Situational Analysis: A Key Component of Planning to End the HIV Epidemic

November 12, 2020 I 3:00 – 4:30 PM

NASTAD

Agenda

- CDC: Welcome
- Overview
- Council of State and Territorial Epidemiologists (CSTE): Using the epidemiologic profile to inform planning
- Jurisdictional example: Massachusetts
- Additional examples
- Discussion and Q&A

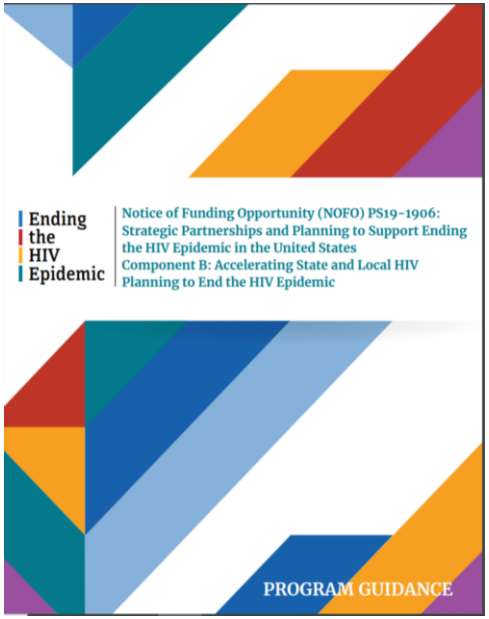
Situational Analysis (SA)

Purpose:

To better understand the local context of HIV prevention and care.

CDC PS19-1906 Component B

Program Guidance:
https://www.cdc.gov/hiv/pdf/funding/announcements/ps19-1906/cdc-hiv-PS19-1906-component-B-program-guidance.pdf



Features of SA

Format

Strengths

Challenges

Gaps / Opportunities

Barriers

Features of SA

- Local epidemiologic profile

  Core Epidemiologic Questions

  1. What are the sociodemographic characteristics of the general population in your service area?
  2. What is the scope of HIV burden in your service area?
  3. What are the indicators of risk for HIV infection in the population covered by your service area?

Integrated Guidance for Developing Epidemiologic Profiles (2014):

https://www.cdc.gov/hiv/pdf/guidelines_developing_epidemiologic_profiles.pdf

Features of SA

- Engagement:
  - Local planning bodies
  - From other local partners
  - Local community engagement efforts
  - Federal and state/locally-funded implementation partners
- Informed by previously developed plans

Features of SA

Needs assessment

Social determinants of health

New partners/voices

SA Checklist

SECTION III: SITUATIONAL ANALYSIS [NOFO Activity 3]	
Recipients should submit a snapshot summary of a current situational analysis that provides an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities (no more than 10 pages). This snapshot should be organized by pillar and synthesize information from the local epidemiologic data, from the engagement with local planning bodies, and from other local partners and local community engagement efforts.	
Please select a response in the drop-down box for which the recipient provided appropriate information.	
Did the Plan indicate:	
1. A current situational analysis that provides an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities?	Yes
2. Description of identified gaps in local HIV prevention and care activities as well as unmet needs (needs assessment)?	Yes
3. A snapshot that synthesizes information from the local epidemiologic data, from the engagement with local planning bodies, and from other local partners and local community engagement efforts?	Yes
4. If the analysis was informed by and included other federally and state/locally funded implementation partners?	Yes
5. A description of relevant social determinants of health and how they affect HIV outcomes in the jurisdiction?	Yes
6. If the situational analysis was organized by pillar?	Yes

Using the Epidemiologic Profile to Identify Strengths and Opportunities for Improvement

Council of State and Territorial Epidemiologists

Epi Profile Overview

CSTE

Purpose & Benefits of an Epi Profile

- Frames the burden of HIV on a population in terms of sociodemographic, geographic, behavioral, and clinical characteristics.
- Increases public and professional awareness of screening, prevention, and treatment recommendations.
- Provides meaningful planning data to state, local, and clinical health systems.
- Informs policies and priorities for HIV prevention, intervention, and care.

Key Components of a Model Epi Profile

- Consists of current local data.
- Contains core data elements required by CDC and HRSA.
- Has a defined focus or scope.
- Is user-friendly: easy to interpret and apply.

Developing an Epidemiologic Profile

1. Determine the scope
2. Determine the content and organization of the profile
3. Determine the development process & key stakeholders
4. Obtain the data
5. Analyze the data

Overcoming the Challenges of Developing Your Epi Profile

Determining the Scope

- Time period of profile may be predefined
- Time, personnel, and/or funding resources may be limited

Determining the Content and Organization

- Trouble capturing all aspects in the snapshot profile

Overcoming the Challenges of Developing Your Epi Profile cont.

Determining the Development Process

- Profile is developed in silos and the results are not cohesive
- Profile contains jargon and is not easy to read or understand
- Profile is rushed and/or incomplete

Obtaining the Data

- Issues with completeness, reliability and timeliness
- Issues identifying data sources

Overcoming the Challenges of Developing Your Epi Profile cont.

Analysis and Interpretation

- Profile only contains descriptive analysis with no interpretation
- Data is not triangulated
- Lacks data visualization

Reviewing Your Epi Profile and Plan

Does your plan incorporate the Epi Profile core/scope questions and address its findings?

- What are the socio-demographics of your general population?
- What is the scope of HIV burden in your area?
- Who are your high-risk or special populations?
- What are the risk factors associated with HIV infection?

Reviewing Your Epi Profile and Plan cont.

Is your plan cohesive?

- Is your plan easily understood by prevention and surveillance personnel? Is it easily understood by community members and policy makers?

Do your interventions make sense?

- How does your EHE plan compare to or supplement your previous planning efforts?

- Are the correct stakeholders involved in the planning ?

Reviewing Your Epi Profile and Plan cont.

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- Is your plan easily understood by prevention and surveillance personnel? Is it easily understood by community members and policy makers?

Do your interventions make sense?

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Questions?

Thank you!

Contact information:
India Bowman, MPH
Program Analyst for HIV, STD and HCV
ibowman@cste.org

References

Dean, H. D., & Hayes, C. (2004). *Integrated guidelines for developing epidemiologic profiles: HIV prevention and Ryan White CARE Act community planning* (cdc:45789). https://stacks.cdc.gov/view/cdc/45789

Viral Hepatitis Epidemiologic Profiles. (n.d.). Retrieved November 09, 2020, from https://www.astho.org/Viral-Hepititis-Epi-Profiles/

CSTE National Office
2635 Century Parkway NE Suite 700
Atlanta, Georgia 30345

T 770.458.3811
F 770.458.8516
ibowman@cste.org

Ending the HIV Epidemic
Section III: Situational Analysis
Thursday, November 12, 2020

Barry Callis (Barry.Callis@Mass.Gov)
Behavioral Health & Infectious Disease Prevention Unit
Office of HIV/AIDS (OHA)
Bureau of Infectious Disease and Laboratory Sciences (BIDLS)
Massachusetts Department of Public Health

Overview

- Ending the HIV Epidemic (EHE) in Suffolk County
  - Community Advisory System and Structure
- Approach to EHE Situational Analysis
  - Local Epi, Plan Coordination, and Populations
- Priority Populations
  - Tailored Approaches
- Social Determinants of Health
  - Conditions Relevant to Prevention and Care Services
- Needs Assessment by EHE Pillar
  - Themes and Priorities
- Lessons Learned

Ending the HIV Epidemic in Suffolk County

- New Community Engagement and Advisory System
- Eight new community advisory groups
  - Service System Advisory Groups
    - EHE Steering Committee
    - Integrated Prevention and Care
    - Consumer
    - Behavioral Health
  - Population Health Advisory Groups
    - Black, Latinx, Gay Men, and Transgender
    - PWID, Women, Youth and Young Adults

Approach to Situational Analysis

Participatory, intentional, and inclusive

- EHE Steering Committee and 7 additional stakeholder groups

Analytical

- Local data (epi, services, economic, addiction treatment etc.) to understand impact of past decisions, service investments, and plans, as well as underlying contributing factors

Relevant

- Focused on Suffolk County (Boston, Chelsea, Winthrop and Revere)

Comprehensive

- Characterize policy and program successes

Evidenced-based

- Wide range of information and data, both quantitative and qualitative

Priority Populations

- Using data, synthesized local plans and stakeholder recommendations
- What did we do?
  - Wrote paragraphs about impacted populations, including relevant demographics, highlighted mode of exposure
  - Characterized trends based on revised epi
  - Included feedback from advisory group stakeholders

Social Determinants of Health

- Social determinants identified throughout community engagements
  - Lead with racial equity lens
  - Used data to focus on racial/ethnic disparities and mode of exposure (PWID, MSM etc.)
  - Upstream barriers addressed through strategic collaborations

- Descriptive paragraphs – social and community contexts
    - Poverty
    - Immigration Status
    - Housing
    - Mental and Behavioral Health
    - Transportation
    - Aging and HIV
    - Others

Needs Assessment by EHE Pillar

- Needs Assessment by EHE Pillar
  - Organized needs assessment by EHE pillar
  - Formed working groups to identify needs, gaps and barriers
  - Local cross-cutting topic – HIV workforce
  - Needs, gaps, and barriers intentionally and explicitly named
    - Realistically assessed our situation, with all its strengths, weaknesses, opportunities, and threats, including root causes and effects
    - Evidence-informed basis to respond to needs
    - Inform and align EHE service investments
- Basis for developing key strategies and activities
- Focus on data by impacted populations and knowledge of the prevention and care system

Lessons Learned

- Refer to Notice of Funding Opportunity (NOFO) PS19-1906
- Establish and communicate SI plan with stakeholders – revise components as needed
- Be realistic, invest time, and respond to key elements
- Be creative and diversify how to obtain advisory
- Multi-year plans can be adjusted

Snapshot of Peer SA: Baltimore

Substance use (Priority Level 1)

Addressing substance use is a necessary part of ending the HIV epidemic in Baltimore, as one in 10 individuals in Baltimore have a dependence on drugs or alcohol, and dependency can increase risk for HIV. In particular, drugs that are injected increase an individual's risk for HIV when equipment for injection is shared. In 2018 alone, there were 888 overdose deaths in Baltimore City, a 16% increase over 2017 and 9th highest rate out of any county in the US.

Mental Health (Priority Level 1)

Mental health is another important issue in Baltimore and is often cited in BCHD's community engagement work as a risk factor and subsequent unmet need for HIV infection, as well as, retention, adherence and viral suppression in those individuals living with HIV. As many of the new diagnosed cases of HIV are in the younger populations, data showing that 17% of high school students in Baltimore City have attempted suicide in the last year (2017) demonstrates a potential dangerous correlation between mental well-being, risk behavior and HIV infection.

Trauma

Exposure to a lifetime of trauma cannot be overlooked as a driving factor in health outcomes. Data shows that nearly 3 out of 4 middle school students in Baltimore have been in a physical fight (75.6%, 2016) in the recent past. Additionally, an estimated 46.1% of Baltimore City adults have experienced between 3 and 8 Adverse Childhood Experiences (ACEs). The 2018 crime rate in Baltimore, MD was 817 (City-Data.com crime index), which was 3.0 times greater than the U.S. average. It was higher than in 99.0% of U.S. cities. Research has shown a correlation between exposure to ACEs and poor health outcomes.

Medical and Public Health Mistrust

Individual experiences of trauma can be augmented with historical, population-level trauma like the Tuskegee experiments and the proliferation for profit of Henrietta Lack's cells by one of the largest medical institutions and providers in the city. Shared experiences with negative attitudes of providers towards certain socio-demographic populations, difficult to navigate health systems, complicated insurance enrollment and deductibles, etc. have created a commonly shared and internalized trauma and mistrust in some communities that can manifest as avoidance of healthcare services, and in some cases complete disregard and distrust of public health messaging and programming.

Health Care Access (Priority Level 2)

Thirty-two percent of the city's population uses urgent clinics and EDs as a significant source of healthcare. Clear inequities can be seen by poverty, health insurance status and race (Figure 6). Lack of access to primary care means that these individuals often have less access to preventive health information, HIV testing, PrEP and if HIV positive, face challenges in linkage to treatment.

Snapshot of Peer SA: Florida

Pillar Four: Respond

Community-Level HIV Cluster Response

Current intervention responses to disease transmission include partner services for those newly diagnosed with HIV. As a largely individual-level intervention, this work is inherently difficult, which is exacerbated by the number of anonymous and unknown sex and needle-sharing partners. Provided the difficulty in locating all those in need of testing and health services and the large proportion of those at risk for exposure to HIV, it is crucial that public health interventions be designed around broader strategies to enhance positive health outcomes at the community level. Response to HIV transmission clusters at the community level will require the incorporation of novel data analysis along with the building of partnerships with community advocates, local organizations, and care providers to successfully respond to rapidly growing HIV transmission networks.

Data Systems Infrastructure

Although FDOH follows Florida Statutes and CDC guidelines related to the security and confidentiality of HIV surveillance data, there is increased need to improve the state's capacity and infrastructure to be able to share data appropriately. Simultaneously, community concerns about confidentiality should be considered. FDOH continues to streamline and enhance standards of operation for establishing and maintaining data use agreements for improved and ongoing program planning and evaluation.

Provider Ordering and Laboratory Reporting of Genotype Tests

Efforts are needed to educate and inform providers of HRSA recommendations and the necessary function that genetic sequence testing plays in the accurate conducting of molecular HIV surveillance (MHS) and the improvement of MHS programs. Further engagement of health care providers is needed to better understand and assess barriers for the ordering of genetic sequence tests and to strategize to reduce deficits and fill gaps in treatment best practices. A recent publication investigating the cost effectiveness of genotype testing at diagnosis and its clinical impact indicated that baseline genotyping did not provide significant clinical benefit and was not cost effective to the patient when integrase inhibitors are used as first-line regimens. This may have a potential impact on provider attitudes and perceptions.

Snapshot of Peer SA: Philadelphia

Needs Assessment

Health is influenced by many factors such as social environment, economic conditions, accessibility of services, individuals' behaviors, and the infrastructure of the medical care system. Philadelphia is one of 48 counties in the U.S. that have the highest incidence and prevalence of HIV. While newly diagnosed HIV cases in Philadelphia have declined, there remains much work to be done in various communities. Barriers such as poverty, homelessness, HIV stigma, an expanding opioid crisis, and other social determinants of health continue to limit local efforts to end the HIV epidemic.

Of the ten most populated cities in United States, Philadelphia is the poorest. Nearly 26% of residents live in **poverty**. Half of these 400,000 poor residents are also living in deep poverty, at less than half of the federal poverty level. That means in 2018, a family with one adult with two children lived on an annual income of less than $10,000 [9, 10]. Deep poverty is highest among Black and Hispanic residents. People living in poverty are more likely to acquire HIV and develop other chronic diseases that are the leading causes of death. People living in poverty also have shorter life spans. Approximately one-third of Philadelphia residents have health insurance through Medicaid[9].

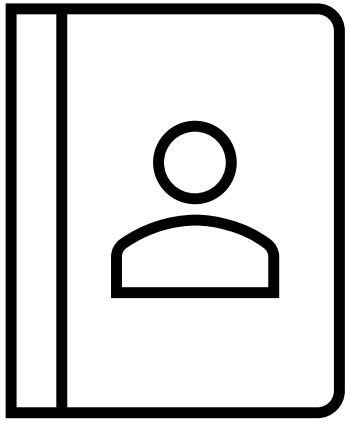
Racial and ethnic minorities represent the majority of Philadelphia's residents, making Philadelphia one of the most diverse cities in the country. **Racism,** in conjunction with poverty, is one of the drivers of health disparities in Philadelphia. Structural and interpersonal racism threaten the sense of physical safety and increases stress responses, which research shows negatively impacts health over time[11]. Structural racism also prevents access to services for racial and ethnic minority communities because of lack of resources in those communities and barriers created by the systems themselves. Philadelphia is one of the most racially segregated cities in the country. Racial segregation impacts the ability to access vital services and needed resources.

Housing in Philadelphia is increasingly expensive, due to gentrification and other forces. Lack of affordable housing is a pervasive problem. There is a lack of federal, state, and local resources to combat the problem. The entrenched nature of poverty makes this lack of housing resources even more acute for many Philadelphians. About half of renters in the city spend more than 35% of their annual income on rent[9]. On a single night in January 2018, the Philadelphia Office of Homeless Services counted 5,788 homeless people. Of these, 149 were PLWH[12]. PLWH experiencing homelessness were 53% less likely to receive ART. PLWH in temporary or unstable

Table 1: Needs Assessment Information for the Philadelphia Jurisdiction by Pillar

Needs and Gaps	Strategies to Address Needs and Gaps
Pillar 1: Diagnose	
An estimated 2,019 PLWH in Philadelphia are unaware of their status. Based on CDC estimates, these individuals accounted for 40% of HIV transmissions in Philadelphia in 2018[18].	Increase access to and options for HIV testing, including expansion of routine opt-out testing at various venues. Implement bio-social screening in health care settings. Realign focused community-based testing efforts to ensure key populations are reached.
Pillar 2: Treat	
In 2018 in Philadelphia, 10% of PLWH (n=1,710) with evidence of medical care were not virally suppressed. Based on CDC estimates, these individuals accounted for 25% of HIV transmissions in Philadelphia[18]. In addition, 2,395 people had no evidence of medical care in 2018, accounting for 35% of HIV transmissions[18].	Maintain and expand current core medical and other Ryan White funded services, as well as fund new services that support re-linkage, retention, and increased viral suppression rates.
Pillar 3: Prevent	
PDPH estimates that nearly 350,000 Philadelphians are at risk for HIV. An estimated 13,900 people in Philadelphia who are HIV negative have an indication for PrEP. This large group includes 8,290 MSM, 2,480 PWID, and 3,130 heterosexuals. Indications	Maintain condom distribution program. Expand access to PrEP, nPEP. Expand syringe service programs.
indication for PrEP in all risk groups. Based on a recent survey of PrEP prescribers, PDPH estimates that a minimum of 2,790 individuals are on PrEP (21% of all people with an indication) in Philadelphia in 2018 for a PrEP gap of 10,323 individuals. The ongoing opioid crisis in Philadelphia has overwhelmed the existing syringe service programs in Philadelphia.	
Pillar 4: Respond	
PDPH recently identified an outbreak of HIV infections among PWID[2]. In 2018, 71 new HIV diagnoses were reported among PWID, reflecting an 115% increase since 2016. Meanwhile, the outbreak in Philadelphia remains concentrated among MSM, indicating the need to investigate new cases in all risk groups. In 2018, rates of newly diagnosed HIV were more than six times greater among MSM compared to PWID and heterosexuals (784 new HIV diagnoses per 100,000 population in MSM compared to 121 per 100,000 among PWID and 30 per 100,000 in heterosexuals).	Investigate and respond to all related HIV cases to stop chains of transmission. Initiate outbreak response. Make systemic changes based on the data.

EHE Directory

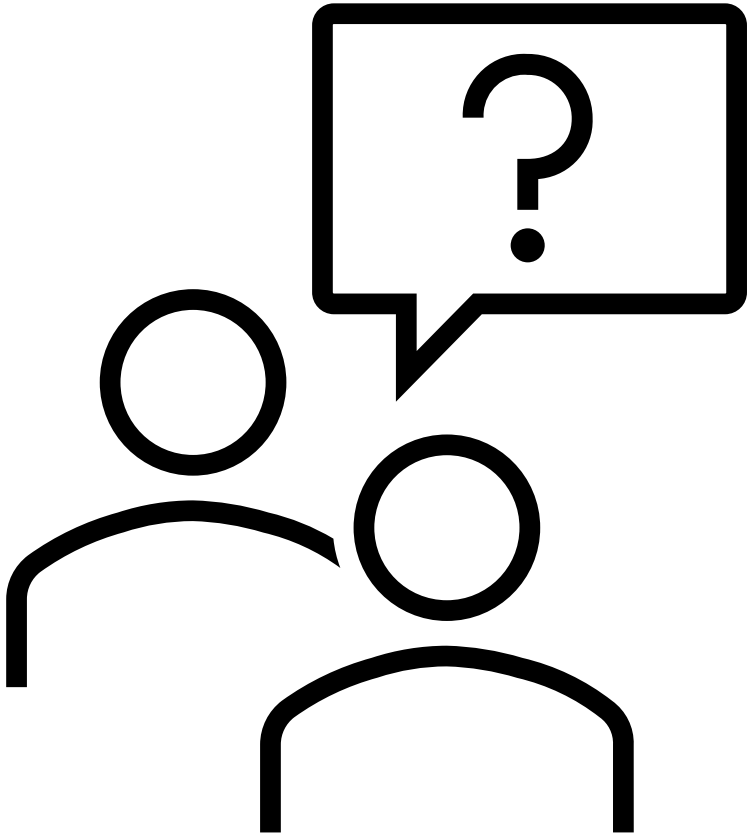


https://www.nastad.org/ending-hiv-epidemic/contact

Discussion

- Poll Question
- What challenges have you faced when conducting the SA?
- What has gone well?
- What would you do differently next time?
- What experiences from peer jurisdictions are you most interested in hearing?

Q&A



Community Engagement Virtual Town Halls

South: Tuesday, 11/17

https://nastad.zoom.us/meeting/register/tJArf--rqjwiG9weIdnD7Uqi0sUbLE5dCxdc

Northeast: Wednesday, 11/18

https://nastad.zoom.us/meeting/register/tJYuc-CuqzIqGtW9qKUrIRsaZwf5QIbk8WKX

West: Thursday, 11/19

https://nastad.zoom.us/meeting/register/tJwkf-urrTgoHNN-TcSX2llzllfAk969cfiS

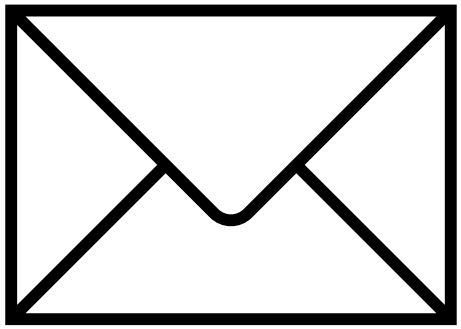
Midwest: Friday, 11/20

https://nastad.zoom.us/meeting/register/tJEofu6prTovE91Bhy0NdUI5NthXpJRG0DXX

Contact Us:

Krupa Mehta, MPH
Manager, Prevention
kmehta@nastad.org

Angela C. Johnson, MPH
Director, Prevention
ajohnson@nastad.org



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