

CDC *Vital Signs* Town Hall Teleconference

HIV Care Saves Lives: Viral Suppression is Key

December 2, 2014

2:00 pm (EST)

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until our question and answer session when you can ask a question by pressing star 1 on your touchtone phone and recording your name when prompted.

This conference is being recorded, if you have any objections you may disconnect and I'd like to turn today's meeting over to Mr. Steve Reynolds, thank you and you may begin.

Steve Reynolds: Good afternoon everyone, I'm Steve Reynolds, the deputy director for the CDC's Office for State, Tribal, Local and Territorial Support. Welcome, I'm glad you could join us here today.

We'll be discussing the latest *Vital Signs* report on the HIV care continuum. Before we get started let's go over some housekeeping details. You can go online and download today's PowerPoint presentation so you can follow along with the presenters.

The easiest way to find the presentation is for you to go to Google and type in "CDC *Vital Signs* Town Hall," again go to Google, type in "CDC *Vital Signs* Town Hall" and click on the top link, that should get you there.

But the direct way is to use the website, that's at www.cdc.gov/stltpublichealth. Again that's www.cdc.gov/stltpublichealth,

look for the highlighted products and resources on the right, click on the *Vital Signs* Town Hall Teleconference logo under that.

On this same page you can access bio's for presenters and you can find audio recordings and transcripts later next week. Now back to our topic of today, viral suppression for people living with HIV.

We are going to hear from three colleagues, first we will hear from Dr. Heather Bradley, an epidemiologist in CDC's Behavioral and Clinical Surveillance Branch in the Division of HIV/AIDS Prevention at the National Center for HIV/AIDS, Vital Hepatitis, STD and TB Prevention.

She will summarize this month's *Vital Signs* report, then we'll hear from Karalee Poschman will present - she is the epidemiologist working at the Florida Department of Health as a CDC Direct Assignee.

She will discuss the HIV continuum care in Florida and then hand the call over to Venus Vacharakitja the director of Support Services at the APICHA Community Health Center in New York City.

Venus will discuss intervention strategies used in New York City as well as the city's continuum of HIV care. There will be time for questions after our presentations but you can get in the queue at any time to ask a question by just pressing star 1. Again press star 1 and record your name when prompted. And now let me turn the call over to Dr. Bradley.

Dr. Heather Bradley: Good afternoon everyone and thanks for joining us today for this town hall. So I'm Heather Bradley and I'm going to present some of the findings from this month's *Vital Signs*, which is entitled HIV Diagnosis, Care, and Treatment Among Persons Living with HIV in the United States in 2011.

So in the US an estimated 1.2 million people are living with HIV. A serious infection that when untreated leads to illness and premature death. Approximately 50,000 people are newly infected with HIV each year. In 2010 the administration released a national HIV/AIDS strategy that outlines priorities and action steps for reducing HIV infections in the US.

The main goals of this strategy are to reduce new HIV infections, improve health outcomes among persons living with HIV, and reduce HIV related health disparities. And so improving outcomes related to HIV diagnosis, care, and treatment are all essential to reaching these goals.

Slide 6, HIV is still a major problem in the US, however we now have important tools for achieving our HIV prevention goals, which are early HIV diagnosis, HIV medical care, and treatment.

When people living with HIV are diagnosed and receive regular medical care they can be prescribed anti-retroviral therapy or ART. Importantly most people with HIV who regularly take ART medications achieve viral suppression, meaning that the virus is kept under control at a very low level in the body.

Viral suppression is the ultimate goal of HIV medical care. ART and viral suppression have two very important benefits. First, persons living with HIV infection have vastly improved health and a nearly normal life expectancy when taking ART medications regularly. And second the risk of sexual HIV transmission from those take ART is reduce to up by 96%.

Slide 7, so how are we doing in the US in terms of helping people living with HIV to achieve viral suppression? The answer to this question, we estimated the percentages of persons living with HIV who were diagnosed, engaged in care prescribed ART and virally suppressed.

And we separately estimated linkage to care for those diagnosed in 2011. For all of these estimates we used 2011 data from two CDC surveillance systems, the national HIV surveillance system and the medical monitoring project.

We estimate that 1.2 million persons were living with HIV in 2011. Of those 86% were diagnosed but only 40% were engaged in HIV medical care and 37% were prescribed ART. Only 30% of people living with HIV achieved viral suppression.

Slide 8, these outcomes are much lower among young people. Among 18 to 24 year olds living with HIV fewer than half were diagnosed, 22% were engaged in HIV medical care and 18% were prescribed ART, only 13% were virally suppressed in this age group.

We also estimated linkage to care within three months among persons diagnosed with HIV in 2011 and found that overall 80% were linked to care. Linkage to care was lowest among young people age 13 to 24 years at 73% and blacks or African Americans at 76%.

Slide 10, last we characterized the 70% of persons who were not virally suppressed in terms of their outcomes along the HIV care continuum. Of the nearly 840,000 persons who were not virally suppressed 20% had never been diagnosed, 66% have been diagnosed but were not engaged in medical care, 4% were in medical care but had not been prescribed ART and 10% had been prescribed ART but did not achieve viral suppression.

Slide 11, so what did these data tell us? Well most importantly the data tell us that improvements are needed across the HIV care continuum to protect the health and persons living with HIV, reduce HIV transmission and reach out national prevention and care goals.

But there are three main opportunities for improvement. First, we must reduce undiagnosed HIV infections, 14% of people living with HIV had never been diagnosed, which means that they couldn't access lifesaving care and treatment and could unknowingly transmit HIV to others.

Second, we have to increase the percentage of persons living with HIV who are engaged in medical care, 60% of persons living with HIV were not receiving HIV medical care, which is key to receiving ART and achieving viral suppression.

While there is a need to improve outcomes along the continuum for everyone, the greatest room for improvement is among young people. Outcomes were lowest for young people at every step along the continuum. Expanding testing and prompt linkage to care and treatment is critical in this age group.

Slide 12, so how can we make these three improvements? Well the good news is that we already have some effective tools. CDC in the United States Preventive Services Task Force recommend that everyone get tested for HIV at least once and those at higher risk get tested at least once a year or even more often.

Second, we have proven effective interventions for linking and retaining patients in HIV care. These include provider notification systems for when patients miss appointments, strength based case management, which encourages patients to identify and use internal strengths to overcome obstacles to staying in care.

And co-locating medical and support services so that both are easily accessible to patients. Persons living with HIV must be in HIV medical care to receive ART and achieve viral suppressions.

Third, US Clinical Guidelines were revised in 2012 to recommend that everyone with HIV received treatment regardless of their CD4 cell count or viral load. Of persons in HIV medical care in 2011, 92% were prescribed ART and 76% achieved viral suppression.

Slide 13, CDC is engaged in a number of activities to improve HIV diagnosis, care and treatment in the US, including providing funding and technical assistance to state and local health departments to reduce undiagnosed infections and improve linkage and engagement in care.

But everyone has important roles to play in making progress along the HIV care continuum. For example health departments and community based organizations can expand HIV testing services and help ensure that all diagnosed persons are promptly linked to care.

While providers can prescribe ART to all patients living with HIV and help patients to stay in care and on ART, which may include linking them to needed supportive services such as nutrition and mental health services.

Slide 14, in conclusion, continued and intensified efforts are needed to improve outcomes along the HIV care continuum. Additional sustained effort from all communities is needed to implement these known effective strategies, to improve the health of people living with HIV and reduce new infections in the United States.

Thanks very much, I'd like to acknowledge the *Vital Signs* writing team and I will now turn the call over to Karalee Poschman who is a CDC epidemiologist assignee in Florida.

Karalee Poschman): Thank you, first of all I want to thank Lorraine Maddox who is the data analysis unit manager in Florida who worked with me on this project and who helped put together most of the graphs in this presentation.

First of all I want to review a few definitions. Overall we're looking at HIV infected and we defined that as the estimated number of persons living with HIV in Florida including those that are unaware and undiagnosed and for that we used the 15.8% national estimate of those unaware or undiagnosed.

For those that are HIV diagnosed we defined that as the number of persons known to be alive and living with HIV in Florida through 2013, regardless of where they were diagnosed. And all of this data that we present was calculated using the data that we have as of mid-year 2014.

Our next definition is linked to care and we really refer to that as ever in care. And so we're looking at the number of persons living with HIV in Florida that have ever had a CD4 or viral load test and the enhanced HIV/AIDS reporting system or eHARS.

In care this year, so instead of looking at retention to care we specifically decided to look at just whether or not a patient was in care in the last year. And so we define that as the number of persons living with HIV in Florida having at least one HIV related care service.

And that could be a viral load or CD4 test or a refill of an HIV related prescription. And we pulled data from eHARS, CAREWare, which is the Ryan

White funded data system, our AIDS drug assistance program or ADAP, and Medicaid data.

On ART and suppressed viral load we used the 2011 medical monitoring project data to estimate both of these data points. And we estimate that 90.6% of persons in care in Florida were on ART and of those on ART 78% had a suppressed viral load.

Some of the limitations of our data, these analyses really depend on the quality of our data, and I'm on slide 19. First and foremost it really depends on the completeness of our laboratory data that is available in eHARS.

Also it depends on maintaining timely reporting of our deaths and also having accurate current addresses in our data system so that we can accommodate for in and out migration.

In the last year we've made significant progress in addressing all of these and we looked to the future to make further improvements. And our last limitation is that we do use estimates from the MMP data for those on ART and those with suppressed viral load. And ultimately in the future we might like to explore our ability to use our actual live core data to calculate these.

So the Florida continuum to care on slide 20, overall in 2013 we estimate that we have a little over 126,000 HIV infected persons living in Florida. Now our continuum is a little bit different from the national continuum in that we do not start our continuum with HIV infected, we based it off of those that are HIV diagnosed.

And so the first bar in this graph represents all of those HIV diagnosed in 2013 alive at the end of 2013. So we have roughly 126,000 persons living with HIV, of those 86% or a little over 91,000 ever had evidence of care, 55%

had evidence of a care visit in the last year, 50% we estimate were on ART, and 39% were on ART and had a suppressed viral load.

Part of our analysis of the continuum of care involved us looking at this same model in many different ways looking at geographic, demographic and risk variables. And one of the most striking pieces of information that we looked at was when we separated out rural versus urban.

So on slide 21, we're looking at our continuum for one of our rural areas in Florida, it's in north central Florida and it's pretty - a large area with a fairly small population. So compared to what we saw for the overall Florida continuum you can see a striking difference in terms of an improvement across the board for all of the measures.

With 94% ever having evidence of care almost more than 2/3 having evidence of care in the last year, over 60% on ART and almost 50% with the suppressed viral load and when we compare that to our next slide, 22, when we're looking at an urban area.

And for reference this is actually Miami-Dade, we see a striking difference, with only 77% ever linked to care, 45% with evidence of care in the last year, 41% on ART and less than 1/3 with the suppressed viral load.

Moving onto slide 23, we can - we also looked as I mentioned at some of the other demographic and risk variables and some of the results that we found from that were that there were higher rates of linkage ART used and viral suppression among females compared to males.

Lower rates of linkage ART used in viral suppression among blacks and Hispanics compared to whites, with Hispanics having the lowest rates of all. Persons aged 25 to 49 had lower rates of linkage ART used in viral

suppression compared to the other age groups with the highest of all of these among persons 50 plus.

And interestingly we found higher rates of linkage in ART use among injection drug users compared to men who have sex with men or heterosexuals, but MSM did have the highest rate of viral suppression among the other risk transmission groups.

So our future plan, slide 24, for our continuum is to assess those persons not linked to care within three months of a HIV diagnosis date. And we want to do this through enhanced linkage to care and a renewed effort to contact the last known facility or provider and we really want to take a proactive approach.

In the past we have waited a year, two years to look back at these data and we definitely found difficulty in keeping our data accurate and as current as possible when we don't take care of these issues right away. And so we now have a process so that as soon as we - someone hits the three-month mark we have a report that goes out and the field can then address these.

Also we want to address and locate the persons that are presumed to be alive but we have not found to be in care at all. So this goes beyond just three-months beyond, after diagnosis but is someone who is maybe is two or three years beyond, eventually we want to try to look at everyone who is not linked to care to the best of our ability. And we also have to address those persons with late HIV diagnosis, which is currently about 20% statewide.

Moving on to slide 25, of course we have to continue to evaluate the completeness of our laboratory data and we want to identify some other databases that might be beneficial for matching with eHARS in order to identify additional sources of care.

And we want to identify some methods to improve our calculation of in and out migration and to incorporate this into our estimate of who is in care. And finally we want to assess the use of some of our other patient care databases such as CAREWare, ADAP, Medicaid for calculating the ART usage compared to using the MMP data.

And compare what we get when we try to calculate it from live data versus using the estimates. Thank you and now I'm going to pass the presentation onto Venus Vacharakitja.

Venus Vacharakitja: Thank you, good afternoon everyone. So I'll be speaking in regard to the intervention strategies along the HIV care continuum and that's on the page - I mean on slide 27, if you can go to slide 28.

This is to give you a brief snapshot of the epidemic in New York. This is the New York City version of the care continuum, which is very similar to the national version you are all probably very familiar with.

Similar to the care continuum for the US, in New York City there is a drop off between diagnosis and viral suppression. Further we see that as a large proportion of all persons living with HIV in New York City are linked to care after initial diagnosis, but not retaining care in 2013.

Now I'm going to go over at what we do at APICHA, APICHA Community Health Center was found in 1989. Our mission is to improve the health of our community and to increase access to comprehensive primary care, preventive health services, mental health, and supportive services.

We are committed to excellence and to providing culturally competent health services that enhance the quality of life. We advocate for and provide

a welcoming environment for underserved and vulnerable people, especially Asian and Pacific Islander, the LGBT committee, and individuals living with an affected by HIV/AIDS. Services provided include medical care and other support services such as care coordination.

If you go to slide 30, if you can see actual in the breakdown of the slide there are APICHA care coordination client demographic based on the client enrolled from December 2009, which is the start of New York City Ryan White Part A, HIV care coordination to March 2013. Most of our clients are younger, below the age of 46, men who have sex with men, Asian, Hispanic, and have at least high school education.

Slide 31, the goal overall for the care coordination program is HIV treatment adherence with the aim of viral suppression. Some of the interventions that APICHA care coordination staff employ to engage clients who care includes case finding, outreach and patient navigation services.

Our care coordination staff continuously conduct case findings at a local, DOH and medical providers who may not specialize in HIV care. When clients miss their medical appointments, the staff will conduct an outreach for reengagement that includes field visit and assist the client to appointments.

With the understanding that patient navigation services are an important aspect of the programs, the care coordination staff play a vital role in bridging the gap between the client and medical care.

It is also important to note that outpatient navigators reflect the committee that they serve such as a Mandarin speaking, Spanish speaking, and Japanese speaking, so that helps to build the relationship between the client and the staff.

Slide 32, care conferencing is another intervention that the care coordination staff utilize in addressing clients treatment adherence. At APICHA predominantly the clients receive medical care at APICHA Medical Health Center, which co-located.

Therefore, our care coordination staff attend a daily morning huddle with the medical staff and attending a weekly multi-disciplinary meeting with the medical and mental health staff to address any client related concerns such as appointments kept, CD4, and viral load values.

Slide 33, as mentioned patient navigators spend much of their time engaging with the clients to address treatment adherence, which includes providing one-on-one health promotion indication that consists of 16 topics. And these topics include but not limited to HIV transmission, safety in relationships, and treatment adherence. In addition the care coordination, staff receive an ongoing training to ensure of update information when delivered to the client.

Slide 34, the care and treatment program is working with the Cuny School of Public Health to conduct an outcome evaluation of the care coordination program. We want to share their findings on the program for the care coordination program overall and the specific outcomes for Apicha clients.

They look at the engagement in care and viral suppressions one year before and after enrollment in the care coordination program. They also categorize clients as the newly diagnosed in the year before enrollment and previously before the year leading up to the enrollment. Now you can find the details of the definition on slide 8 and the further breakdown at the sited listed below.

Slide 35, the study team found a steady particularly significant improvement for both engagement in care and viral suppression for previously diagnosed individuals, which held true for our Apicha clients as well.

They also saw a promising outcome for newly diagnosed clients, we want to learn and share more about what have contributed to this improvement at Apicha.

Go to slide 36, internally at Apicha our care coordination program has two accomplishments over the course of the past year first success based on our quality improvement project was client engagement and treatment adherence.

At the end of the project, 97% of Apicha's care coordination have kept their HIV monitoring visit. The 3% that was missing from the outcome was because, based on the clients appointment rescheduled, which they successfully attend the PCP appointment but after the sampling period.

In 2010, as we started up the program, we had much less success with the DOT or director of therapy services because of the resistance that we see from both medical providers and clients.

At the time, the providers didn't see the tangible benefits of the services, which resulted in no recommendation. For clients, many didn't buy into the idea of meeting with the patient navigator on a daily basis and didn't see the positive outcome.

However, after three years passed we are now servicing to 12 DOT clients. This is because of the positive outcome of the DOT services that showed improve of CD4 counts and lower viral loads. Due to that, we have positive buy-in from providers.

Slide 37, another challenge that we had in early 2014 was surrounding home visits. Our program staff reported that many clients are uncomfortable with staff visiting their home due to confidentiality related concerns.

Baseline data from January to March 2014 suggested that a care coordination program has only 42 success rate in conducting home visits. As a support service provider we understand that many concerns on treatment adherence go beyond exam room, which makes home visit vital in providing appropriate services.

Based on the result, program staff undertook the quality improvement project and two intervention strategies were implemented. The intervention includes, weekly monitoring between patient navigator and care coordinators as well as retraining the program protocol.

With the two strategies success rate increased by 58%, which resulted in 100% of home visit for the program client and that concludes my presentation. Thank you, now I'm going to hand it off to Steven.

Steve Reynolds: Thank you Venus, thank you everyone for that outstanding presentation, it was great. This is our - we've got a good number of people on the call with us today.

So this is our opportunity or your opportunity to ask questions, share your success stories, your challenges, lessons learned. You don't necessarily have to ask a question just press star 1, say your name and the Operator will put you in the queue to ask your question or give us your comment or your success stories of today.