Program Collaboration and Service Integration

One Size Does Not Fit All

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PCSI: A Syndemic Approach

“A syndemic-oriented approach first defines the population in question, identifies the conditions that create and sustain health in that population, examines why those conditions might differ among groups and determines how those conditions might be addressed in a comprehensive manner.”

PCSI: In Context

- Focus on HIV/AIDS, STD, Viral Hepatitis, and Tuberculosis
  - Work with specific populations impacted by these diseases and conditions
  - Look at diseases and conditions together and recognize interactions
- Focus on the client - A holistic approach
- Structural intervention
  - Connect specialties
  - Networked approach
- Consider:
  - Integrated surveillance
  - Integrated programming
  - Integrated training
Five Principles of PCSI

- ** Appropriateness**: integration “must make epidemiologic and programmatic sense and should be contextually appropriate”
- ** Effectiveness**: prevention resources should be used on effective and proven interventions
- ** Flexibility**: programs should have the “ability to respond to changes in disease epidemiology, demographic change, advances in technology, and policy/political imperatives”
- ** Accountability**: programs should have the “ability to include key aspects of their prevention services and gain insight into how they can optimize operations to maximize opportunities for prevention”
- ** Acceptability**: PCSI must be accepted by program staff members and services providers, as well as by the persons they serve

PCSI Priorities & Strategies

- ** PCSI when applicable...**
  - Impact, efficiencies
  - Redundancy, missed opportunities
  - Consistency...messages, standards, quality
  - Resiliency, back-up, surge capacity
- ** Strategies**
  - Organizational Accountability
  - Data-driven decision-making
  - Standards of Care, Data Quality, Data Use
  - Innovation in Programs for Expanded Impact

Operationalizing PCSI:
*Examples from DC and Philadelphia*

- ** Know the epidemiology **
- ** Know the populations **
- ** Know the organization(s) **
- ** Define the priority activities/services **
- ** Be accountable **
In 2008, the District of Columbia...

- Reported 16,513 HIV/AIDS cases to CDC, cumulatively from the beginning of the epidemic through December 2008
- Reported 145 primary and secondary syphilis cases in 2008; 621 over the last 5 years with 160 cases co-infected with HIV
- Reported 3,530 persons living with chronic hepatitis B (2004-2008); 9.2% co-infected with HIV
- Reported 12,624 persons living with chronic hepatitis C (2004-2008); 8.5% co-infected with HIV
- Reported Chlamydia infection rate at 1,166 per 100,000 persons in 2008
- TB cases declined substantially since 1992 (54 cases, rate 9.1) in 2008: 321 TB cases 2004-2008); 16.7% of TB cases co-infected with HIV in 2008
  - 38.9% of TB cases occurred in U.S. born blacks (case rate 6.0)
  - 51.9% of TB cases occurred in foreign born (case rate 33.7)

Philadelphia PCSI Epidemiology

Table 1: Cases and Rates (per 100,000) of PCSI-relevant Diseases, 2005-2007

<table>
<thead>
<tr>
<th>Disease</th>
<th>2005 Cases</th>
<th>2005 Rate</th>
<th>2006 Cases</th>
<th>2006 Rate</th>
<th>2007 Cases</th>
<th>2007 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS (newly reported)</td>
<td>719</td>
<td>47.4</td>
<td>752</td>
<td>49.6</td>
<td>726</td>
<td>47.8</td>
</tr>
<tr>
<td>HIV (newly reported)</td>
<td>NR*</td>
<td>~1,279</td>
<td>84.3</td>
<td>1,256</td>
<td>82.8</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (acute and confirmed chronic)</td>
<td>480</td>
<td>31.6</td>
<td>494</td>
<td>32.6</td>
<td>754</td>
<td>49.7</td>
</tr>
<tr>
<td>Hepatitis C (acute and chronic)</td>
<td>7,014</td>
<td>462.2</td>
<td>5,227</td>
<td>344.4</td>
<td>4,628</td>
<td>305.0</td>
</tr>
<tr>
<td>Syphilis, Total</td>
<td>417</td>
<td>27.5</td>
<td>540</td>
<td>35.6</td>
<td>500</td>
<td>32.9</td>
</tr>
<tr>
<td>Syphilis, Primary &amp; Secondary</td>
<td>86</td>
<td>5.7</td>
<td>125</td>
<td>8.2</td>
<td>136</td>
<td>9.0</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>15,577</td>
<td>1,026.5</td>
<td>17,199</td>
<td>1,133.3</td>
<td>17,029</td>
<td>1,122.1</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>471</td>
<td>31.0</td>
<td>621</td>
<td>41.7</td>
<td>654</td>
<td>33.2</td>
</tr>
</tbody>
</table>

*Name-based HIV reporting was implemented in October 2005
**About 90% of high-risk latent infections complete full treatment regimen

Systemic Areas of Interest Between Tuberculosis (TB) and HIV/AIDS, 2007 Philadelphia, PA

Legend:
- TB cases and deaths
- HIV/AIDS cases and deaths
Know the populations:

- General Population
- Living with HIV/AIDS
- Corrections
  - Sexually Active Men
  - MSM
  - Sexually Active Women
  - Pregnant Women
- IDU/Drug and Alcohol
- Recent Immigrants
- Medical/Long-Term Care
- Homeless
- Youth

Know the Organization:

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

Internal Collaboration & Integration
Define priority activities/services

- Routine HIV Testing and Expansion: More Tests, Higher CD4+ Counts
- Partner Services: Expanded & Integrated
- Youth STD Outreach Testing, Condom Distribution/Training
- Integrated Data System: shared data, data for data use

Where’s TB?

HAHSTA-Wide Results Frame

- Elements of Success:
  - Supportive organizational structure(s)
  - Leadership
  - Flexible funding across categorical programs
  - Cross-program performance plans
  - Administrative/operations efficiencies
  - Regular program capacity-building meetings

Our Lessons Learned
Our Lessons Learned

Potential Challenges
• Buy in by all internally
• Bureaucratic inertia
• Overall funding cuts
• Loss of specialized expertise
• Loss of program identity
• Unequal program “weight”

PCSI: Tailor to Your Area

...and try it on for size