

Welcome

Office for State, Tribal, Local and Territorial Support
presents . . .

CDC Vital Signs

HIV Care Saves Lives: Viral Suppression is Key

December 2, 2014

2:00–3:00 pm (EST)



Agenda

- | | | |
|----------------|------------------------------------|---|
| 2:00 pm | Welcome & Introductions | Steven L. Reynolds, MPH
Deputy Director,
Office for State, Tribal, Local and Territorial Support, CDC |
| 2:04 pm | Presentations | Heather Bradley, PhD
Epidemiologist, Behavioral and Clinical Surveillance Branch, Division of
HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and
TB Prevention, CDC

Karalee Poschman, MPH
Epidemiologist, HIV Incidence and Case Surveillance Branch, National
Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC; Direct
Assignee to the Florida Department of Health

Venus Vacharakitja, MA
Director, Support Services, Apicha Community Health Center |
| 2:30 pm | Q&A and Discussion | Steven L. Reynolds, MPH |
| 2:55 pm | Wrap-up | |
| 3:00 pm | End of Call | |



CDC
Vitalsigns™ Teleconference
to support STLT efforts and build
momentum around the monthly
release of CDC *Vital Signs*



Vital Signs Town Hall Teleconference

HIV Diagnosis, Care, and Treatment Among Persons Living with HIV—United States, 2011

Heather Bradley, PhD

Behavioral and Clinical Surveillance Branch
Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention

December 2, 2014

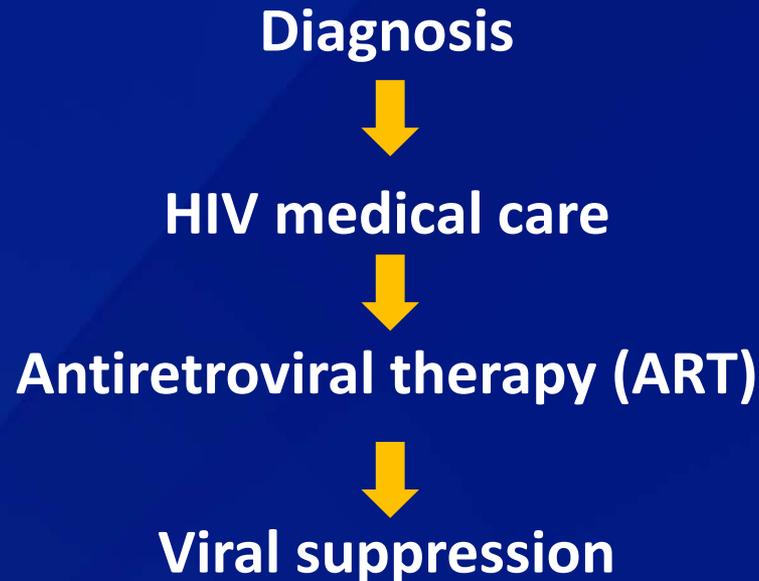
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention



HIV in the United States

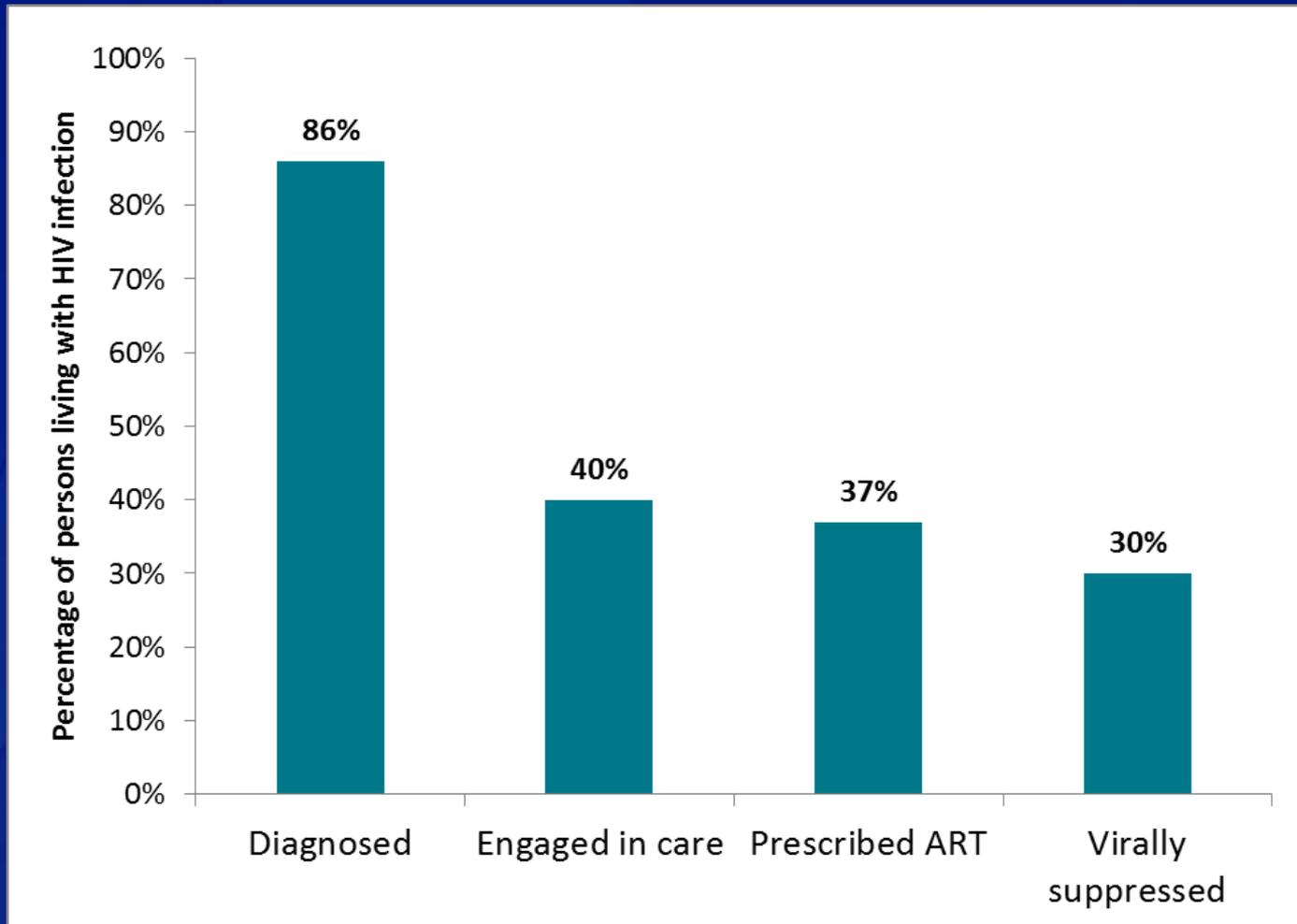
- ❑ 1.2 million people living with HIV
- ❑ 50,000 new infections each year
- ❑ **Goals of National HIV/AIDS Strategy**
 - Reduce new HIV infections
 - Improve health outcomes among persons living with HIV
 - Reduce HIV-related health disparities

HIV Diagnosis, Medical Care, and Treatment

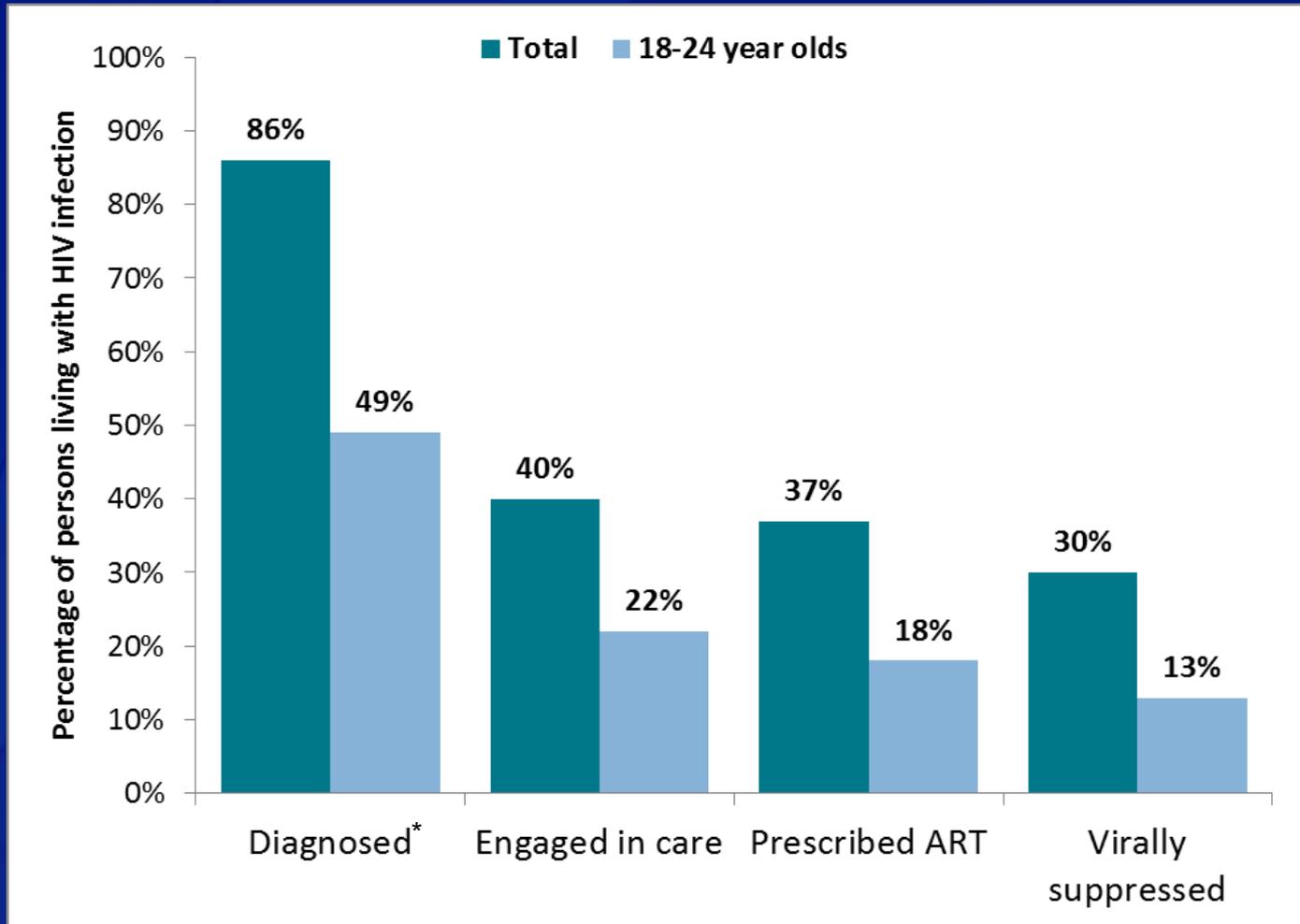


- ❑ Improved health and nearly normal life expectancy among persons living with HIV infection
- ❑ Risk of sexual HIV transmission reduced by 96%

HIV Care Continuum Among 1.2 Million Persons Living with HIV—United States, 2011



HIV Care Continuum Among 18–24 Year Olds Living with HIV—United States, 2011

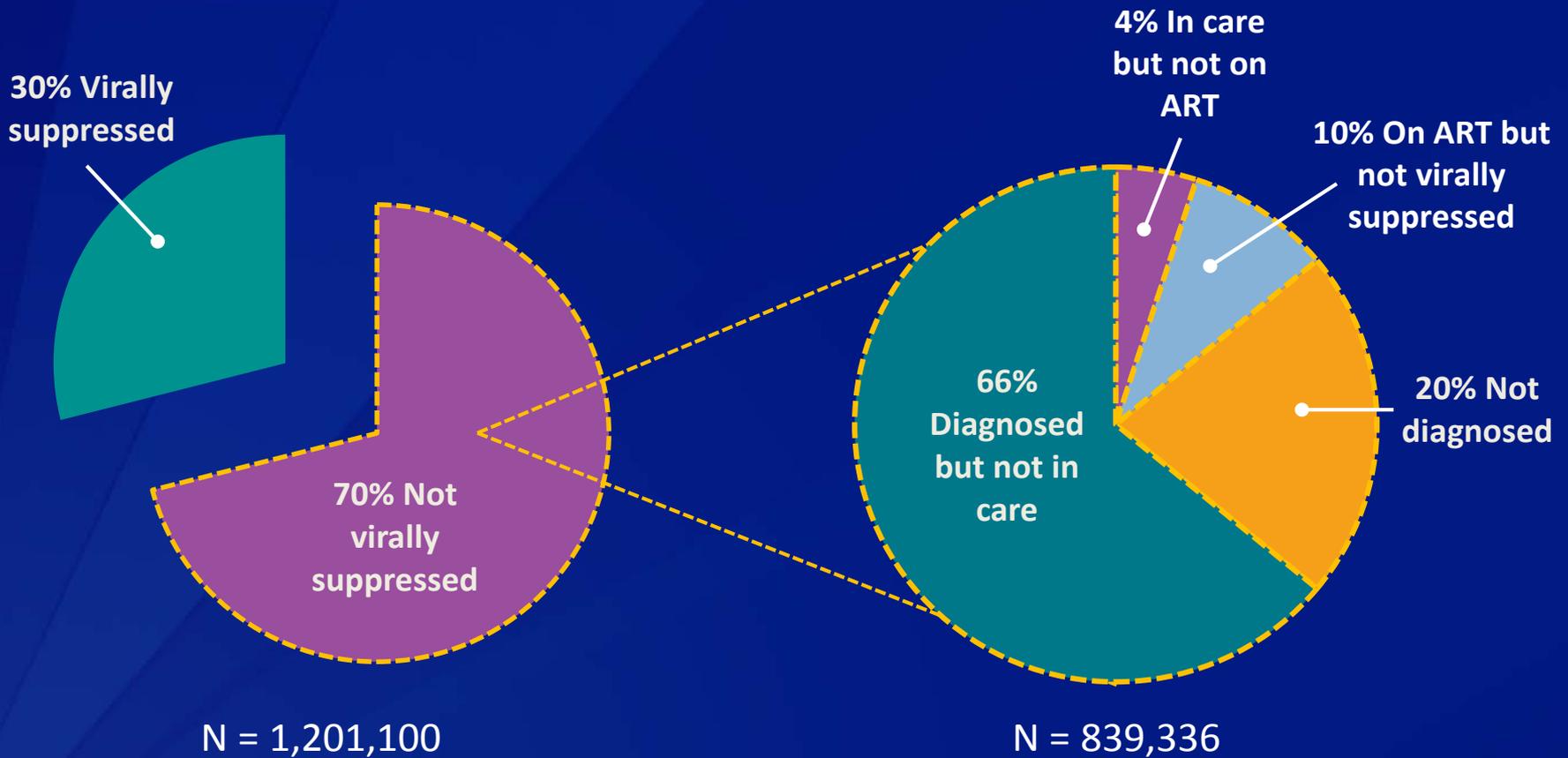


*Percentage diagnosed estimated among 13–24 year olds

Linkage to HIV Medical Care Within 3 Months— Persons Diagnosed with HIV in 2011

Characteristic	Linkage to care
Total	80%
Sex	
Male	79%
Female	82%
Age	
13–24	73%
25–34	78%
35–44	83%
45–54	84%
55+	84%
Race/ethnicity	
Black/African American	76%
Hispanic or Latino	82%
White	85%
Other	86%

Diagnosis and Treatment Status of Persons Living with HIV Who Are Not Virally Suppressed— United States, 2011



What Do These Data Tell Us?

- ❑ **Improvements are needed across the HIV care continuum to**
 - Protect the health of persons living with HIV
 - Reduce HIV transmission
 - Reach national prevention and care goals

- ❑ **Greatest opportunities for improvement**
 - Reduce undiagnosed HIV infections
 - Increase percentage of persons living with HIV who are engaged in HIV medical care
 - Improve outcomes along HIV care continuum for young people

What Should Be Done?

- ❑ **HIV testing**

- ❑ **Linking and retaining patients in HIV care**
 - Provider notification systems
 - Strengths-based case management
 - Co-located medical and support services

- ❑ **Prescribing ART as part of HIV medical care**
 - ART recommended for all persons living with HIV
 - 92% of persons in medical care were prescribed ART
 - 76% of persons in medical care achieved viral suppression

How Do We Get There?

- ❑ **CDC is providing funding and technical assistance to state and local health departments to reduce undiagnosed infections and improve linkage and engagement in care**
- ❑ **Health departments and community-based organizations can expand HIV testing services and link all diagnosed persons to care**
- ❑ **Healthcare providers can prescribe ART to all patients living with HIV and help patients living with HIV stay in care and on ART, including linking them to supportive services**

Conclusion

- ❑ Continued and intensified efforts needed to improve outcomes along the HIV care continuum
- ❑ Effort from all communities needed to implement effective strategies to improve the health of people living with HIV and reduce new infections

Thank You!

*Vital Signs*co-authors

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Florida Continuum of HIV Care

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Definitions

- HIV-Infected: Estimated number of persons living with HIV in Florida, including those unaware/undiagnosed (15.8% national estimate)
- HIV-Diagnosed: Number of persons known to be alive and living with HIV in Florida through 2013 (regardless of where diagnosed) as of 06/30/2014
- Linked to Care (Ever in Care): Number of persons living with HIV in Florida (regardless of where diagnosed) who ever had a CD4 or viral load (VL) test in the Enhanced HIV/AIDS Reporting System (eHARS)

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Definitions (cont'd)

- In Care this Year: Number of persons living with HIV in Florida (regardless of where diagnosed) having at least 1 HIV-related care service (VL or CD4 test or refill of HIV-related prescription) in eHARS, Careware, AIDS Drug Assistance Program (ADAP), or Medicaid
- On Antiretroviral Therapy (ART): Estimated 90.6% of persons in care in Florida per 2011 Medical Monitoring Project (MMP) data
- Suppressed VL: Estimated 78.0% on ART with a suppressed VL (<200 copies/ml) in Florida per 2011 MMP data

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Limitations of the Data

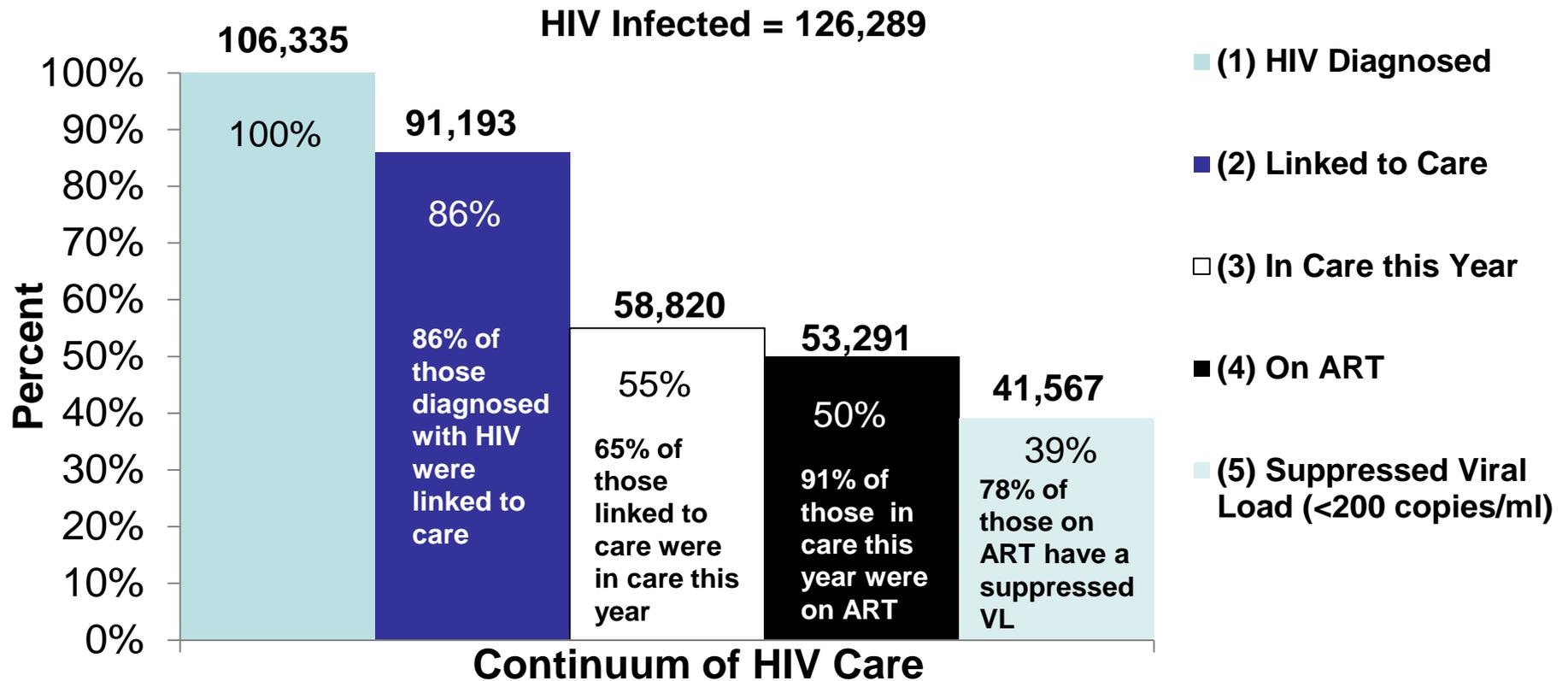
- The analysis of these data depends on
 - The completeness of laboratory reporting in eHARS
 - Maintaining timely reporting of deaths
 - Maintaining accurate current addresses, accommodating for in- and out-migration
- Significant strides have been made in the past year to address all three at both the state and local levels and continued efforts will be made to further improve the completeness
- Data for persons on ART and those with a suppressed VL were estimated based on MMP data

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Number and Percentage of HIV-Diagnosed Persons Engaged in Selected Stages of The Continuum of HIV Care—Florida, 2013

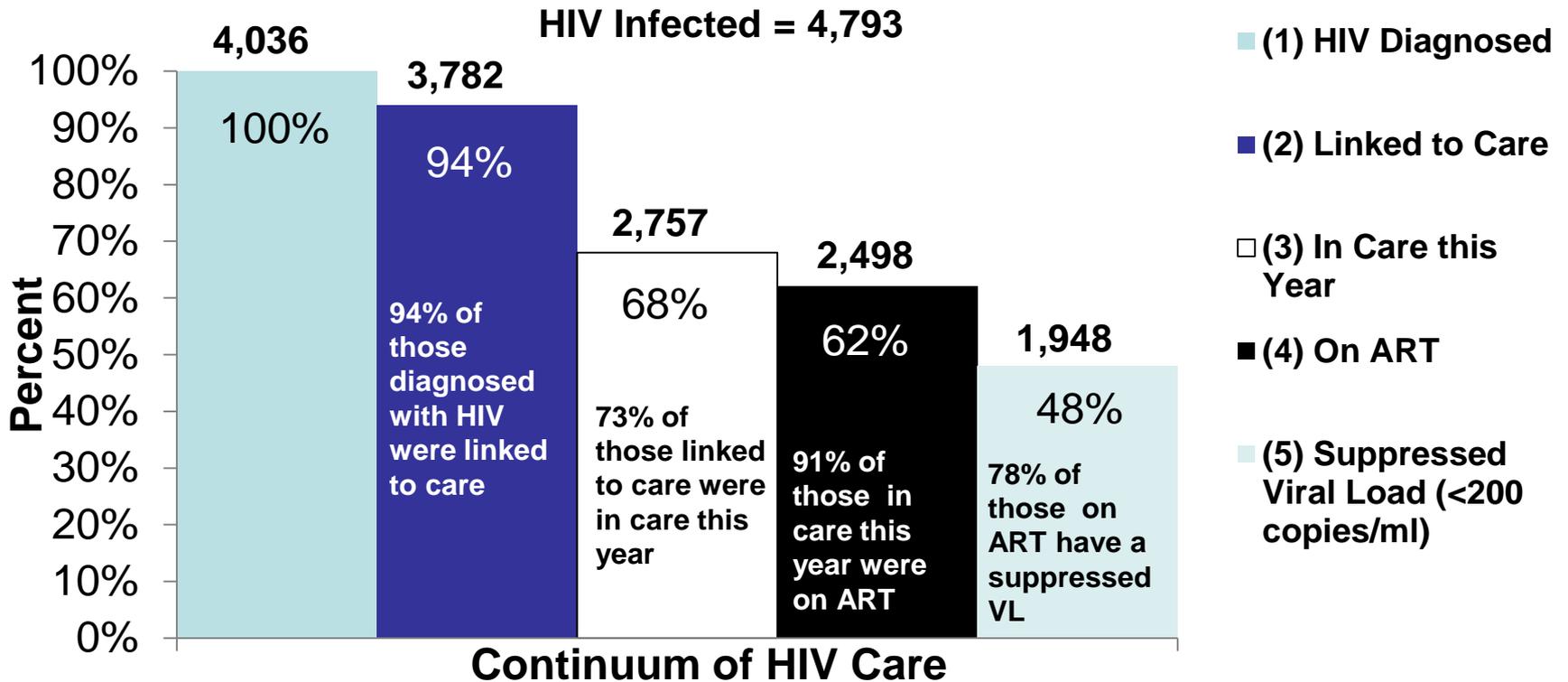


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Number and Percentage of HIV-Infected Persons Engaged in Selected Stages of The Continuum of HIV Care—Rural Area, 2013

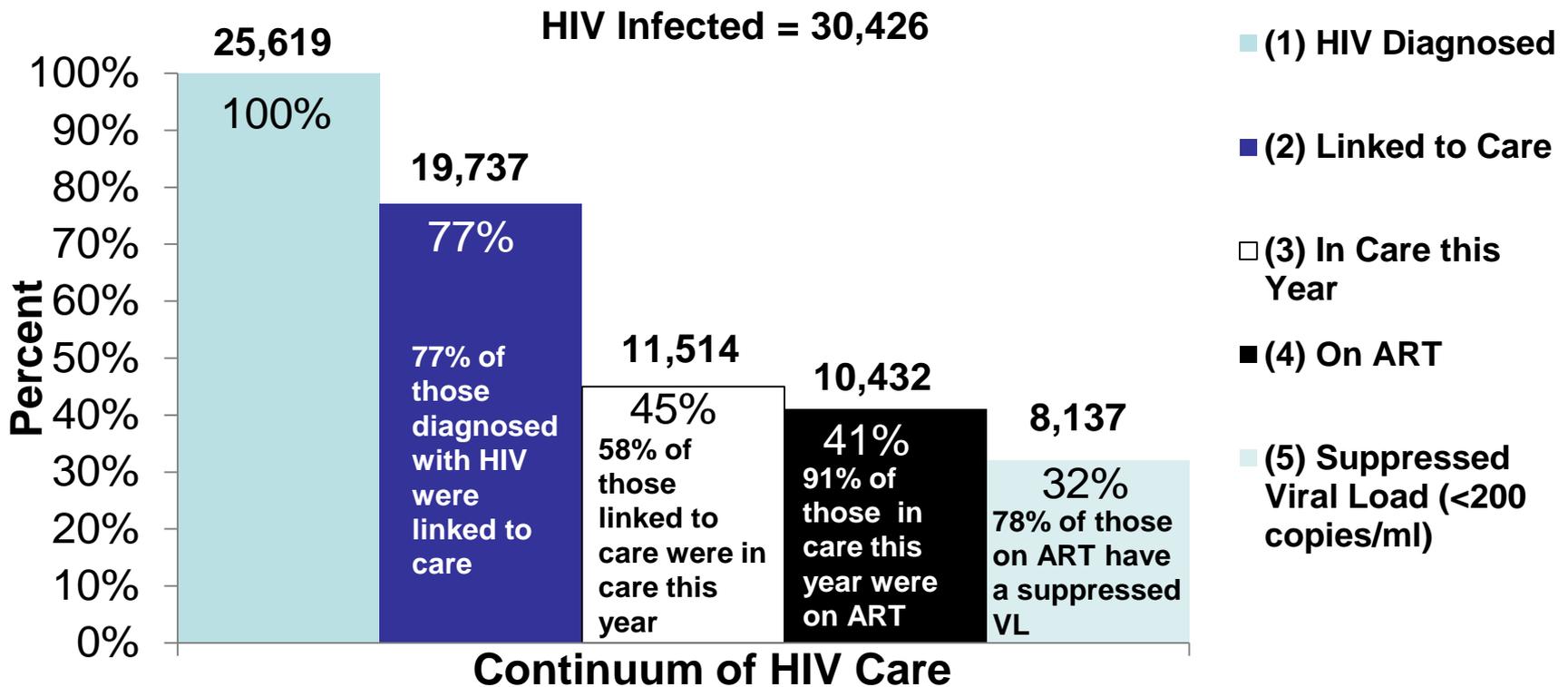


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Number and Percentage of HIV-Diagnosed Persons Engaged in Selected Stages of The Continuum of HIV Care—Urban Area, 2013



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Demographic and Risk Trends

- Higher rates of linkage, ART use, and viral suppression among females compared to males
- Lower rates of linkage, ART use, and viral suppression among blacks and Hispanics compared to whites, with Hispanics having the lowest rates
- Persons aged 25–49 years had lower rates of linkage, ART use, and viral suppression compared to other age groups (highest among persons 50+ years)
- Higher rates of linkage and ART use among injection drug users (IDU) compared to men who have sex with men (MSM) and heterosexuals
- MSM had highest rate of viral suppression

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Future Plans

- Assess those persons NOT linked to care within 3 months of the HIV disease diagnosis date
 - Enhanced linkage to care
 - Contact last known facility/provider
 - Proactive approach
- Address and/or locate persons that are presumed to be alive AND found NOT to be in care at all (beyond 3 months after diagnosis)
- Address those persons with late HIV diagnoses, currently around 20% statewide

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Future Plans (cont'd)

- Continue to evaluate completeness of laboratory data in eHARS
- Identify other available databases that may be beneficial for matching with eHARS in order to identify additional sources of care
- Improve the calculation of in- and out-migration and incorporate this into estimates of who is in care
- Assess use of the patient care databases (Careware, ADAP, Medicaid) for calculating ART usage compared to using MMP data

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Thank you
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INTERVENTION STRATEGIES ALONG THE HIV CARE CONTINUUM

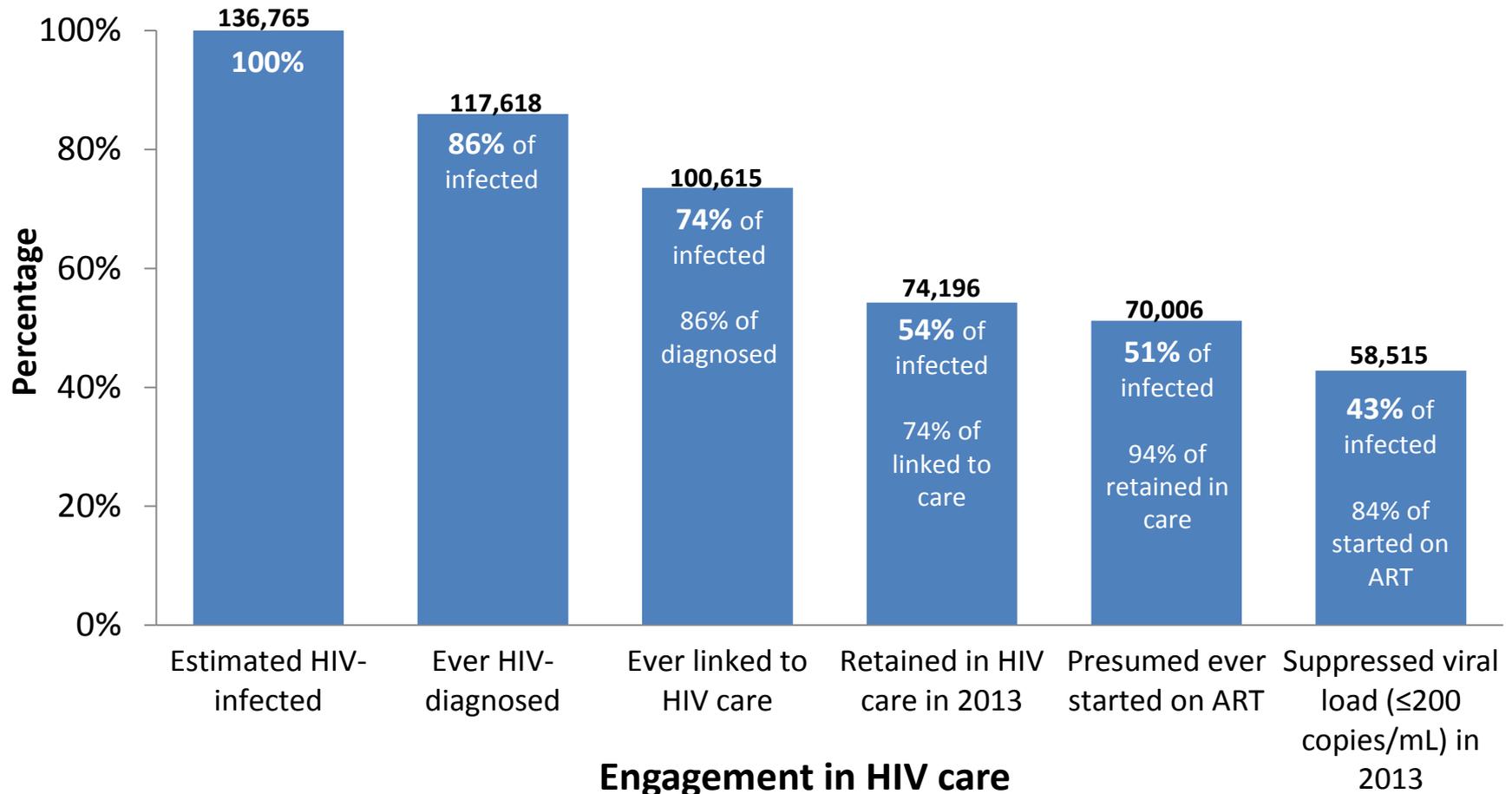
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TELECONFERENCE
DECEMBER 2, 2014*

Venus
Vacharakitja,
MA

Director of
Support
Services

Apicha
Community
Health Center

Number and Proportion of Persons with HIV in New York City and Engaged in Selected Stages of the Continuum of Care at the End of 2013



Of all persons estimated to be infected with HIV in NYC, 43% have a suppressed viral load.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2014.

For definitions of the stages of the continuum of care, see the New York City HIV/AIDS Surveillance Slide Sets: <http://www.nyc.gov/html/doh/html/data/epi-surveillance.shtml>

Apicha Community Health Center

Background

- Located in Manhattan (a hub of all transportation)
- Providing HIV-related services for 25 years
- Federally Qualified Health Center 'look-alike' since 2012
- Level 3 Patient-Centered Medical Home Center since 2013
- Primary Care Services including Primary Trans* Health Care



HIV-related prevention or other health promotion services

- Care coordination
- Primary Care model of medical care including evening hours twice a week (9:15 am–7:00 pm)
- Nutrition Health Education
- HIV/STI testing with immediate linkage to care: targeted testing model
- Culturally competent multilingual and multicultural staff
- Health Home
- NY State of Health Marketplace health insurance enrollment on site

Apicha Care Coordination Client Characteristics (N=235)

Variable	Category	Percentage
Age Group (as of 2013, calculated as 2013 – year of birth)	≤35	41%
	36-45	34%
	46+	25%
Gender Identity	Male	88%
	Female	10%
	Other	2%
Transmission Risk	MSM	71%
	Heterosexual	11%
	IDU	5%
	Unknown/Missing	13%
Race/Ethnicity	Asian/Pacific Islander	49%
	Hispanic	23%
	Non-Hispanic Black	17%
	Non-Hispanic White	8%
	Other	3%
Educational Level	≥High School	84%
	<High School	15%
	Unknown/Missing	1%
Income Level	<Federal Poverty Level	60%
	≥Federal Poverty Level	29%
	Unknown/Missing	11%

Ryan White Part A Care Coordination Program (CCP): Intervention Strategies

Outreach and Patient Navigation

- Case Finding
 - Linkage to care efforts for newly diagnosed and/or those out of care
- Outreach for Reengagement
 - Missed Appointment Procedure: For clients who are enrolled in Care Coordination; begins immediately following missed appointment
 - Daily phone calls and online resources used to locate client
 - Field/home visit after 3 days of failed phone outreach
 - Field/home visits continue weekly until client is located
 - Letter sent after two weeks of failed outreach
 - Second (certified) letter sent after two months of failed outreach
- Patient Navigation
 - Patient Navigators are key players on the care team
 - Most interaction with the clients
 - Community Health Workers
 - Bridge the gap between the clinic and the community
 - Reflect the community they serve



Ryan White Part A Care Coordination Program (CCP): Intervention Strategies, cont'd

Case Conferencing

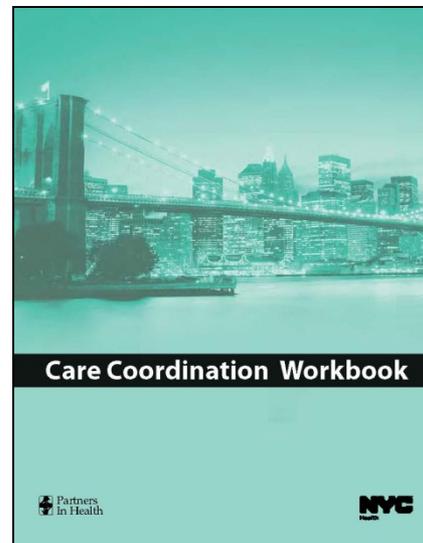
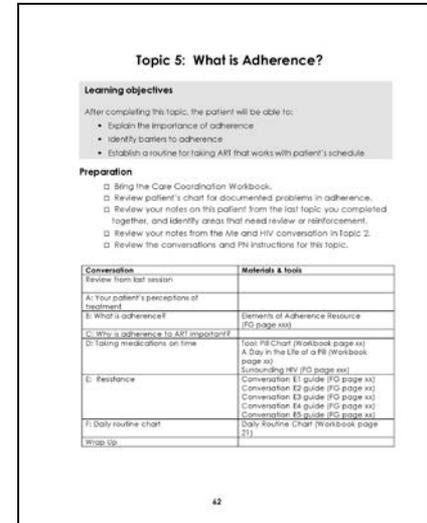
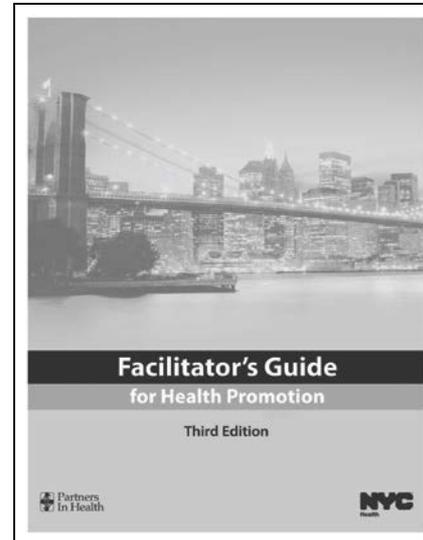
- Daily morning huddle with Apicha medical providers
- Weekly multidisciplinary meeting with both medical and mental health providers to discuss patients who missed medical appointments
- All relevant staff involved in patient care participate
 - Care Coordinators, Patient Navigators, Program Director, Clinician, Patient (optional)
- Review several aspects of care
 - Lab values, Adherence (medications and appointments), Home conditions, Develop/update care plan



Ryan White Part A Care Coordination Program (CCP): Intervention Strategies, cont'd

Health Promotion and Coaching

- Comprehensive HIV education, coaching and counseling
- Standard 16-topic curriculum used across all NYC Care Coordination Programs
 - Nine (9) core topics
 - Six (6) discretionary topics
 - One (1) final wrap-up topic
- Patient Workbook
- Conducted by Patient Navigators
- One-on-one sessions
- Staff receive ongoing training



CCP Outcomes Evaluation¹

Outcome Measures

- Outcome measures were constructed from NYC HIV Surveillance Registry viral load (VL) and CD4 data for Ryan White Part A Care Coordination clients. Agency assignment is based on initial CCP enrollment at a given agency. However, VL and CD4 data were included regardless of the agency of report.
 - Engagement in Care (EiC): ≥ 2 CD4 or VL tests ≥ 90 days apart, with ≥ 1 in each half of 12-month period
 - Viral Load Suppression (VLS): VL ≤ 200 copies/mL on most recent test in 2nd half of 12-month period (*Note: Missing VL in 2nd half of period was considered equivalent to unsuppressed VL*)

Statistical Analysis

- GEE used to estimate post- vs pre-enrollment relative risks (RRs) for desired outcomes

Clients Eligible for Outcomes Evaluation

- Enrolled by March 2011, matched to Registry, and alive for ≥ 1 year of follow-up
 - Newly Diagnosed: HIV diagnosis date ≤ 12 months before enrollment
 - Previously Diagnosed: HIV diagnosis date > 12 months before enrollment

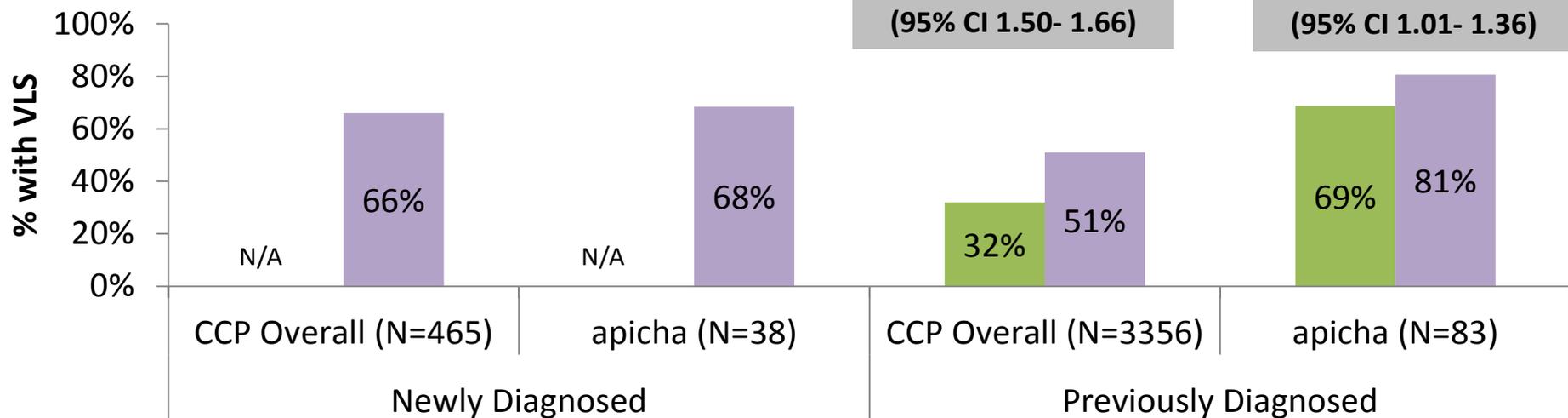
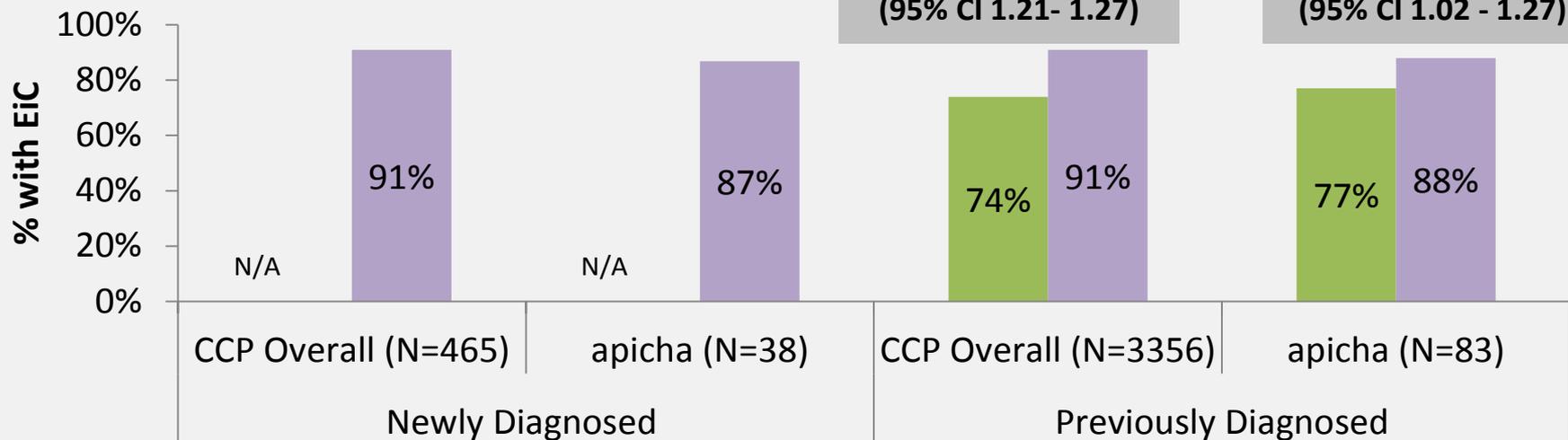
Results were prepared by the NYC Department of Health and Mental Hygiene, Bureau of HIV Prevention and Control, with data reported to the NYC HIV Registry as of September 30, 2012.

¹Irvine, Mary K., et al. "Improvements in HIV care engagement and viral load suppression following enrollment in a comprehensive HIV care coordination program." *Clinical Infectious Diseases* (2014): ciu783.

CCP Outcomes: EiC and VLS¹

■ 12 months prior to CCP enrollment

■ 12 months post CCP enrollment



Successes, Challenges, Lessons Learned

Success: Adherence to HIV monitoring visits (Engagement in Care)

Comprehensive HIV education, coaching and counseling

- Baseline period: 6.1.2012–9.30.2012
- Results: 97% of scheduled clients adhere to their HIV monitoring visits
 - 95 clients scheduled PCP HIV appointments
 - 92 clients adhered to scheduled appointments
 - Three (3) clients were scheduled to be seen after sampling period

Success: DOT (Direct Observed Therapy)

Program provides DOT services to 12 active clients as of 2.28.2013

- Number of clients receiving DOT services has increased from six (6) clients in 2011–2012 contract year to 12 clients in 2012–2013 contract year
- All 12 DOT clients achieved 100% adherence with their HIV medications

Successes, Challenges, Lessons Learned

Challenges: Home/field visits with active clients

- Baseline period: January 1, 2014–March 31, 2014
- Result: 42% of clients had any home/field visits in the period
 - Program staff decided it was important to raise this rate and undertook a QI project
 - Project would focus on the Patient Navigators who conduct home/field visits with active clients

Lesson learned: Quality improvement project for home/field visits

- 2 interventions strategies were implemented
 - Tracking tools (i.e., Excel spreadsheet)
 - Staff training on program protocol
- Result: 58% increase from baseline
 - Program staff successfully maintain 100% completion
 - Care Coordinators and Patient Navigators continue to implement these strategies with active clients
 - Improvement has been seen on client engagement and retention in care overall



Acknowledgements

- Julie Rwan, MPH (Project Officer, Bureau of HIV/AIDS Prevention and Control)
- Mary Irvine, DrPH, MPH (Director of Care and Treatment Research and Evaluation Unit, Bureau of HIV/AIDS Prevention and Control)
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- Kim F. Tong (Database Manager, Apicha Community Health Center)
- Timothy Au, LMSW (Care Coordinator, apicha community health center)
- Kazuko Ko (Care Coordinator, Apicha Community Health Center)

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www.cdc.gov/vitalsigns/SocialMedia.html

Prevention Status Reports

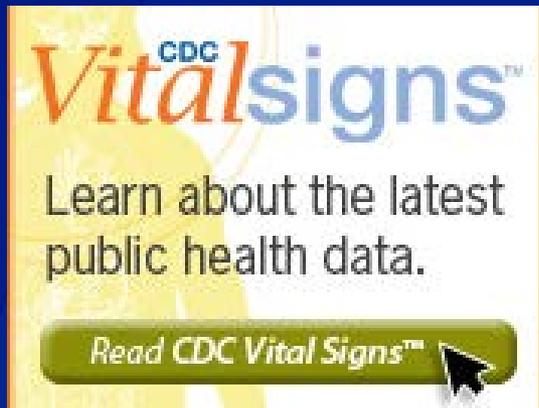
- The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce 10 important public health problems.

Health Topics Covered by the PSRs	
 <p>Excessive Alcohol Use Excessive alcohol use is responsible for 88,000 US deaths each year.</p>	 <p>Motor Vehicle Injuries Motor vehicle crashes cause about 32,000 US deaths and 2.6 million injuries a year.</p>
 <p>Food Safety Each year, about 48 million Americans get sick from foodborne illness.</p>	 <p>Nutrition, Physical Activity, and Obesity More than one-third of US adults and 17% of children are obese.</p>
 <p>Healthcare-Associated Infections Each year, 1 in 20 hospital patients gets a healthcare-associated infection.</p>	 <p>Prescription Drug Overdose Deaths involving opioid painkillers have more than quadrupled since 1999.</p>
 <p>Heart Disease and Stroke Cardiovascular disease is the leading cause of death in the United States.</p>	 <p>Teen Pregnancy Each year in the United States, 750,000 teens become pregnant.</p>
 <p>HIV About 1 in 6 persons with HIV don't know they are infected.</p>	 <p>Tobacco Use Tobacco use is the leading cause of preventable death in the United States.</p>

<http://www.cdc.gov/psr/>

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January 13, 2015

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