Partners*: DOH IT Staff | n/a | Data Centralization completed and reported to HPG by calendar year end 2023 |
| 70 | Ensure complete reporting of newly diagnosed individuals with HIV to the Pa DOH. | *Need:* accurate and timely HIV diagnosis reporting | HIV Surveillance, disease investigators | 100% of newly diagnosed HIV cases were reported to the Pa. DOH through conducting facilities audit in 2021 | 95% of newly diagnosed HIV cases are reported to the Pa. DOH by conducting facilities audit |
| Strategy 4C: Data Sets informing this objective: Needs Assessments | | | Key Disparity metrics:<br>n/a | | |
| **Strategy 4D: Ensure comprehensive monitoring and evaluation** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 71 | Create a data dashboard depicting HIV data relative to the Division's work. | *Need*: HIV-related data communication to inform Division planning and work | Division and HIV Surveillance staff; *Partners*: DOH IT Staff | n/a | Successful completion of dashboard |
| 72 | Create a dashboard to monitor and evaluate progress on IHPCP goals. | *Need*: HIV-related data communication and transparency | HPCP, HPG, Division | Dashboard development completed 2022, awaiting IHPCP approval | Maintain and update dashboard at least semi-annually |
| Strategy 4D: Data Sets informing this objective: Data assessment, Stakeholder Input Data # 10 | | | Key Disparity metrics: n/a | | |
| **Pa. IHPCP Pillar: Support** | | | | | |
| *Goal*: To facilitate the success of the above Pillars, and reflective of the most recent National HIV/AIDS Strategy (NHAS) and the Philadelphia IHPCP, this goal promotes collaborative efforts to address the full breadth of the HIV epidemic so that every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life extending HIV care that is free from stigma and discrimination. | | | | | |
| **Strategy 5A: Expand capacity and educational messaging addressing HIV, comorbidities, and social determinants of health** | | | | | |
| 73 | Include/partner with representatives from Viral Hepatitis and STD in outreach efforts to affiliates or when establishing/building new working relationships. | *Need*: greater synchronicity of comorbidity testing and education services | Division staff, field staff, Vital Hepatitis staff | n/a | # of desired/projected new partnerships |
| 74 | Support and promote HIV anti-stigma campaigns and related surveys and | *Need*: Stigma | HPCP; | One HIV anti-stigma | Maintain and report on one |

| | | | | | |
|---|---|---|---|---|---|
| | campaigns (such as PrEP awareness) as identified by the Division and/or HPG. | reduction; *Barrier:* Stigma, lack of issue awareness; *Priority pop*: specified communities impacted by HIV-related issues | *Partners*: HPG, providers, community groups, other stakeholders as applicable | campaign active in 2022; one PrEP Awareness campaign (CDC) was promoted in 2021 | HIV anti-stigma campaign and at least one additional supported/promoted social media campaign |
| 75 | Support culturally competent HIV-related messaging to key and underserved/under-resourced communities, such as individuals experiencing aging and/or long-term survivorship, rural communities, or young black Men who have sex with men (MSM) and transwomen. | *Need*: culturally competent HIV messaging; Barrier: lack of issue awareness/ education; *Priority pop*: specified communities impacted by HIV-related issues | HPCP; *Partners*: HPG, providers, community groups, other stakeholders as applicable | HPCP commenced culturally competent messaging/pilot programming engaged in 2022 for rural community outreach and supporting SILK communities | Develop and pilot culturally competent outreach program to individuals experiencing aging and/or long-term survivorship; continue and report on efficacy of culturally competent messaging/pilot programming for any other specified communities' outreach |
| 76 | Monitor proposed/pending state legislation and provide legislative assessments or analysis as requested on | *Need*: Scientifically and | Division *Partners:* HPG | n/a | Report yearly to the HPG on all legislation |

| | | | | | |
|---|---|---|---|---|---|
| | their potential impacts on PLWH and communities at risk for HIV, including but not limited to issues such as HIV decriminalization, syringe service programs, aging, discrimination, employment, housing, poverty, health care, etc. | professionally accurate guidance to legislative activities impacting communities impacted by HIV | | | flagged and all assessments provided to the Pa legislature |
| Strategy 5A: Data Sets informing this objective:<br>Stakeholder Input Data # 1, 3, 4, 5, 7, 8, 10, 11, 16 | | | Key Disparity metrics:<br>Unique to each activity; activities should be assessed based on their engagement success of their specific priority populations, such as aging populations, members at risk in disability communities, young MSM of color, rural communities, etc. | | |
| **Strategy 5B: Expand Division and related service partners' training and internal capacity/competency** | | | | | |
| 77 | Incorporate trainings that speak to appropriate and person- centered language into all aspects of the Division and related service partners' work, including specific trainings that speak to the needs of people aging with HIV, PWD and HIV, and people experiencing long-term survivorship. | *Need*: ensure Division competency with needs of people aging with HIV and overall capacity and cultural humility | Division staff and service partners<br>*Partners*: Department of Aging | n/a | Number of trainings held/participants at each training |
| 78 | Incorporate Trauma Informed Care trainings into all aspects of the Division and related service partners' work. | *Need*: ensure Division capacity and cultural competency | Division staff and service partners | n/a | Number of trainings held/participants at each training |
| 79 | Conduct Act 148, and other relevant data security and confidentiality trainings to all relevant staff and the HPG. | *Need:* ensuring secure data | Division and DOH Legal staff; HPG | 0% completion of annual | 100% completion of annual security |

| | | | | | |
|---|---|---|---|---|---|
| | | | *Partners*: HIV Surveillance staff DOH IT Staff | security and confidentiality training/briefing by HPG in 2021 | and confidentiality training by all Division staff & inclusion in HPG orientation by December 31 of each reporting year |
| Strategy 5B: Data Sets informing this objective: Stakeholder Input Data # 9, 14 | | | Key Disparity metrics: n/a | | |
| **Strategy 5C: Support the HPG and SPBP Advisory Council** | | | | | |
| 80 | Ensure the HPG, as the body representing HIV Prevention and Care services stakeholders in Pa., meet and make recommendations to the Division on HIV-related issues, policies and procedures, and community needs and experiences. | *Need:* PLWH and stakeholder input in HIV Planning; *Priority pop*: PLWH and all HIV stakeholders | Division, HPCP, HPG *Partners*: PLWH and all HIV community stakeholders | The HPG held quarterly meetings throughout the 2021 calendar year | The HPG will hold a minimum of quarterly meetings throughout a calendar year |
| 81 | Ensure reflective membership and diverse community engagement in the HPG and its planning processes, statewide outreach will occur in townhall meeting formats and other formats as identified and approved by the HPG and Division. | *Need:* PLWH and stakeholder input in HIV Planning; *Priority pop*: PLWH and regional HIV stakeholders | Division, HPCP, HPG *Partners*: RWPB Regional Grantees, PLWH and all HIV community stakeholders | 1) HPG Town Hall meetings were not held in 2021 due to COVID 2) A Stakeholder Engagement Plan was reviewed and approved by | 1) HPG Town Hall meetings will be held twice a year in different regions across the state; 2) A Stakeholder Engagement Plan will be reviewed and |

| | | | | | |
|---|---|---|---|---|---|
| | | | | the HPG in 2021 | approved by the HPG once per year |
| 82 | Ensure that the HPG meetings are inclusive of representation of relevant planning partners and agencies from associated/intersectional services (Example agencies include Viral Hepatitis, STD, and Departments such as Education, Aging, DDAP, Corrections, Medicaid, etc.) | *Need:* stakeholder input in HIV Planning; *Priority pop*: intersectional agencies | Division leadership, HPCP, HPG community members and planning partners (agencies) | The HPG has representative/active partnerships with 16 of the 18 intersectional agencies the HPG has identified for planning Partner membership collaboration | Recruit and maintain partnerships with 100% of intersectional planning partner agencies |
| 83 | Facilitate HPG research and proposals for improving employment opportunities and resources for PLWH. | *Need*: Employment opportunities for PLWH; *Barrier*: lack of employment, employment discrimination; *Priority pop*: PLWH | HPG; *Partners*: HPCP, Division | The HPG has convened an Employment workgroup and outlined the initial recommendations included in this plan | The HPG shall: 1) research and report to the full HPG and Division employment-supporting activities in other jurisdictions; 2) Assess the current and desired status of employment services for PLWH; 3) Identify appropriate |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | and allowable funding sources/ opportunities to support or promote employment services |
| 84 | Facilitate an HPG workgroup for research and proposals for improving outcomes and resources for people aging with HIV and people experiencing long-term survivorship. | *Barrier*: lack of competency and tailored resources for people aging with HIV or experiencing long-term survivorship. *Priority pop*: people aging with HIV and/or people experiencing long-term survivorship; PLWH with disabilities | HPG; *Partners*: HPCP, Division, Department of Aging, statewide representative for PWD | n/a: workgroup needed | The workgroup shall: 1) research and report to the full HPG and Division aging needs and barriers, as well as existing resources 2) Identify appropriate and allowable activities, trainings, resources, or pilot interventions to support or promote services/outcomes for these populations |
| 85 | Facilitate an HPG workgroup for research and proposals for improving HIV-related disparities among communities of color. | *Need*: improving equity in HIV | HPG; *Partners*: HPCP, Division, DOH Equity, priority | n/a: workgroup needed | The workgroup shall: 1) research and report to the |

| | | | | | |
|---|---|---|---|---|---|
| | | outcomes for communities of color *Barrier*: discriminatio n; health disparities *Priority pop*: BIPOC communities at-risk for or living with HIV | community leaders/groups | | full HPG and Division needs and barriers to racial equity along the HIV continuum, as well as existing resources 2) Identify appropriate and allowable activities, trainings, resources, or pilot interventions to support or promote services/outco mes for these populations |
| 86 | Ensure the SPBP Advisory Council, as the body representing RW ADAP stakeholders in Pa., advises the SPBP and the Division on the SPBP formulary and programmatic policies and procedures. | *Need:* stakeholder input in the SPBP Advisory Council; *Priority pop*: PLWH | Division and SPBP staff, SPBP Advisory Council members, HPCP; Partners: RWPB regional grantees, community stakeholders | Four meetings were held in 2021 | A minimum of four meetings will be held per calendar year |
| Strategy 5C: Data Sets informing this objective: federal guidance, Stakeholder Input Data # 1, 7, 10 | | | Key Disparity metrics: HIV stakeholders engaged in planning, esp. BIPOC and SGM communities | | |
| **Strategy 5D: Enhance CB/Technical Assistance (TA)Trainings** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 87 | Develop and maintain a Case Management training curriculum that includes special conditions and populations, including but not limited to aging, long-term survivorship, and disability. | *Need*: Case Management training resources *Priority pop:* case managers | MAAETC | n/a | Successful development and implementation of training |
| 88 | Develop a Division PowerPoint and maintain annually or as needed. | *Need*: internal Division resources | Division staff | n/a | Successful development and implementation of presentation |
| 89 | Internally assess CB assistance needs and develop and implement a CB assistance plan if warranted. | *Need*: CB training resources | Division staff, HPCP | n/a | Successful development and implementation of assessment, including plan if warranted |
| 90 | Ensure training needs are identified during annual on-site monitoring of contracted providers as well as through a bi-annual (every other year) capacity needs assessment distributed to both prevention and care providers. | *Need*: CB training resources *Priority pop:* prevention and care providers | Division staff, HPCP *Partners*: Prevention and care grantees and providers | n/a | Successful development and implementation of needs assessment |
| 91 | Develop and maintain annual training schedules based on capacity needs assessment. | *Need*: CB training resources | Division staff, HPCP, MAAETC *Partners*: Prevention and care grantees and providers | Annual training schedules were developed and | Successful development and implementation of training schedules |

| | | | | | |
|---|---|---|---|---|---|
| | | | | implemented by HPCP and MAAETC in 2021 | |
| Strategy 5D: Data Sets informing this objective: CB Needs assessment, Stakeholder Input Data # 8 | | | Key Disparity metrics:<br>Track and improve emphasis on racism and racial disparities in one or more trainings | | |

# Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

## 1. 2022-2026 Integrated Planning Implementation Approach

This section describes the infrastructure, procedures, systems, and tools that will be used to support the phases of integrated planning and ensure the success of the IHPCP goals and strategies. These tools and systems revolve around the complementary responsibilities and strengths of the HPG, the Division, and the HPCP.

### A. Implementation

This plan defines the activities, partnerships, planning, data and assessments necessary to implement the vision of the Division for the state of Pa. The workplan is specifically structured to demonstrate the Division's every initiative and programmatic effort and how it ultimately addresses either a need or targeted concern. Coordination with the Philadelphia Part A, and their EHE plan, as well as opportunities to support the Pittsburgh "Getting to Zero" plan are significant opportunities to further the advancement of the work of each and provides a more comprehensive approach to addressing the needs and concerns in the commonwealth overall. The strategies and activities of the workplan are designed to incorporate those efforts, as well as meet the expectations and requirements of the federal funders who make this work possible. PLWH provide an essential aspect to ensuring the IHPCP is both effective and relevant. Relevant in not only the intention, but the approach. Respect to those served by the IHPCP is paramount, and foundational to its ultimate success.

As stated, the goals, strategies, and activities of this IHPCP encompass all operational elements of the Division's work. Accordingly, all available resources, reports, and staff effort are ultimately dedicated to the progress of the IHPCP. This synergy across the Division's operations with its IHPCP strategies and activities demonstrates the increasingly cohesive and clearly articulated approach to addressing HIV in the state of Pa. This more fully integrated, data driven approach also streamlines reporting requirements by better synchronizing CDC and HRSA annual reporting requirements with the work indicated and outlined by this IHPCP, which further ensures implementation and evaluative compliance and success. This relationship is described further in subsection 2 below.

### B. Monitoring

The monitoring of the IHPCP has a two-pronged approach, one specific to and completed by the Division, and the other specific to and completed by the HPG planning body. The Division is held accountable for the funds received for HIV prevention and care services through federal reporting. The Division is also held accountable for the HIV prevention and care services delineated in both the CDC Integrated HIV Prevention and Surveillance grant and the HRSA RWPB grant. The Division provides written narratives of activities required by federal funders as well as data and funding updates to support

the written narrative. Section V of the IHPCP serves as the workplan for the Division and encompasses the federal grant requirements as well as needs identified through assessments and HPG input.
Reportable program data within Section V is linked to responsible parties who will report on their work (i.e. internal and external partner accountability) and indicates specific data sets that should be used and updated to enable the monitoring and assessment of Division programs and IHPCP progress. For example, performance measures are linked to most Division contractual partner agreements, and IHPCP activities are linked to these performance measures. This holds the Division and any other named responsible party for that activity accountable for their IHPCP-identified progress data/reporting/outcomes. As another example, the IHPCP indicates in the Respond goal that epidemiological data will be compiled and reviewed annually, which in turn supports monitoring and programmatic adaptation, measurable outcomes of various activities, and the annual updates that will be developed to in turn continually improve this IHPCP. These update processes are described in subsection four below.

The HPG plays several key roles throughout the monitoring and evaluation tasks associated with the implementation of this IHPCP. The first of these responsibilities is situational monitoring. Similarly, to one of its tasks in the last planning cycle, the HPG or a designated subcommittee is tasked by this IHPCP—in line with federal HPG definitions and expectations—to monitor the impact that this IHPCP is having in communities throughout the jurisdiction. Just as the Division collects data on its programs (above) for their monitoring responsibilities, the HPG is responsible for reviewing data related to the status of the HIV care continuum in the jurisdiction under this IHPCP. This monitoring work can be based on any available sources described in this IHPCP, such as demonstrable needs, assessments, qualitative/community-based data or surveys, utilization data or epidemiological reports from the Division and its partners, and programmatic and/or planning partner reports. The goal of HPG monitoring is to identify and assess potential needs, gaps, or changes impacting programs or communities. Any findings are summarized and provided to the Division and should include recommendations for improving the community or programmatic issue(s) through revising the IHPCP but may also include additional recommendations such as policy updates, programmatic adaptations, or possible interventions that may improve or ameliorate current issues. In other words, the HPG is tasked with using all data sources available, combined with their own expertise and key perspectives, to monitor and assess existing or emerging needs, gaps, or changes in services impacting Division programs, priority communities, or the HIV continuum of care in Pa. All recommended improvements to the IHPCP require a majority vote of voting HPG members in order to be presented to the Division. The recommendations are subject to feedback and approval by the Division prior to being included in the IHPCP.

### C. Evaluation

While the monitoring tasks by both the Division and HPG revolve around translating programmatic and community efforts or issues into data and actionable planning (e.g. via improving the IHPCP), evaluation activities revolve around the critical assessment of data against benchmarks and goals outlined in the IHPCP. Specifically, the Division is responsible for internally regularly assessing the data collected by

monitoring activities to determine progress towards the IHPCP 2026 activity goals. Utilizing the input from the HPG, monitoring epidemiological data, information from a variety of assessment tools/activities, as well as direction/input from federal funders, the Division will routinely review available information to determine the effectiveness of the IHPCP. Specific attention will be directed towards identifying and assessing any changes in the landscape of HIV in the commonwealth, the populations affected by HIV, available funds, and changing needs. The Division will ensure the IHPCP strategies and activities measures are progressing, or determine approaches to rectify the lack of progress, and make the IHPCP reflective of those changes.

Additionally, the Division also make programmatic data and reporting available to the HPG, as they are tasked with conducting an independent review of the IHPCP strategies and/or activities. In addition to receiving data and reports from the Division as part of HPG operations, the HPG and/or its designated subcommittee (e.g. the HPG Evaluation subcommittee during the last planning cycle) may submit requests for data, reports, or analysis from Division and program staff to fulfill their role in the analysis of the workplan outcomes. Based on their analysis, the HPG is tasked to make recommendations to the Division regarding potential improvements to the IHPCP to help ensure the progression, and effectiveness of the IHPCP goals, strategies, and activities.

### D. Improvement

Through the operationalization of the IHPCP, the Division will ensure continued progress in meeting not only its vision, but the purpose and intention of the federal funders, the EHE, and the NHAS. However, as the landscape of HIV potentially changes, and the results of the various efforts of the Division may not provide the intended results, the Division will be diligent in its responsiveness to the potential need for change. The analysis of the Division's Epidemiological profiles, program data, and/or reports or findings issued by the HPG monitoring body, as well as recommendations authored by the HPG's evaluative work, and presented to the Division annually, will be taken into consideration to be integrated into the IHPCP. Such revisions will help to ensure the IHPCP is responsive to the vision of the Division and HPG, the needs of individuals at risk for acquiring HIV, and PLWH. In addition to the input from the HPG and/or the data derived from the plan itself, responsiveness to federal funders enhancements to service delivery expectations and requirements, will be utilized to ensure changes for the betterment/progress of the IHPCP are continuous. The annual revision by the HPG, Division, and HPCP facilitators to the 2022-2026 IHPCP requires a vote of confidence to ratify the revisions each year.

### E. Reporting and Dissemination

Two major activities for progress reporting and two mechanisms for planning/planning update dissemination have been built into the IHPCP.

For progress reporting, the first activity is the IHPCP annual update itself. As described in subsection four above, the HPG and the Division will collaboratively monitor the annual published revision to the IHPCP. Beyond this publication, however, HPCP has also developed a powerful reporting dashboard for the 2022-2026 IHPCP. This tool, housed on the HPG's website www.stophiv.com, quantifiably tracks all IHPCP progress from activities through strategies up to the goals themselves, utilizing the HPG's

Evaluation activities and reports. This dashboard will not only promote greater dissemination of HIV planning awareness and literacy but will support transparency and provide further opportunity for both the HPG and Division to review progress and develop potential changes for the betterment of the IHPCP.

The HPG protocols clearly define HPG member responsibilities for engaging and educating their respective communities regarding HIV planning efforts and updates. In response to barriers and challenges presented by Pa.'s large size and population, the HPG meeting structure has been developed and refined to maximize stakeholder engagement through the use of 'mobile' townhall-style HPG meetings. This novel adaptation of the traditional townhall process has the HPG members select two of their six meeting locations in different geographic regions with diverse epidemiological profiles and needs. (The other four HPG meetings are held in the relatively central location of Harrisburg, Pa.) As with all HPG meetings, members are compensated and supported in their travel. This arrangement allows for members and the Division to interact directly with regional stakeholders and PLWH, regional RWPB recipients and subrecipients, PPA providers, CMHDs and other intersectional agencies in the region. This approach provides highly impactful communication between communities and planning parties, allowing both to better understand the roles, experiences, and efforts of the another. This process results in effective planning dissemination, and was used, for example, in July 2022 to introduce communities in Erie Pa. to this draft of the 2022-2026 IHPCP.

Secondly, the HPCP manages a Stakeholder Engagement Plan (SEP) collaboratively with the HPG. The SEP is updated annually. It is reviewed, improved, and approved by the HPG, and implemented on a yearly basis. While the SEP adapts and responds each year to the needs of the communities it serves, the body of the 2022 SEP is included here for reference:

> "The SEP incorporates Twitter and Facebook for online outreach activities. Twitter is also utilized to share HPCP and partner announcements, HPG news, and relevant DOH, national, and federal funders campaigns with followers. It promotes collaboration and visibility of local HIV and related service organizations through retweets. Facebook's advertising features are used to direct similar messages to priority populations across the state. Both social media outlets serve important roles in virtual stakeholder engagement, education, event and HPG recruitment.
>
> Surveys, assessments, and focus groups are utilized on an as needed basis for requests from the HPG and the Division. Traveling townhall meetings were an extremely successful piece of HPCP programming in previous years, though they were paused during the COVID-19 pandemic, as of July 2022 they have been re-initiated, and will continue as the on-going pandemic allows. Finally, the SEP ensures access to HPG news bulletins and other jurisdictional updates via email listserv software. The HPG news bulletins are based on announcements from HPG meetings and share all relevant updates. News bulletins are created using an online software called Emma. This software provides useful information on mailing success such as open rates and where contacts clicked

within the newsletter. It also securely manages contact information, providing a means to keep these records up to date and accurate."

**SEP Community Engagement Activities**

| Method | Description | Schedule |
|---|---|---|
| Townhall Meetings | Community-led meetings held in rotating locations across Pa., as guided by the epidemiological profile | Twice annually |
| Focus Groups and/or Needs Assessments | Topic-focused discussions facilitated by HPCP staff, as requested by HPG membership | As needed |
| Ad hoc committees | Topic-focused committees made up of HPG members, DOH staff, HPCP staff, and outside stakeholders to address specific issues in depth | Meeting schedules developed by committees |
| Public HPG meetings | Increased membership and public participation, especially from priority populations | Annually for membership drive, ongoing for quarterly meetings |
| Social Media accounts | Twitter and Facebook pages maintained to distribute information of HPCP and partners | Ongoing |
| Website/blog updates | Website and blog present HPCP activities and timely health information | Ongoing |
| Newsletter | Distributed to contacts via email marketing software with HPCP and partner updates | Quarterly |
| Networking through existing contacts | Distribution of relevant information and distribution of relevant information and HPG-related news and recruitment materials | Ongoing |

## F. Updates to Other Strategic Plans

As previously stated, this IHPCP outlines the activities of the Division. As every aspect of the Division is incorporated into this plan, this plan then is also reflected in other state internal plans and responsibilities of the Division such as the DOH Strategic Plan and the Pa. Governor's Budget Performance and Measures Plan. No updates to the IHPCP should be required resulting of these internal plans as the activities of the internal plans are based off of the activities identified in the IHPCP.

Throughout the IHPCP numerous links are provided to internal resources such as the annual DOH Bureau of Epidemiology's Epidemiological HIV Profile for the state of Pa. These resources will automatically provide access to the most current version available.

Finally, the Philadelphia EHE and Philadelphia IHPCP have been included by reference within this document and through the dedicated efforts and input of the Philadelphia planning partner and community members on the Pa. HPG. Later updates to the Pa. 2022-2026 IHPCP may further align these documents based on availability and feasibility.

## Section VII: Letter of Concurrence

To the Centers for Disease Control and Prevention (CDC) and Human Resources and Services Administration (HRSA):
The Pennsylvania (Pa.) HIV Planning Group (HPG) ***concurs*** with this submission by the Pa. Department of Health (DOH) Division of HIV Disease (Division) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (IHPCP), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The HPG planning body has reviewed the IHPCP submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body ***concurs*** that the IHPCP submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The HPG was provided regular updates on the status, design, content and progress of the IHPCP draft during every meeting of 2021 and 2022. Moreover, the HPG has been an integral partner with the Division throughout this planning cycle in the creation of recommendations and content that now comprise/support multiple sections of the 2022-2026 IHPCP.

Finally, the HPG reports that the Division and the current IHPCP reflect ongoing good faith efforts with the Philadelphia IHPCP and planning bodies. While this document was created prior to the development of Philadelphia's document, the ongoing support and participation of Philadelphia's planning partner representatives and community members on the Pa. HPG has provided invaluable perspectives in helping to align these two complementary Plans.

The signature below on behalf of the voting members of the HPG have unanimously confirmed their ***concurrence*** of the planning body with the representativeness, federal compliance, planning involvement, and efforts to promote jurisdictional collaboration with Philadelphia regrading this IHPCP.

Signature:

Sonny Concepcion
*Planning Body Community Chair*

Date: September 8, 2022

## Appendix A: Stakeholder Feedback for the 2022-2026 IHPCP

This appendix explains the various outreach measures that were taken to gather feedback from diverse voices and impacted communities in the finalization of IHPCP. This appendix stems from a recognition that seeking diverse perspectives from impacted stakeholders improves the IHPCP, is a critical and federally required component of the HIV planning process and improves transparency and community trust. The following sections summarize the years of engagement work that comprise the feedback mechanisms used for this IHPCP.

### A. Statewide planning bodies

Both the HPG and SPBP Advisory Councils have been consulted in different ways for their expertise and valuable perspectives related to this IHPCP.

The HPG, as the statewide HIV planning body, has been involved and kept informed of the development of the IHPCP during their regular meetings since work began on the document in 2020 (i.e. following the 2019 update to the 2017-2021 IHPCP approved by the HPG). This included 1 update in 2020, 4 in 2021, and 5 between January and September 2022 (not counting email correspondence). These updates included the planned inclusion of recurring and new topics in the plan, document planning, revisions, and internal mapping/document organization, updates on the HPG's recommendations' incorporation into the Plan (as outlined in Section II), the status of federal guidance (especially during the changing timelines of 2021 during the COVID-19 pandemic) and increasingly specific updates on the outline and contents of the various sections of the plan as they developed. The HPG received the full draft contents of the IHPCP in three waves throughout the summer of 2022 as the drafts were cleared through internal Division review, along with additional email updates and requests for feedback on each new part of the Plan. The HPG was also tasked with both completing and distributing the Community Perceptions and Feedback Survey (see discussion of the survey below). Finally, the HPG was provided with a separate virtual working group meeting in late July once all sections of the IHPCP were released to have additional, dedicated time to talk about the plan together with the authors and Division leadership.

The SPBP Advisory Council (SPBPAC), as a related body with significant statewide expertise on the HIV Continuum in Pa, was presented with a detailed update on the status and contents of the IHPCP in July 2022. Although the presentation to the SPBPAC outlined the entire Plan, the conversation and feedback of the members focused on the draft contents of Section V. The members provided valuable feedback during this meeting, were invited to be contributors to the Community Perceptions and Feedback Survey and were partners in its further distribution among their own community networks.

Changes made to the drafts of the IHPCP based on planning body feedback including both meetings, written comments, and the dedicated working group time include:

- Improvements in people-first language throughout the document
- Miscellaneous typos throughout the document
- Inadvertent topical omissions/improving the emphasis of specific issues, including HIV decriminalization and employment opportunities for PLWH

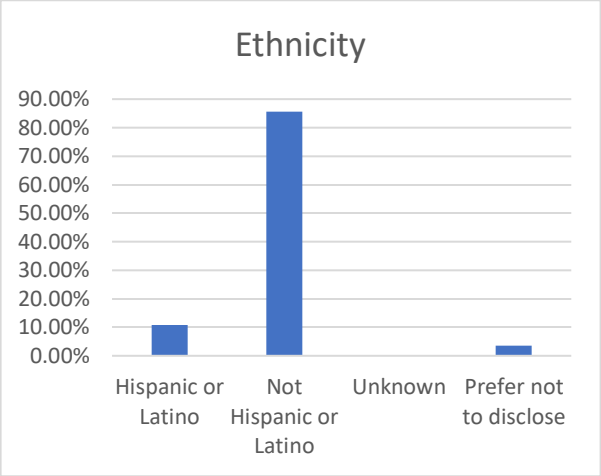
- Improvements to 13 different activities and two Strategies in Section V, including (for example) activities around data security, status neutral linkage-to-care education and trainings, increasing the scope of the Division's infectious disease collaborations from being COVID-19 specific to any public health emergency that impacts PLWH and communities at risk of HIV acquisition (i.e. to include work around emerging viral threats like monkeypox), providing nonpartisan, public health expertise as requested to state legislators, and integrating Hepatitis testing and treatment opportunities for providers.

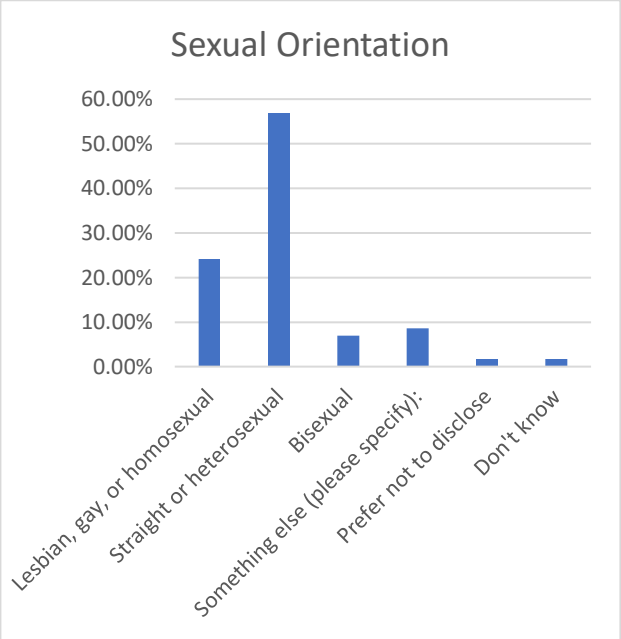
## B. Community perceptions and feedback survey

The Community Perceptions and Feedback Survey was developed and distributed electronically statewide to provide a low-barrier mechanism for communities to review and respond to the strategies that comprise Section V (the heart of the IHPCP). The survey, like the General Summary at the beginning of the IHPCP, was designed with a high school reading level as measured by the Flesch-Kincaid Reading Score. The survey was distributed to both the HPG and SPBP Advisory Council for completion and further distribution into their professional and community-based stakeholder networks. Additionally, the Division's HIV planning contractor HPCP leveraged their community-based networks and social media networks, the Division's own SPBP client email list, and contacts with all RWPB regional grantees to promote and distribute this survey to priority populations in Pa. Notably, due to time constraints and institutional barriers, incentives/participant payments were not able to be included in the survey distribution for this cycle.

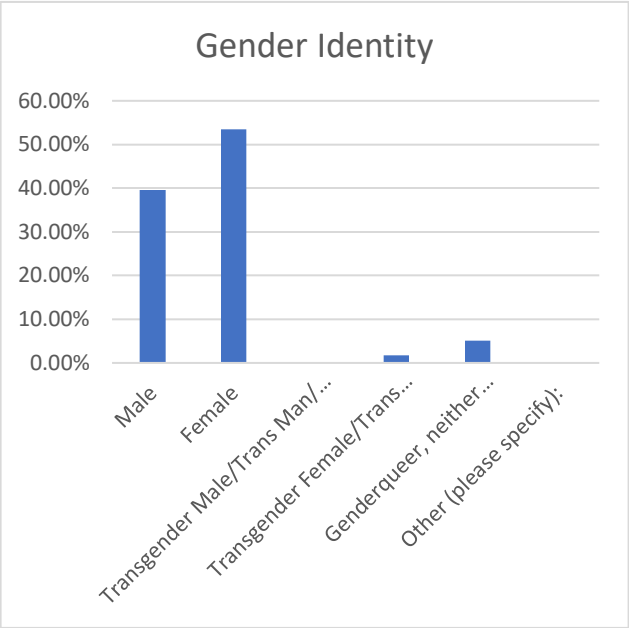
Results: This survey ran from July 28-Sept. 1. All responses are anonymous and were recorded and analyzed using Qualtrics professional survey software. A total of 328 responses were recorded (applies to all Figures below unless otherwise specified).

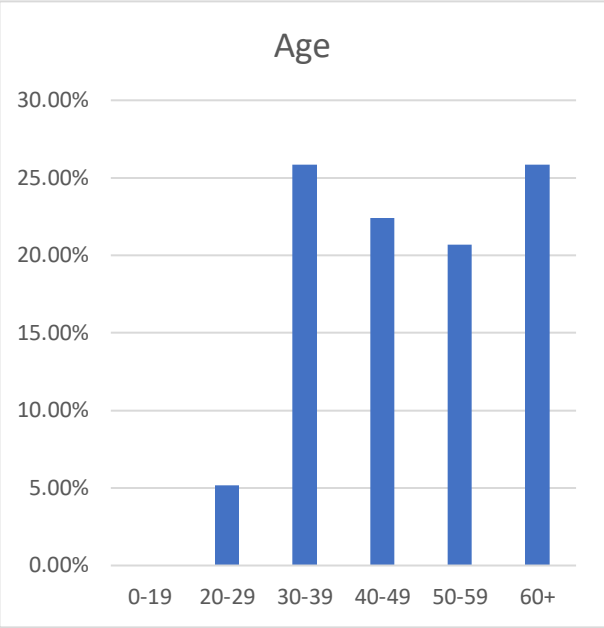
**Figures 5 & 6: IHPCP Survey Respondents Ethnicity and Sexual Orientation**

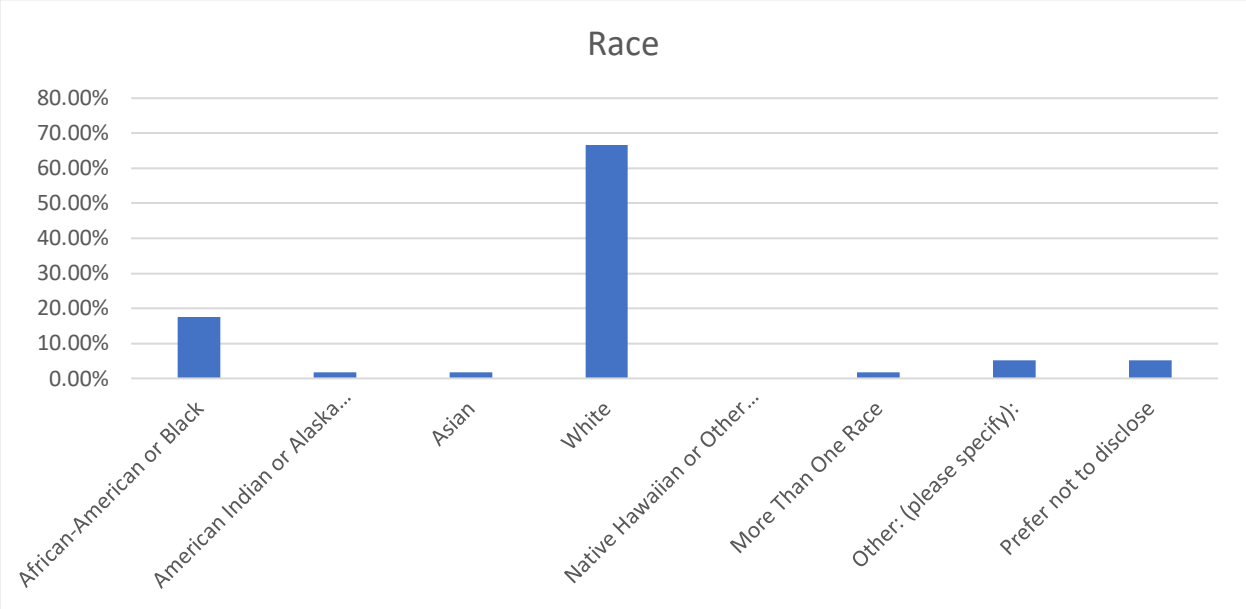


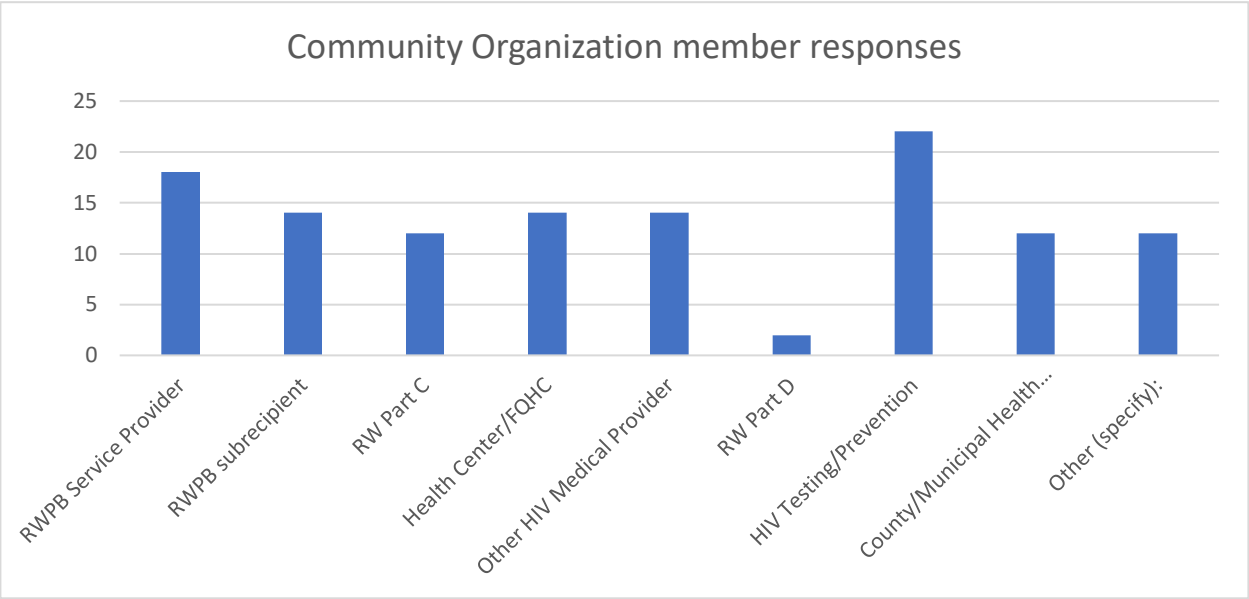
**Figures 7, 8, 9: IHPCP Survey Respondents Gender Identity, Age, and Race**



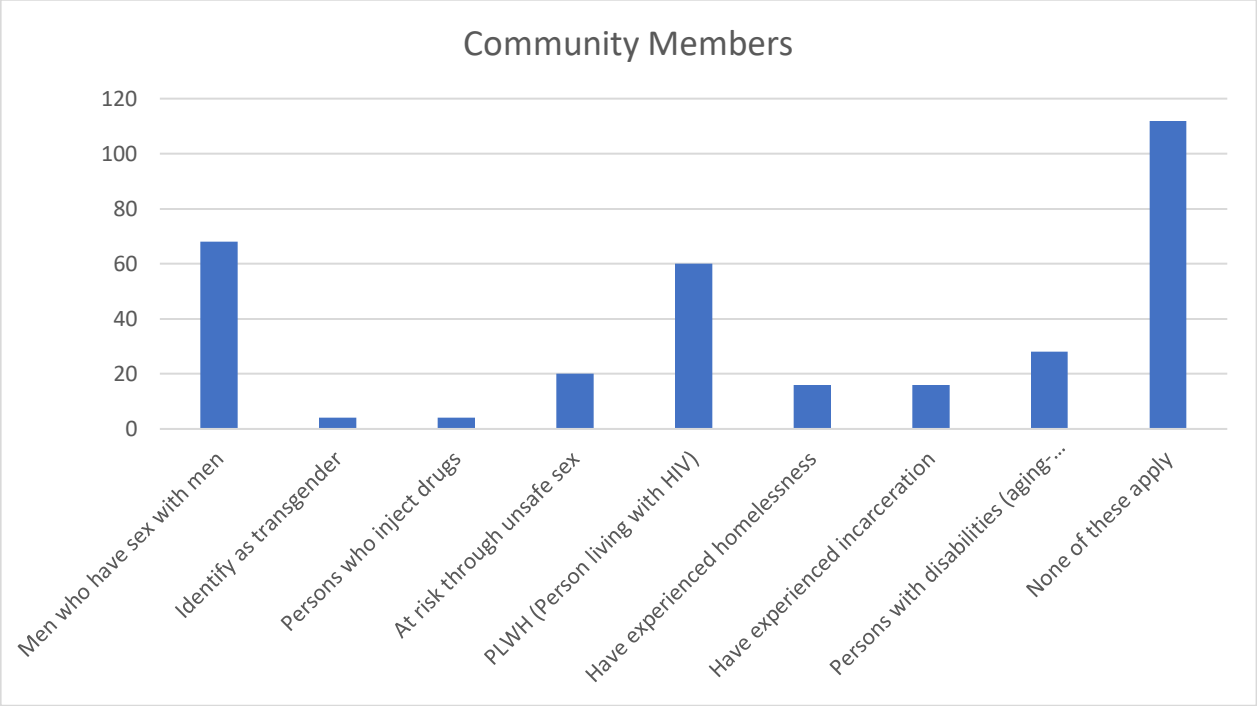



**Figures 10 & 11: IHPCP Survey Respondents Community Affiliation and Organization Affiliation**




*(Above: N=160)*




*(Above: N=328)*

IHPCP Strategies Importance Rating Table: This survey described to respondents each activity (including examples of the activities it contained) and asked them in indicate how important they felt that activity was in impacting the HIV Continuum in their community. To assess the results of the survey, responses were aggregated so that a rating of either "very important" or "important" were combined and

the proportion of positive responses were used to indicate which strategies are viewed the most positively by those who participated. For example, a strategy listed as "100%" in this scale received all "very important" and/or "important" responses, while a strategy in the 84-80 percent range received 16-20 percent of responses that were either "neither important nor unimportant" and/or "unimportant" (no strategy received any "very unimportant" responses).

**Table 5: IHPCP Strategies Importance Ratings**

| Percentage of respondents who rated the strategy "Very Important" or "Important" (combined) | 100% | 99-95 | 94-90 | 89-85 | 84-80 |
|---|---|---|---|---|---|
| Number of Strategies | 4 | 11 | 10 | 1 | 1 |

Number of comments: 31 (*excluding* comments that were simply "yes" or "no" in response to the prompts asking for comments in each section)

Examples of stakeholder comments: Examples of feedback that may be used to begin the revision/update process for the IHPCP include:

- Develop specific HIV media campaigns… for teenagers, young adults and [people] over 45 years old: include dual HIV, Hepatitis and PrEP
- …In order to truly achieve the goal of ending the HIV epidemic, the state Medicaid program must join the Division of HIV/AIDS (Division) in planning for and implementing the IHPCP. …[for example], training Medicaid providers on PrEP could be added to activity 1C6; the 1C10 activity of increasing research for PrEP update among underserved populations could include partnering with Medicaid; strategy 1D is to expand the STD Data-to-PrEP initiative and could include partnering with Medicaid because they would have access to STD diagnoses and claims data; strategy 1H is to support perinatal prevention services and partnering with Medicaid will be important because Medicaid financed 34 percent of the births in Pennsylvania in 2020.
- The Division should include outreach to first nation communities in this Plan...
- Collaboration with DDAP is a great way to address key at risk populations.
- There needs to be an emphasis on testing at every level of care-ER, PCP, specialists, FQHC etc. Too many providers think it's irrelevant for them since they aren't ID specialists.
- ...I think that the state needs to engage providers as well as regional grantees in some of these activities, in order to get better, more durable results. I understand the philosophy is that the regions will communicate on behalf of the providers, but I think it's often more complicated than that. To truly be bi-directional, the state needs to be very mindful of how communication is flowing to and from the providers that are actually providing care services, and make sure the 'provider perspective' is substantially incorporated into RWPB documents.
- [Case management] support is desperately needed and SPBP info and support as well. For our organization, I can say we are slammed all the time so having the ability to make one call or go to one site for info, support, etc. would be so helpful.

- As a former MAI linkage to care coordinator myself, I think it's pivotal that state level entities be responsible for disseminating information about linkage services to prisons, rehab centers, hospitals, county health departments etc. There are so many people who could use this service but there simply isn't enough awareness that it exists.
- I think, in terms of monitoring the IHPCP, priority should be placed on using a trauma-informed approach, refraining from using terms such as 'compliance', and minimizing top-down actions in favor of building partnerships to accomplish goals.

A full list of all comments has been provided to the Division and will be available to the HPG working on IHPCP revisions.

Any IHPCP changes made based on survey results: One incorrect acronym was caught and revised, and the word "compliance" was changed to the less pejorative "adherence." More than a dozen other constructive points of feedback have been recorded by this survey and will be available to the HPG as they begin the yearly process of revising/updating the IHPCP.

Survey results analysis: Survey results overall demonstrate strong approval for the importance of the strategies developed and described in the IHPCP. As the chart above demonstrates, all strategies except two had 90 percent or more of all respondents rate them as "very important" or "important." Most favorably perceived strategies (those with 100-99 percent positive responses) include:

- Strategy 1A: Implement Data-to-Care (D2C) approaches to direct HIV testing
- Strategy 1B: Continue and enhance evidence based ARTAS and HIV Navigation Services (HNS)
- Strategy 1C: Support and expand PrEP screenings and services
- Strategy 2A: Continue and expand HIV testing
- Strategy 3B: Continue the Special Pharmaceutical Benefits Program (SPBP) Medicine Adherence Program
- Strategy 3C: Continue the Minority AIDS Initiative (MAI).

Conversely, strategies perceived as *relatively* less important (in descending order) include Strategy 4B: Facilitate monitoring by statewide stakeholder bodies and Strategy 4D: Ensure comprehensive monitoring and evaluation. Strategy 1H: Support Perinatal Prevention Services is also notable because, while it falls into the 90 percent importance rating overall, it was the *only* strategy to also receive "unimportant" responses (one and half percent of the total responses for this strategy).

Several limitations are inherent in this analysis. As noted above, this approach aggregates positive responses, which results in a loss of granularity in the data. It is also comparative data, which highlights the few lower rated strategies (i.e. a strategy that received a 90.16 percent positive response is not singled out, while the strategy with 88.9 percent positive responses is). Most importantly, however, are the limitations caused by the representativeness of the data. While all demographic categories closely resemble the overall makeup of the state of Pa, they fall short to varying degrees in reflecting the communities most impacted by the epidemic. To that end, care should be taken in interpreting these results, as the survey has (for example) more white, female and older respondents than the majority of communities living with or impacted by HIV. Finally, one additional possible limitation is that all demographic data was self-reported. While the survey was entirely secure and confidential, some

respondents may not have felt comfortable sharing aspects of their identity; this may help partially explain in particular the high number of "none of these" responses in the community affiliation question.

Plans for ongoing feedback and improvement*:* As noted above, improving the demographics of HPG outreach is one critical area for improvement (the IHPCP noted in Section II the ways the COVID pandemic has harmed our communities and outreach networks). The IHPCP will continue to be improved on an annual basis (as outlined in Section VI), and stakeholder feedback will remain a key part of that ongoing development. The HPG approves the Stakeholder Engagement Plan yearly to define and direct those efforts to priority communities. Additionally, a process is already in development to engage RWPB grantees, PPA providers, and CMHDs during the Fall of 2022 to conduct key informant interviews as a way to solicit high impact feedback for the 2023 revision to the IHPCP.

## Appendix B: 2022-2026 IHPCP Quick Reference Acronym List

This IHPCP follows the Pennsylvania Department of Health Communications Style Guide, which explicates the full name of any acronym once and then uses the abbreviation or acronym in every instance thereafter. The authors felt that a quick reference sheet, such as the one found below, would increase the accessibility and readability of the entire document. It is our hope that encapsulating all the acronyms and their meanings in one place will more fully empower readers with any level of familiarity with HIV to more quickly and easily utilize the IHPCP.

| | |
|---|---|
| ACA | Affordable Care Act |
| ADAP | AIDS Drug Assistance Program |
| AI/AN | American Indian/Alaska Native |
| ART | Anti-Retroviral Treatment |
| BIPOC | Black, Indigenous and People of Color |
| CB | Capacity Building |
| CBO | Community Based Organization |
| CD4 | CD4 T Lymphocyte |
| CDC | Center for Disease Control and Prevention |
| CDR | Cluster Detection Response |
| CECs | Continuing Education Credits |
| CMHD | County Municipal Health Department |
| CQM | Clinical Quality Management |
| CSL | Customer Service Line |
| CY | Calendar Year |
| D2C | Data to Care |
| DDAP | Department of Drug & Alcohol Programs |
| DHS | Department of Human Services |
| DIS | Disease Intervention Specialist |
| Division | Division of HIV Disease |
| DOH | Department of Health |
| EFA | Emergency Financial Assistance |

| | |
|---|---|
| EHE | Ending the HIV Epidemic (CDC & HRSA funded initiative) |
| EIIHA | Early Identification of Individuals with HIV/AIDS |
| EIS | Early Intervention Services |
| EMA | Eligible Metropolitan Area |
| FAQ | Frequently Asked Questions |
| FQHC | Federally Qualified Health Center |
| HCBHS | Home Community Based Health Services |
| HCIT | HIV Cluster Investigation Team |
| HCPT | HIV Cluster Plan Team |
| HCV | Hepatitis C Virus |
| HOPWA | Housing Opportunities for People with AIDS |
| HPCP | HIV Prevention and Care Project |
| HPG | HIV Planning Group |
| HRSA | Health Resources & Services Administration |
| HST | HIV Self-Test |
| HUD | United States Department of Housing and Urban Development |
| IHPCP | Integrated HIV Prevention & Care Plan |
| IDU | Injection Drug Use |
| IT | Intelligence Technology |
| LGBTQIA+ | Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, plus. While each letter in LGBTQIA+ stands for a specific group of people, the term is intended to encompass the entire spectrum of gender fluidity and sexual identities. |
| LtC | Linkage to Care |
| MAAETC | Mid-Atlantic AIDS Education & Training Center |
| MAI | Minority AIDS Initiative |
| MCM | Medical Case Management |
| MOU | Memorandum of Understanding |
| MSM | Men who have sex with men |
| NHAS | National HIV/AIDS Strategy |

| | |
|---|---|
| NHPI | Native Hawaiian & other Pacific Islander |
| OMHSAS | Office of Mental Health & Substance Abuse Services |
| ORP | Operational Response Plan |
| Pa. | Pennsylvania |
| PAHCODRP | Pennsylvania HIV Cluster Outbreak Detection Response Plan |
| PA-NEDSS | Pa. National Electronic Disease Surveillance System |
| PCP | Primary Care Physician |
| PDA | Pennsylvania Department of Aging |
| PEHTI | Pennsylvania Expanded HIV Testing Initiative |
| PEP | Post Exposure Prophylaxis |
| PLWH | People living with HIV |
| PNS | Partner Navigation Services |
| PPA | Participating Partner Agreement |
| PrEP | Pre-Exposure Prophylaxis |
| PS | Partner Services |
| PWD | People with disabilities |
| PWID | People who inject drugs |
| RW | Ryan White |
| RWPB | Ryan White Part B |
| SCA | Single County Authority |
| SCSN | Statewide Coordinated Statement of Need |
| SEP | Stakeholder Engagement Plan |
| SGM | Sexual & Gender Minority |
| SMART | Specific, Measurable, Achievable, Relevant, and Time-bound |
| SNNLS | Status Neutral Navigation & Linkage Services |
| SOR | State Opioid Response |
| SPBP | Special Pharmaceutical Benefits Program |
| SPBPAC | Special Pharmaceutical Benefits Program Advisory Council |
| SSP | Syringe Service Program |

| | |
|---|---|
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TA | Technical Assistance |
| TB | Tuberculosis |
| U=U | Undetectable [HIV Viral load] =Untransmittable |
| VL | Viral Load |