



**CO-COUNTY WELLNESS SERVICES
PROGRAM UNITS:
BERKS AIDS NETWORK
SCHUYLKILL WELLNESS SERVICES**

**ANNUAL REPORT OF THE EXECUTIVE DIRECTOR
JULY 2009 - JULY 2010**

Here we are in 2010, almost thirty years since the HIV epidemic began. The journey has taken us from a place of fear and panic to a state of national complacency. In between, Hepatitis C came on the scene and we came to recognize the common threads linking Hepatitis to HIV and other STDs. Now, we find ourselves on the brink of a new beginning with the unveiling of President Obama's National HIV/AIDS Strategy and several other national initiatives.

Today the Centers for Disease Control and Prevention (CDC) estimates that more than one million people are living with HIV in the United States; one in five (21%) of those living with HIV remain unaware of their infection; and new infections continue at the unacceptable level of more than 56,000 each year. Sadly, AIDS related deaths in this country continue to exceed 18,000 annually.

Though less deadly, the data for other STDs is no less disturbing. In 2008 (the most current CDC report) the nation reported 1.2 million new Chlamydia infections and it is estimated the actual number of cases is more than twice that figure. While the number of Gonorrhea cases is holding steady at 336,742, Syphilis continues to raise concerns. Despite having been on track to achieve the goal of Syphilis elimination as we approached the new millennium, we have seen a steady increase in Syphilis cases during the first decade of the 21st century.

Regardless of sexual identity or orientation, men who have sex with men (MSM*) have been and continue to be severely impacted by these health issues. MSM represent the majority of persons who have died as a result of AIDS related complications; account for more than half (53%) of new domestic HIV infections each year; represent nearly half (48%) of people living with HIV; accounted for 63% of the Syphilis infections in 2008; and are over 44 times more likely than other men to become infected with HIV or Syphilis – all this while accounting for just 4% of the male population (aged 13 and over).

Turning to the racial/ethnic profiles of HIV and STDs, we find that African Americans face the most severe burden of these diseases in the nation. Blacks represent approximately 14% of the US population, but they account for almost half (46%) of people living with HIV in the US, as well as nearly half (45%) of new infections each year; and at some point in their life, approximately 1 in 16 black men will be diagnosed with HIV as will 1 in 30 black women. Young females, in general, bear the major burden of common STDs, but the highest rates of Chlamydia and Gonorrhea in the country occur among young African-American women; and African-American men have the highest rate of Syphilis in the nation.

Latinos are also disproportionately impacted by HIV and STDs. Representing 15% of our population, Latinos account for an estimated 17% of people living with HIV and 17% of new infections. The rate of new HIV infections among Hispanic men is more than double that of white men and the rate among Hispanic women is nearly four times that of white women. Syphilis rates among Latinos are double that of whites, Gonorrhea rates are more than twice that among whites, and Chlamydia rates are almost triple that of whites.

Turning our attention to Hepatitis, it is estimated that as many as 5 million Americans are chronically infected with Hepatitis B or C. The general lack of awareness about Hepatitis C, together with the asymptomatic phase which often lasts two decades or more, has led to HCV being labeled "the silent epidemic." While there have been significant declines in the incidence of Hepatitis A and B infections since 1990 and 1995 respectively, and vaccinations are available for both of those viruses, we do not see a similar profile for Hepatitis C. The incidence of acute Hepatitis C peaked in 1992, declining thereafter; however, the incidence decline reached a plateau in 2003 and we have yet to develop an HCV vaccine to help us abate the spread of this disease.

Although the decline of HCV during the 1990s is believed to be related to behavior change among injection drug users (IDUs), the majority of new cases today are associated with the risk factor of injection drug use. As we know, injection drug use is also associated with high risk of HIV infection so, it comes as no surprise that approximately 25-35% of people living with AIDS are co-infected with HIV/HCV, HCV is considered to be an AIDS defining opportunistic infection, and Hepatitis C is now the leading cause of AIDS-related deaths.

Since the HIV epidemic began, through 2007, there have been well over half a million AIDS-related deaths in this country alone; the annual number of deaths associated with HCV-related liver disease, throughout this decade, has been 12,000; and while loss of life data is not readily available for many of the more common STDs, we know that cervical cancer is associated with HPV and untreated STDs are estimated to cause at least 24,000 women to become infertile each year.

These diseases – HIV, STDs and Hepatitis – directly and disproportionately impact the most marginalized and the most vulnerable members of our community: women in general and woman of color in particular; youth and young adults; racial, ethnic, and sexual minorities; and injection drug users. In many cases, the layers of stigma and discrimination laid upon these groups are further compounded by poverty and its many consequences.

But in the end, the quality of each of our lives is impoverished to the degree that any one of our lives is diminished. In the words of Franklin Delano Roosevelt, "The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

It is from this perspective then on these health issues, which form the very core of our mission that I can say this year has brought some welcome news. The CDC's "Program Collaboration and Service Integration" (PCSI) white paper – focusing on HIV, viral Hepatitis, STDs and TB – was released in 2009; the ban on federal funding for syringe exchange was lifted as 2009 drew to a close; in early 2010 the National Training Center for Integrated Hepatitis HIV/STD Prevention Services launched an online training site aimed at frontline workers like our staff; and on July 13th President Obama released the first ever comprehensive National HIV/AIDS Strategy. Together these long overdue initiatives will, hopefully, bring

attention and revive a sense of urgency regarding these three public health concerns. Health and Human Service Secretary Kathleen Sebelius's comment in response to the National HIV/AIDS Strategy can be readily applied to STDs and Hepatitis as well, "We're merely keeping pace, when we should be gaining ground."

The vision for the National HIV/AIDS Strategy (NHAS) is simple: *The United States will become a place where new HIV infections are rare and when they do occur, 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 care, free from stigma and discrimination.*

This is a vision we, at Co-County Wellness Services, have held for a quarter of a century and a vision we expanded, to include STDs and Hepatitis, a decade ago.

The Obama administration's strategy lays out three primary goals that hinge on the key elements of prevention, treatment, and equitable access to quality care: reduce the rate of new HIV infections; increase access to care for people living with HIV/AIDS in order to optimize health outcomes, and reduce HIV-related health disparities across socio-economic, racial, and ethnic lines. Recognizing the importance of implementation, a fourth goal of achieving a more coordinated national response to the domestic HIV epidemic was added. These same goals, underlying PCSI and the work of the National Training Center mentioned above, are also the very foundation of our mission at Co-County Wellness Services.

While these goals are not necessarily new the strategy for achieving them is. According HHS Secretary Katherine Sebelius, "we knew we couldn't keep using the same approach and expect different results. We also knew that at a time when all of us - the federal government, the states, communities, non-profit groups, and businesses - are being forced to do more with less, we couldn't expect a big infusion of new resources. So while the strategy does highlight areas for additional investment, it also identifies how we can use the resources we have more effectively to prevent, diagnose, and treat HIV/AIDS."

In looking a bit more closely at the three main goals the strategy also outlines some specific actions that collectively must take in order to achieve the main goals.

In order to reduce new HIV infections we must:

- Intensify HIV prevention efforts in communities where HIV is most heavily concentrated.
- Expand targeted efforts to prevent HIV infections using a combination of effective, evidence-based approaches
- Educate all Americans about the threat of HIV and how to prevent it.

In order to increase access to care and improve health outcomes for people living with HIV/AIDS we must take the following steps:

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV.
- Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
- Support people living with HIV and co-occurring health conditions who have challenges meeting their basic needs, such as housing.

In order to reduce HIV related health disparities we must:

- Reduce HIV-related mortality in communities at high risk for HIV infection.
- Adopt community-level approaches to reduce HIV-infection in high-risk communities.
- Reduce stigma and discrimination against people living with HIV.

Finally, in order to achieve a more coordinated national response we must:

- Increase the coordination of HIV programs across the Federal government and between federal agencies and state, territorial, tribal and local governments.
- Develop improved mechanisms to monitor and report on progress toward achieving national goals.

I am pleased that I can say, with all honesty, the day-to-day work of Co-County Wellness Services fully reflects this national HIV strategy and our work extends this strategy to include STDs and Hepatitis. To see and hear the strategies we have embraced for years now being articulated at the national level is both affirming and gratifying.

The remainder of this report will focus on a look at our local accomplishments during the last fiscal year. For a detailed look at our client & prevention service statistics please review the graphs that can be found at end of this report.

CARE SERVICES

Our care services consist of case management - a client centered service designed to link clients with medical care, psychosocial services and other supportive service through ongoing assessment, development of a client centered plan and collaboration with other community providers. In FY 2009-2010, 258 clients (including 60 new clients) received 5,685 hours of case management's services, 63% of who were HIV+ and 37% who are living with AIDS. Other service participation included: 94 clients received 369 hours of Medication Adherence Education by one of our three AIDS certified RNs; 215 clients received over 4,700 meals; 195 clients received harm and risk reduction services and 55 clients benefitted from support group or life-skills sessions. Some other highlights from our client data show that our HIV/AIDS population is aging - 53% of our clients are between 45 and 64 and 43% are between 25 and 44. A full 70% of our clients are below the poverty level and, not surprisingly, 24% of our client base is uninsured. Of those who are insured, the majority (54%) are on Medical Assistance, 14% are on Medicare and 8% carry private insurance.

PREVENTION SERVICES

Our prevention services continue to target those most at risk for HIV/STDs and Hepatitis while continuing to reach the general population with updated, factual, accurate information about these critically important public health issues. Whether the message is delivered to an individual or a group; on a college campus, in a high school, prison, drug rehabilitation facility or a community setting our primary focus is to meet people where they are with a message they can personally relate to and understand.

This year, thanks to the willingness of our staff to work outside normal hours, we were able to implement an outreach and testing program at the Red Star – a gay bar in Reading. This is an important first step toward reaching at risk populations in locations that are comfortable for them, allowing us to establish and build relationship within this community. In the coming fiscal year, drastic changes in our HIV Testing and Counseling Participating Provider Agreement with the state will support us to do more testing at offsite high risk locations outside of normal business hours (6 pm – 6am) in order to reach those most at risk.

We recognize that prevention is currently the only cure for HIV, as well as being the healthiest strategy against other STDS and Hepatitis C, so we place a strong emphasis on risk reduction counseling that supports individuals in behavior changes that will reduce their risk of infection. If someone tests positive for HIV, at our agency, we are the perfect resource to help them gain access to the medical & psychosocial services that are critical to their well-being – in keeping with the new National Strategy.

In the past fiscal year over 13,000 individuals received over 3,600 hours of prevention services. Staff distributed more than 40,000 prevention tools, pamphlets or promotional items. Our HIV testing/counseling program continued to offer traditional HIV tests through blood draws or OraSure(oral swab) and the OraQuick Rapid HIV test (in Berks County) for a total of 647 tests with 6 positives identified for an almost 1% positivity rate. In keeping with the direction that the region, state & CDC are moving we only spent 19% of our time providing outreach and health communications (generalized information to larger groups) and 81% of our time in individualized and group level interventions which are more targeted toward helping participants identify and commit to reducing personal risk.

STD CLINICS

The STD Clinics continue to be extremely busy screening and treating patients for Syphilis Gonorrhea, Chlamydia, Trichomonas, Genital Warts, and Herpes as well as offering the traditional HIV test. The clinics conducted over 2,500 patient visits, up 20% from last year, pointing to the fact that the need for this service is high and those in need are comfortable accessing services at our agency. Another contributing factor to this increase may have been the initiation of a walk-in clinic day, every Monday, at our Reading location. This has helped us to reach and treat those with symptoms while reducing the wait time, for a scheduled appointment, to an average of 2 weeks.

The clinics are an important source of medical care for the uninsured and under insured in our community and yet, they remain a significantly under-funded service. We opened the clinics in 2001 and have received no increase in our reimbursement structure from the state. In fact, state cut backs have resulted in lost reimbursements for a number of STD services we continue to provide – free of charge for our patients – because we believe that they are critical to maintaining the public health of our community.

CONCLUSION

Despite a number of obstacles, the past year was another successful one for CCWS. While we lost money, the loss was minimal compared to the number of funding cuts we experienced after the fiscal year contracts were in place. We did not have to eliminate any services and managed to keep our doors open with no layoffs during the protracted 100 day state budget battle last summer.

From an operational perspective we face a couple obstacles each year. First, almost 88% of our budget is based on fee for service contracts, meaning that we must first provide the service and then bill the funder for reimbursement – usually at a unit rate that has not been increased in several years. Secondly, a great deal of effort must be placed on fulfilling our contracts often causing staff to be stretched so thin that we do not have the time or resources to develop new and innovative programs or apply for additional foundation funds.

As a result, we rely on and are grateful for the continued community support we receive from United Way's in Berks & Schuylkill County, through local foundations, generous private donors, board support and our

special events. It is only through raising these often non-designated funds that we are able to continue to fulfill our mission and meet the needs of those we serve.

John F. Kennedy said, "There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction." These words came to mind when I first heard President Obama make his campaign promise to, if elected, develop a National HIV/AIDS Strategy. Those of us who have been doing this work for what feels like a lifetime know the price that has been paid, for years, by comfortable inaction. It is heartening that at long last we have a program of action. This program of action, the National HIV/AIDS Strategy is a significant milestone in the history of the epidemic. Remember that the history of this now almost 30 year old epidemic is filled with instances of finger-pointing and hand wringing, where the responsibility for this disease was placed on one group or another. It was a "gay-disease", a "Haitian disease", "a black disease", a drug-user's disease", a prostitutes disease", a disease of "those people" and the blame was merely shifted from one group to another, instilling a sense of complacency in others until the blame was pointed at them.

I agree completely with the thoughts of Dan O'Neill on the Bilerico Project Blog when he writes that it would serve us well at this pivotal juncture in the history of the HIV/AIDS epidemic to remember the words of William Budd, a seventeenth century English physician and contemporary of John Snow, the famed father of epidemiology, credited with halting London's 1848 cholera epidemic by removing the Broad Street pump. Budd's work with the poor who suffered most from cholera gave him a deep appreciation of how inequities in access to health care, wealth and other social disparities impact the health of all of society.

"By reason of our common humanity, we are all more nearly related here than we are apt to think. The members of the great human family are, in fact connected by a thousand secret ties, of whose existence the world in general little dreams. And he that was never connected with his poorest neighbor by deeds of Charity and Love, may one day find, when it is too late, that he is connected with him by a bond which may bring them both, at once, to a common grave." (William Budd)

Since becoming Executive Director, now almost 15 years ago, I have repeatedly argued that education about and treatment for HIV, STDs and Hepatitis are all about improving public health and that public health is a common good. The more we allow these diseases to divide us by placing blame elsewhere, the more ground we will continue to lose.

Co-County Wellness Services, our passionate staff, dedicated Board and community supporters can be proud of the role we have played and will continue to play in improving public health through the fulfillment of our mission which is focused on prevention and compassionate care for community health needs, including HIV/AIDS. Together we have made a difference in the lives of thousands of people because of our willingness to live those words of JFK, taking the risks and bearing the costs, to assure a program of action is in place that addresses these critical public health issues in our community.

Carolyn M. Bazik

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Executive Director
July 27, 2010

Sources

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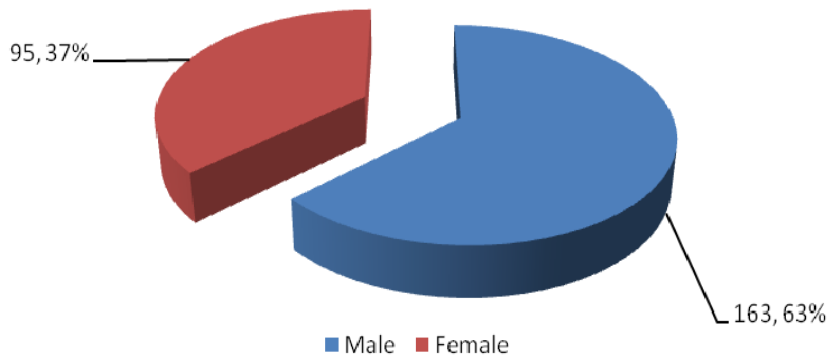
Dan O'Neill, July 15, 2010

* The CDC refers to men who have sex with men (MSM) throughout their reports because it indicates risk behavior(s) for transmission/acquisition of HIV/STDs rather than how individuals self-identify in terms of their sexual orientation.

Care Services - Gender Distribution

7/2009 - 6/2010

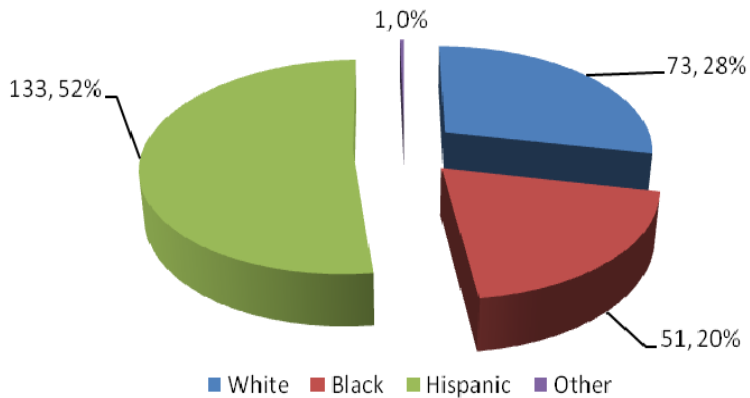
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Care Services - Ethnicity Distribution

7/2009 - 6/2010

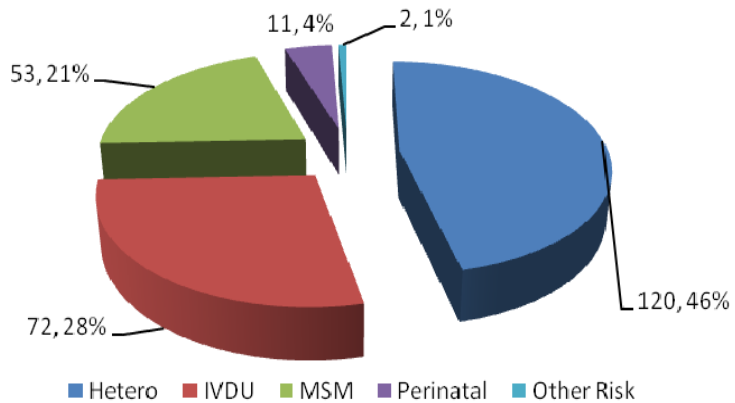
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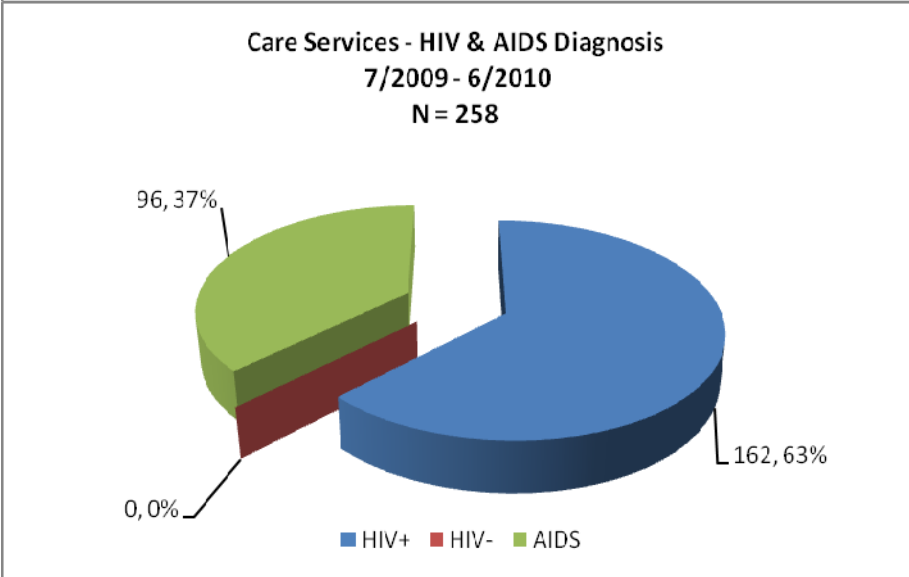
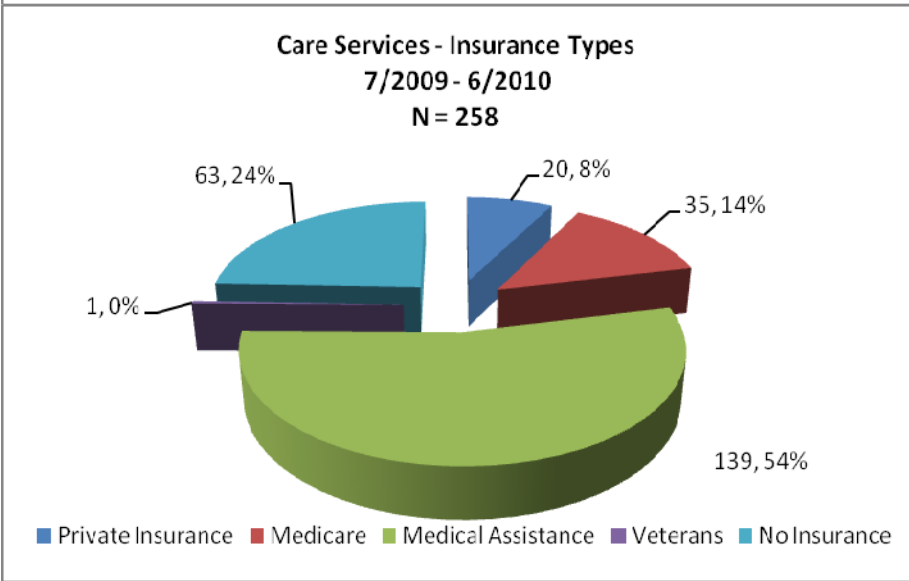
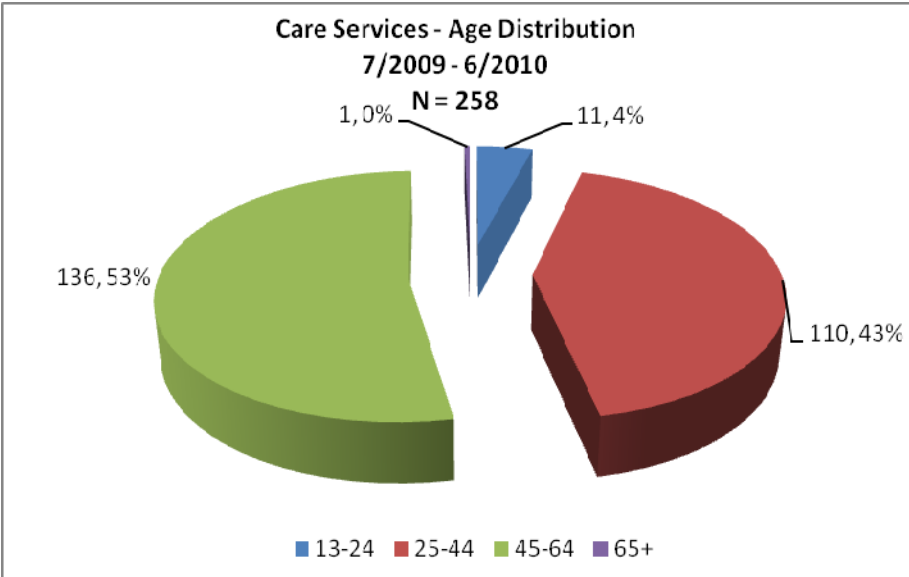


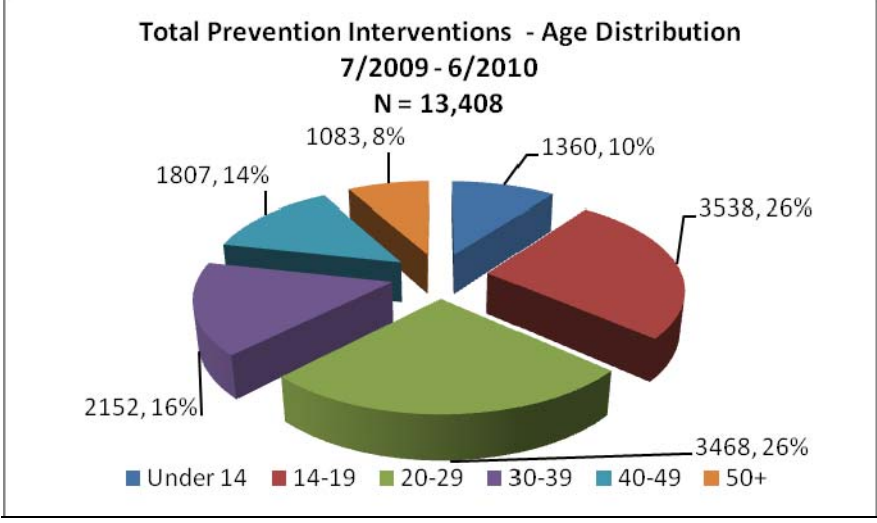
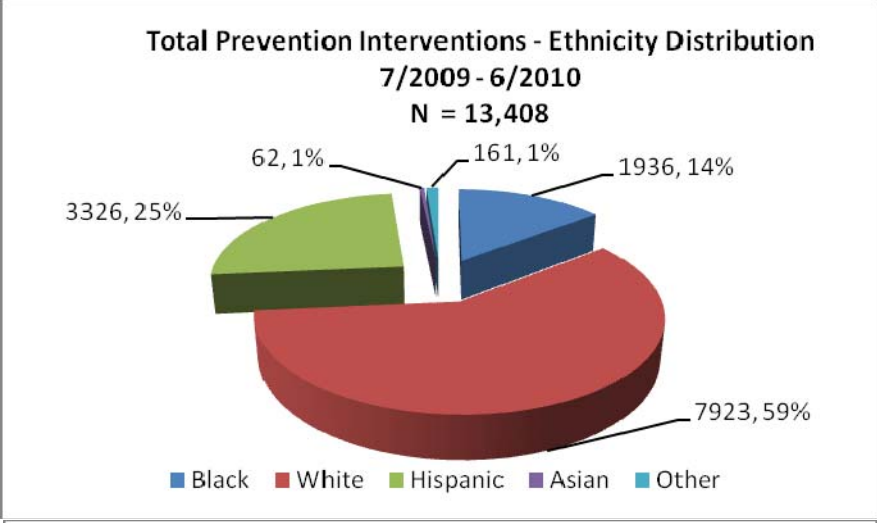
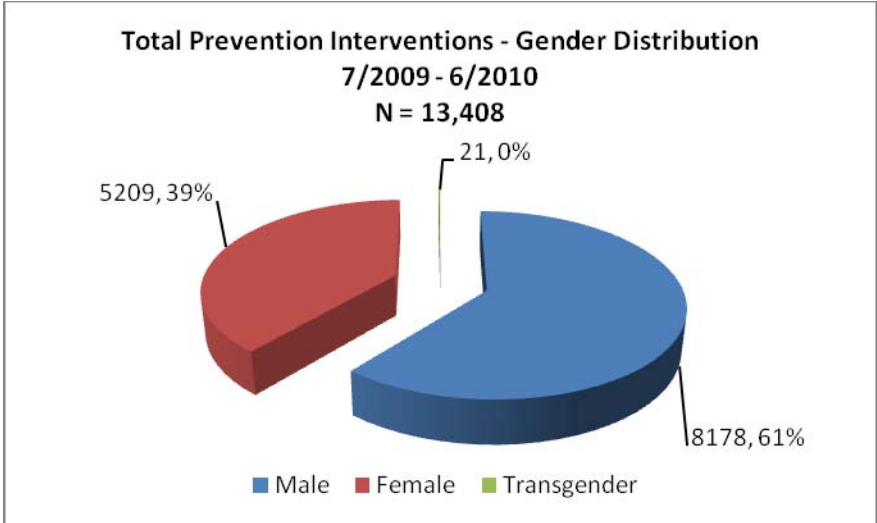
Care Services - Transmission Mode

7/2009 - 6/2010

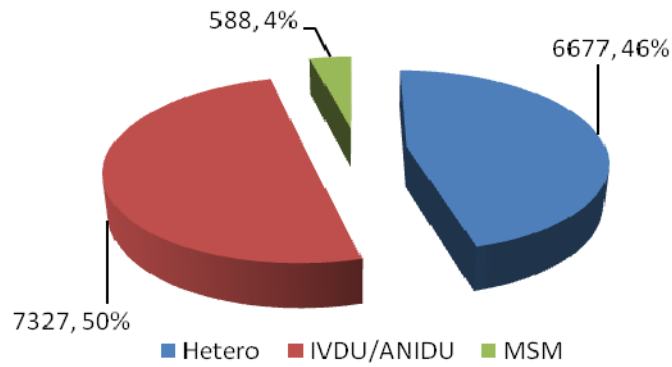
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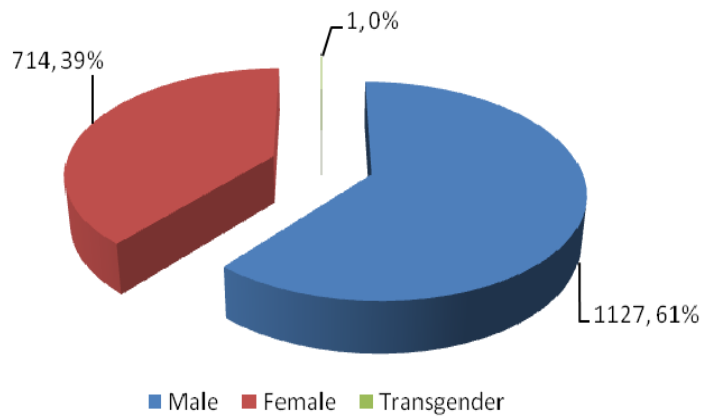




Total Prevention Interventions - Transmission Mode
7/2009 - 6/2010
N = 13,408



IDI - Gender Distribution
7/2009 - 6/2010
N = 1,842



IDI - Ethnicity Distribution
7/2009 - 6/2010
N = 1,842

