Lessons from Sexually Transmitted Infections II: Prospects for HIV Treatment as Prevention

Lessons from Cook County Hospital, 1982 – 1998: Prospects for Improving HIV Prevention and Care By Expanding Access to Care and Treatment

Renslow Sherer
University of Chicago
Learning Objectives & Disclosures

At the end of the session, the participant will be able to:

• Review strategies to improve HIV testing and entry into care
• Cite innovations in retention in HIV care for special populations
• Utilize local and national care cascades to maximally expand effective HIV treatment

• Research or grant support – none
• Advisory board with honoraria – Bristol Meyers Squibb
• Speakers bureau – none
• Stock shareholder – none
• Other support – none

This talk will include off-label and investigational uses of antiretroviral drugs.
Outline

• Introduction

• Lessons from the Cook County Hospital HIV Care Cascade, 1998

• Prospects for Improving Diagnosis, Entry and Retention in Care
Which statement best describes your current mental status as an HIV care provider?

1. I have post traumatic stress disorder
2. I have post traumatic stress disorder
3. I have post traumatic stress disorder
4. I might have post traumatic stress disorder
5. Other
6. Denial is not just a river in Jordan
Dedication

To HIV front line caregivers & the HIV care team
...please take care of yourselves, too
Global HIV Imperatives

Human Rights

Prevention  Care

(epidemiology)  (support)
Lessons in this presentation:

• Things that I did *not* do....but others did, in collaboration & partnership
• We listened to the expressed needs of our patients
• We built a ‘medical home’ in 1983 that evolved to 1998, and to the CORE Center
In this presentation:

• Focus: Left side of HIV care cascade
• There is less work needed on the right side of the cascade in the US in this era
  – Guidelines: Treat all HIV+
  – Majority of treated pts < detection
  – Greater understanding, strategies for adherence

Source: MMWR: December 2, 2011 / 60(47);1618-1623
Last Words on ART as Prevention -> PrEP

• On January 9, 2013, a young MSM walked into my office asking for PrEP. He was well informed.

• We did screening tests, and I gave him his script. When the tests cleared, I called him, and he started PrEP.

• He has insurance. The same standard of care should be available in the public sector.
Last Words on ART as Prevention -> PrEP

• With proper adherence, PrEP further reduces risk by 86-96% in men and women at risk*

• HIV risk is NOT static
  – In Partners Prep, after 3 years, only 36% had same level of ongoing HIV risk
    • REST: Partner on ART or no longer partner w/ HIV+

For King Holmes
1996 – 2010: Epidemiology of HIV and STI post-HAART, Europe, particularly in MSMs

- Dramatic resurgence of STI in US and Europe, esp. in MSM
  - Syphilis, GC in MSM
  - LGV proctitis return in MSM
  - Hepatitis C in MSM; no longer confined to IDUs
- GC fluoroquinolone resistance from Asia to US, concentrated in MSM
- GC decreasing cephalosporin susceptibility, concentrated in MSM
- Azithromycin resistant T. pallidum in US, Dublin; in MSM

Which statement best describes your current experience with PrEP?

1. I have initiated PrEP discussions
2. I have initiative PrEP discussions and prescribed PrEP
3. I am willing to recommend PrEP but have not had the opportunity
4. I am not willing to recommend PrEP yet
5. Other
Outline

• Introduction

• Lessons from the Cook County Hospital HIV Care Cascade, 1998

• Prospects for Improving Diagnosis, Entry and Retention in Care
Cook County Hospital
Chicago’s only public hospital
The Sable/Sherer Clinic
Established May, 1983, CCH

- Ron Sable, MD
- Fierce advocate for Human Rights
  - rights of gay men and women
  - women’s rights
  - just treatment of prisoners
  - national health care, PNHP
  - People living with HIV/AIDS
    - Founded Sable/Sherer Clinic at Cook County Hospital 1983
    - Founded AIDS Foundation of Chicago
  - Candidate for 44th Ward Alderman 2x

- Mardge Cohen, MD

Ron Sable, M.D.
HIV Patients at Cook County Hospital, 1982 – 1998*

Clinic census 2,801 pts 1998

1998 at CCH
75 of 280 beds – HIV+
Cumulative: 3,717 pts
Quarterly Memorials - 2+ deaths/wk

Clinic census 141 pts 1984

### HIV Caregivers, 1986 & 1997

<table>
<thead>
<tr>
<th>1986</th>
<th>1997</th>
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<tr>
<td>• 2 clinics/week</td>
<td>• 10 clinics/wk, evenings</td>
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<tr>
<td>• 2.5 MDs</td>
<td>• 12 MDs, fellows</td>
</tr>
<tr>
<td>• RN</td>
<td>• 8 RNs</td>
</tr>
<tr>
<td>• 2 NPs (in &amp; out pt)</td>
<td>• 4 NPs</td>
</tr>
<tr>
<td>• SW</td>
<td>• 6 SWs, drug counselors</td>
</tr>
<tr>
<td>• Health Educator</td>
<td>• 4 Health educators</td>
</tr>
<tr>
<td></td>
<td>• 1 Pharm D</td>
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HIV in Chicago 1998

- Estimated 10,000 HIV+ (#7 in US)
- CCH 2,800 (1/4-1/3 of total known HIV+ in care)
  - 2/3 AA, 1/6 white, 1/6 Hispanic (1/3 Mex, 1/3 PR, 1/3 otr)
  - 1/3 MSM, 1/3 IDU, 1/3 hetero
  - 2/3 men, 1/3 women
  - 1/5 adolescents and young adults age < 30
  - 2/3 uninsured, 1/3 Medicaid/Medicare, 2% private
- Md CD4 266; 34% < 200, 34% 2-500, 21% > 500
- Median VL: < 500 (= undetectable)
- US Gdln ART initiation: 350 cell/ml
CCH Cascade 1997-8

- 4,520 estimated HIV+ (38% above known HIV+)
- 2,801 HIV+ diagnosed (62%)
  of total est. HIV+: 62%
- 2,528 enrolled in care (≥2 visits)
  of known HIV+ at CCH: 90%
  of total est. HIV+: 56%
- → 139 deaths (5.2%)
- → 688 lost to follow up (29%)
- 1,716 retained in care (65.8%)
  of known HIV+ at CCH: 61%
  of total est. HIV+: 38%
- 1,135 on ART (66%)
  of known HIV+ at CCH: 45%
  of total est. HIV+: 25%
- 570 VL < 500 (51%)
  of known HIV+ at CCH: 20%
  of total est. HIV+: 13%

Sherer et al, AIDS Care 2002;14(S):S31-S44.
HIV Care Cascade
Cook County Hospital, 1997-8

4,520 (estimate, 36% above known HIV+)

Sherer et al, AIDS Care 2002;14(S):S31-S44.
Of known HIV infections (2,801),

90% entered care and 61% were retained in care

Sherer et al, AIDS Care 2002;14(S):S31-S44.
Of known HIV infections (2,801),
90% entered care and 61% were retained in care.

Sherer et al, AIDS Care 2002;14(S):S31-S44.
So what did we do? Priorities

• Integrated Patient education, condoms, counseling and testing
  – MSM, AA & Hispanic educators & staff, women for women, former IDUs

• Effective care in a safe, non-judgmental setting w/ flexible hours, evenings

• People, caregivers and patients, first
• To the extent possible, ‘one stop shopping’
• Pastoral care for grieving, spiritual support
So what did we do?

And two critical other items

• Jonathan Mann’s annual lecture at the International AIDS conferences; and ...

• We had great parties, we mourned and celebrated together….quarterly memorial services
The Cook County HIV Primary Care Center

- Care and prevention integrated ....which enabled personal ‘accompaneur’ for HIV+ to clinic....and this made a big difference
  - Co-location of HIV, STI, drug treatment, pharm
- Women and Children with HIV Program
  - Co-location of ob-gyne, peds, adult, psych, child psych, on site day care, drug counseling

A Model for the Delivery of Care for HIV-Positive Clients

Expand HIV Testing
Expand HIV Testing in STI Clinic & Trauma

CCH walk-in STI clinic

- 41/504 HIV+ (8%)
- 110/515 syphilis (21%)
  - Of syph 13/41 (31%) HIV+

CCH trauma unit

- 1,049 admis 6-9/1988
- 41 HIV+ (4.3%)
  - STI Hx, IDU, HBV/HCV, youth

Sexually Transmitted Diseases March-April, 1994

HIV and Syphilis Seroprevalence Among Clients With Sexually Transmitted Diseases Attending a Walk-in Clinic at Cook County Hospital

DAVID A. ANSELL, MD, MPH, TZYY-CHYN HU, RN, MS, MICHELLE STRAUS, MD, MARDGE COHEN, MD, AND RENSLOW SHERER, MD

Sloan E et al

Sloan E et al

HIV VCT CCH 1988-98

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<thead>
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<th>'88</th>
<th>'90</th>
<th>'92</th>
<th>'97-98</th>
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<td>Counsel</td>
<td>2,084</td>
<td>2,040</td>
<td>4,605</td>
<td>5,433</td>
</tr>
<tr>
<td>Test</td>
<td>1,142</td>
<td>1,536</td>
<td>3,367</td>
<td>4,855</td>
</tr>
<tr>
<td># pos</td>
<td>272</td>
<td>364</td>
<td>485</td>
<td>388</td>
</tr>
<tr>
<td>% pos</td>
<td>24%</td>
<td>24%</td>
<td>14%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Health educators: black and Hispanic men and women MSMs, former IDUs
Who engendered trust, first, and then HIV VCT
Acted as ‘accompagneur’ for all HIV+ at first clinic visit

Sherer et al, AIDS Care 2002;14(S):S31-S44.
Ensure Entry and Retention in Care
AIDS Care
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713403300

HIV multidisciplinary teams work: Support services improve access to and retention in HIV primary care
R. Shererab, K. Stieglitza; J. Narra; J. Jaseka; L. Greena; B. Moorea; S. Shottb; M. Cohena
a The CORE Center (formerly The Cook County HIV Primary Care Center), Cook County Hospital, USA
b Rush Medical College, Chicago, USA

Online publication date: 27 May 2010
Support services significantly increased retention in HIV care, 1997–1998

- 20% increase in regular visits (>2/year) in an urban clinic with support services

Sherer R et al, *AIDS Care*, August, 2002
Project CONNECT

University of Alabama, Birmingham multidisciplinary care team initiative to connect newly diagnosed HIV-positive persons into HIV care within DAYS of diagnosis

• Achievements, 2007
  – 81% attended primary HIV provider visit
  – 12% Drop in “no-show” from 31% to 19% ($P < .01$)
  – Cost: $200 per client/ $1628 per additional client linked to care > SOC
CCH HOSUS Outcomes II

- Retention in care associated with significantly lower viral loads
- Support services significantly increased clinic visit and regular clinic care
- HAART prescriptions rose from 70% in 1996 to 82% in 1998
- Overall low mortality: 5.3% in early HAART era
  - higher in women 8.6%.
- Predictors of poorer access and retention
  - lower age; IDU; and lack of insurance
- Greater need for all services in women

Sherer R et al, AIDS Care, August, 2002
Mortality in Women 1989-1999


Steven Whitman, PhD; James Murphy, MPH; Mardge Cohen, MD; Renslow Sherer, MD

Women and Children with HIV Program at Cook County--1987

Women as share of prevalent AIDS cases

- Single site program
  - Comprehensive medical & psychosocial care
  - Women & children together
  - Drug Treatment, mental health, domestic violence counseling
  - NIH research within the context of this care
Women with HIV shape their care

• Protect Confidentiality
• Test older children
• Medication side effects - comorbidities

• Importance of violence, trauma, comorbidities like liver disease, drug use, smoking

• Address multiple vulnerabilities – Flexible appointments – Support groups – Peer education programs

• "Ambience of caring"

Support group named "The evolution of Dignity"

WE-ACT Rwanda
Mardge Cohen, MD
Activities Promoting Entry & Retention in Care

People to people
- Low/no income
- MSM
- Women and children
- IDUs
- Adolescents
- Jail detainees

Community & systems
- Systems collaboration
  - City, County, AFC, NGOs
- Training
  - MATEC, local
- Integrated research
  - WIHS, WITS, CPCRA, local
- Outcomes research
  - HOSUS
Ruth M. Rothstein CORE Center for HIV and related infections
Ruth M. Rothstein CORE Center for HIV and related infections

- Private public partnership, Cook County Bureau of Health Services and Rush University
  - Ruth M. Rothstein and Leo Henikoff; private fundraising by Christie Hefner
  - $27M – county, federal, state, and private funding

- **First floor**: separate pharmacy; STI screening and care; on site chemical dependency treatment center; community support services;
- **Second floor**: research, teaching classrooms, alternative Rx (massage & acupuncture), admin
- **Third floor**: adult and women/children’s clinics, on-site day care, integrated pharm D, mental health, case management, nursing
- **Fourth floor**: dental clinic, lab, phlebotomy, diagnostic procedures

- Current leadership: Bob Weinstein, David Barker, Cathy Braswell, Board of Directors. Stroger Hospital and Rush MDs. CCBHS Staff
Outline

• Introduction
• Lessons from the Cook County Hospital HIV Care Cascade, 1998
• Prospects for Improving Diagnosis, Entry and Retention in Care
IHI change package

• 2000-2002 Institute for Healthcare Improvement HIV Initiative
• 75 Ryan White Title III Clinics serving 75,000 persons; HRSA funded
• IHI change package.....Plan, Try, Study, Act
• Physician support, patient self management (Adherence), health system, clinic mgmt

Institute for Healthcare Improvement. www.ihi.org
HIV Collaborative Results

10,311 HIV+ persons x 18 mos

mean

• Retention in care:
  16% increase  83%

• % on HAART:
  12% increase  76%

• Adherence:
  22% increase  88%

• % Pts with VL < 50:

IHI Collaborative led to the HRSA initiated SPNS Projects to improve entrance and retention into HIV care 2002 - 2008

Sherer R. The IHI Breakthrough Collaborative on HIV/AIDS. Presented at the 6th Annual Meeting of the Institute for Healthcare Improvement, San Francisco, CA. 12.6.00
Retention in Care in 291,000 Ryan White Program Patients: 76%
2 visits in > 3 mos

Doshi RK et al, CROI 2013, poster 1031a
How Can HIV Care Cascades Help?

• Widely varying methodologies need standardization
  – Population versus single site
  – Varying denominators

• Value in attention to overall care outcomes
  – Should inform interventions to address weaknesses
  – Should enable monitoring over time

• LOCAL HIV Care cascades encouraged
  – Longitudinal and informed by local epidemiology
  – Relevant for, and sensitive to, specific sub-groups

• Most important purpose
  – To define what care system modifications work

Programmatic Challenges – A Health Department Perspective

- **Testing**
  - Insufficient testing
  - Access to testing sites
  - Who pays
  - Language and cultural issues
  - Stigma and confidentiality

- **Linkage to care**
  - Delays in getting first appointment
  - Language and cultural barriers
  - Housing instability
  - Lack of knowledge about services
  - Intake barriers
  - Access to community providers
  - Bad initial provider experience
  - Problems navigating care
  - Insurance

- **Retention**
  - Insufficient follow up after linkage
  - Facility access issues
  - Difficulties making appointments
  - Multiple provider sites

DC DOH HAHSTA, 2012-2014 Comprehensive Plan
Greenberg, CROI 2013
Challenges from the Patient Perspective

- **Linkage to Care (n=695)**
  - Did not want to think about being positive (21%)
  - Felt well (18%)
  - Did not believe test result (8%)
  - Drinking or using drugs (4%)
  - Incarcerated, unable to get appointment, no money, too busy, moved out of town (1-3%)

- **Reasons did not take last dose of ART (n=1071)**
  - Forgot (38%)
  - Changed daily routine (12%)
  - Was busy (11%)
  - Side effects (7%)
  - Cost, depressed, too many pills (1-2%)

- **Need for ancillary services in past year (n=1,650)**
  - HIV case management (45%)
  - Mental health (33%)
  - Dental (32%)
  - Social services (31%)
  - Transportation (25%)
  - Meals or food (18%)
  - Shelter or housing (15%)

MMWR Surveillance Summaries, Sep 2, 2011, Vol 60 (11)
Greenberg, CROI 2013
National Cascade-Related Goals Established, 2010

- **Testing** – ↑ percentage of people living with HIV who know their status from 79% to 90%

- **Linkage** – ↑ proportion of newly diagnosed patients linked to clinical care within 3 mos from 65% to 85%

- **Retention** – ↑ proportion of Ryan White clients in continuous care from 73% to 80%

- **Viral Suppression** – ↑ proportion of HIV-diagnosed gay and bisexual men, Blacks and Latinos with undetectable viral load by 20%

Greenberg, CROI 2013
Standardized Cascade-Related Measures

- IOM expert committee recommended standardized cascade-related measures
  - **Linkage** - Proportion of people newly diagnosed with HIV who are linked to care for HIV within 3 mos. of diagnosis
  - **Retention in care** – Proportion of people with diagnosed HIV infection who are in continuous care (2 or more visits for routine HIV care in the preceding 12 mos. at least 3 mos. apart)
  - **Viral Suppression** – Proportion of people with diagnosed HIV infection who have been on ART for 12 or more mos. and have a viral load below the level of detection
Figure 1: Percentage of estimated number of HIV-infected persons* in stages of continuum of HIV care in four large United States cities through December 2009

* Includes people diagnosed with HIV in 2008 and living with HIV through 2009 and an estimated additional 20% who are unaware of their infection.
HIV Diagnosis
Expanded HIV Testing Program
Chicago South Side

• Lead: University of Chicago Hospitals (UCH)
• Members of the South Side Health Collaborative (SSHC) will also participate. 12+ local CHC organizations:
  – Access Community Health Network, Beloved Community Family Wellness Center, Chicago Family Health Center, Community Health Center, Friend Family Health Center, Holy Cross Hospital, IMAN Health Center, La Rabida Children’s Hospital, Mercy Family Medical Center, Near North Health Services Corporation (Komed Holman Health Center), TCA Health Inc., and South Side Help Center

• Linkage to care will be at the UCH DCAM or the Access Grand Blvd. Clinic

David Pitrak, M.D. et al, Chicago DOPH, September 28, 2011
222 HIV+ identified
99 previously HIV+
44 not in care – 91% linked
108 new HIV+
90 linked (83%)
Publicly-Supported HIV Rapid Tests in DC

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Test Count</th>
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<tbody>
<tr>
<td>FY2007</td>
<td>191</td>
</tr>
<tr>
<td>FY2008</td>
<td>332</td>
</tr>
<tr>
<td>FY2009</td>
<td>319</td>
</tr>
<tr>
<td>FY2010</td>
<td>355</td>
</tr>
<tr>
<td>FY2011</td>
<td>391</td>
</tr>
</tbody>
</table>

Median CD4 Count at Diagnosis

Slide courtesy of DC DOH HAHSTA
Greenberg, CROI 2013
DC Cascade-Related Programs

- **Linkage to care**
  - HIV testing providers funded to link HIV clients to medical care
  - **Red Carpet Program**
    - DC residents newly diagnosed or returning to HIV care
    - No insurance required
    - Clinic appointment within 1-2 business days at one of 18 clinics

- **Retention and re-engagement in care**
  - **Recapture Blitz!** – finds and re-engages clients lost to care

1375 clients reported as lost → 970 clients not found in system or inactive > 6 mos → 404 clients contacted → 174 clients recaptured

Greenberg, CROI 2013

Haukoos et al. JAMA 2010;304:284-92

* = Number of Tests
■ = Number of Positive Tests

- Targeted testing
- Routine testing
- Enhanced targeted testing

Year

Number of Tests Performed

Number of Positive Tests

0 5 10 15 20 25 30 35
0 1,000 2,000 3,000 4,000 5,000 6,000

† The DECC was added as a clinical site in October 2008. There have been no positives in the DECC.
† The AUCC was added as a clinical site in September 2009.

Haukoos et al. JAMA 2010;304:284-92
How do we increase HIV diagnosis?

- **CDC Guidelines 2006**  
  (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm)

- **USPSTF Draft Recommendation Statement**  
  (http://www.uspreventiveservicestaskforce.org/uspstf13/hiv/hivdraftrec.htm)

- Normalizing HIV testing
  - DECREASING HIV STIGMA

- **Home HIV testing**

Gardner E. ACTHIV 2013.
Linkage to HIV Care
Proven Effective Measures to Improve Linkage to Care

• Limited, strengths-based case management
• Intensive outreach via case managers
• Patient navigators
• Retention messaging

Gardner et al. AIDS 2005;19:423-31
Garner E, unpublished observation, ACTHIV 2013
ARTAS: Percentage of Clients Linked to Care by 6 Months and Who Persisted in Care at 12 Months

Gardner et al. AIDS 2005;19:423-31
Use of Case Managers to Actively Link Persons with HIV to HIV Care, Denver Health:
Percentage of persons identified with new HIV infection linked into care within 6 months

NEW

Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel

Melanie A. Thompson, MD; Michael J. Mugavero, MD, MHS; K. Rivet Amico, PhD; Victoria A. Cargill, MD, MSCE; Larry W. Chang, MD, MPH; Robert Gross, MD, MSCE; Catherine Orrell, MBChB, MSc, MMed; Frederick L. Altice, MD; David R. Bangsberg, MD, MPH; John G. Bartlett, MD; Curt G. Beckwith, MD; Nadia Dowshen, MD; Christopher M. Gordon, PhD; Tim Horn, MS; Princy Kumar, MD; James D. Scott, PharmD, MED; Michael J. Stirratt, PhD; Robert H. Remien, PhD; Jane M. Simoni, PhD; and Jean B. Nachega, MD, PhD, MPH

Recommendations

1. **Systematic monitoring** of successful entry into HIV care is recommended for all individuals diagnosed with HIV (II A)

2. **Systematic monitoring** of retention in HIV care is recommended for all patients (II A)

3. **Brief, strengths-based case management** for individuals with a new HIV diagnosis is recommended (II B)

4. **Intensive outreach** for individuals not engaged in medical care within 6 mos of a new HIV diagnosis may be considered (III C)

5. Use of **peer or paraprofessional patient navigators** may be considered (III C)

Other Reasonable Retention Strategies

• Substance abuse counseling and treatment services
• Mental Health diagnosis and care
• Housing for homeless individuals
• Address competing needs
• Improve the system of health care delivery

Gardner E. ACTHIV 2013.
Evolution of the Cascade of HIV Care: 
British Columbia, Canada (1996-2010)

HIV Care in Canada: Single-Payer Health Service, Free Access to ART

- HIV Diagnosed: 53% (1996), 86% (2009)
- Linked to Care: 43% (1996), 79% (2009)
- Retained in Care: ~30% (1996), 55% (2009)
- Prescribed ART: ~20% (1996), 46% (2009)
- HIV RNA Suppressed: 2% (1996), 32% (2009)

Hope for the future?

HIV Care Cascade: King County, Washington and the US

Dombrowski J, et al. 20\textsuperscript{th} CROI. Atlanta, 2013. Abstract 1027.
Summary I

• The care cascade is best approached locally – If you don’t have one, it’s worth developing
• Start with the necessary data, relationships, collaborations and partnerships needed at each stage
Summary II:
Expanded HIV testing collaborations

• Health dept, STI clinic, ob-gyne & MCH clinics, high schools
• ALL family practice, general medicine....
• BIG problem at present: WE ARE FAILING TO IMPLEMENT CDC GUIDELINES
• Must have primary care clinics engaged, expand routine testing, REVISE ROUTINE LAB TESTING PROCEDURES FOR ALL NEW ADOL & ADULT PATIENTS
Summary III: Access and retention in care

• ACA, expanded Medicaid should help this
• Danger if ‘medical homes’ have insufficient HIV expertise....so make partnerships!
• Probably the strongest argument for the expansion of Ryan White
Summary IV

Medical Home

• The Medical Home is a culmination of 3 decades experience in HIV care

• The key elements are:
  – Patient centered (don’t forget that) accessible hours, one-stop shopping
  – One stop shopping (to the extent possible)

• Opportunity for ACA to improve integration of HIV with primary care and non-HIV causes of morbidity and mortality...if we are careful and do it well
  – And if the feds, state, local gov’ts allow and enable us to do so
Global HIV Imperatives

Human Rights

Prevention (epidemiology)

Care (support)
Jonathan Mann
Recipient of the first Ron Sable Award 1995
Thank You

Chicago
• Ron Sable
• Mardge Cohen
• Ginny Cohen
• Bonnie Lubin
• Mildred Williamson
• Jim Lovette
• Jim Delacerda
• David Pitrak
• Nathan Linsk
• Barbara Schechtmann

CROI, ACTHIV, and HRSA
• David Greenburg
• Ed Gardner
• Laura Cheever

HIV and Human Rights
• Jonathan Mann