



MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)

Date/Time: Wednesday, April 20, 2016, 12:30 p.m.

Location: Governmental Center Room A-335

Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 4/20/16 Agenda and 3/16/16 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
 - a. Monthly Expenditure/Utilization Report by Category of Service (WP Item 2.1) (Handout A)
4. **UNFINISHED BUSINESS**

None.
5. **MEETING ACTIVITIES/NEW BUSINESS**

<i>Goal/Work Plan Objective #:</i>	<i>Accomplishments</i>
PSRA Timeline	ACTION ITEM: Review and approve the PSRA timeline (Handout B)
Data Review	ACTION ITEM: Review and discuss Florida Department of Health 2014 Broward County epidemiological data (Handout C)
Barriers to Care Overview	ACTION ITEM: Review barriers to care information from Quality Management Committee (Handout D)
MAI Strategies	ACTION ITEM: Finalize models that address MAI access issues including barriers, retention and VL suppression (Handouts E-F)

6. **SUBCOMMITTEE REPORTS**

None.
7. **GRANTEE REPORTS**
8. **PUBLIC COMMENT** (Please sign up on the Public Comment Sheet)
9. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** May 25, 2016; **12:30-4:30 p.m. Venue:** A-337

<i>Goal/Work Plan Objective #:</i>	<i>Accomplishments</i>
Review relevant PSRA data (WP Item 1.2)	ACTION ITEM: Review data relevant to the PSRA process (including epi data, recommendations from QM, and service category scorecards)

10. **ANNOUNCEMENTS**
11. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE PRINCIPLES IDEAS OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

- Linkage to Care • Retention in Care • Viral Load Suppression •

VISION: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care

MISSION: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment



MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)

Date/Time: Wednesday, March 16, 2016, 12:30 p.m. **Location:** Governmental Center Room GC-302

Chair: Carla Taylor-Bennett

Vice Chair: Rick Siclari

ATTENDANCE				
#	Members	Present	Absent	Guests
1	Bell, J.	X		Hamlet, L.
2	DeSantis, M.	X		Rodriguez, J.
3	Gammell, B.	X		
4	Grant, C.	X		Grantee Staff
5	Hayes, M.	X		Green, W.E.
6	Katz, H. B.	X		Card, W.
7	Lopes, R.	X		Jones, L.
8	Reed, Y.		A	Anderson, T.
9	Schickowski, K.	X		
10	Shamer, D.	X		HIVPC Staff
11	Proulx, D.	X		Holloman, K.
12	Siclari, R., <i>Vice Chair</i>		E	Johnson, B.
13	Taylor-Bennett, C., <i>Chair</i>	X		Ewart, L.
	Quorum = 8	11		Jackson, M.

1. CALL TO ORDER:

The Chair called the meeting to order at 12:45 p.m. The Planning Council Vice Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

Motion #1: To approve today's meeting agenda with the discussion of the PSRA timeline without approvals

Proposed by: DeSantis, M. **Seconded by:** Hayes, M.

Action: Passed Unanimously

Motion #2: To approve meeting minutes from 2/17/16

Proposed by: Hayes, M. **Seconded by:** Grant, C.

Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS:

- a. Monitoring Expenditures/Utilization Report (WP Item 2.1): William Card, the Grantee's representative reviewed the updated expenditures for the FY15-16. He explained that his office is still awaiting some of February's expenditures, as well as final FY billing. He has projected that most service categories are on track to expend all of their allotted funding. He stated that the Food Bank and Pharmaceutical categories would have a bulk purchase with any funds remaining.

4. UNFINISHED BUSINESS:

None.

5. NEW BUSINESS



- a. **MAI Strategies:** The PC Manager gave an update on the programs that could be applied as MAI strategies that were discussed at last PSRA meeting in February: HIV Care Coordination, STYLE and the Women of Color Initiative. The PC Staff has taken the different programs and created a presentation of what each program would look like if it were implemented in the Broward Part A Program (see Handout A on file).

The STYLE program was implemented in North Carolina and targeted at YMSM of color. If applied in Broward the program would cover Black MSM Part A clients age 18-24. The committee discussed the program's various components and lack of evaluation and cost analysis. The committee next reviewed the HIV Care Coordination Program implemented in New York City. The Human Services Administrator asked what components/services were funded by the NYC program, and Staff explained that the program uses Medicaid expansion to fund the medical components of the program while the Health Department and the EMA fund the wrap around case management, navigator services, and training components of the program. There were questions from the members about the cost components of the program, and the PSRA Chair stated that it would be more cost effective in the long run than what we are paying for our current clients who are not achieving their health outcomes. The Chair stated that if Disease Case Managers were co-located at provider agencies, the Part A costs would cover the DCM services and training, while the medical services would be billed through OAMC or HICP, the current billing mechanism. The PC Manager stated that the NYDOH had explained that they found the most cost-effective clients were those who were not engaged and virally suppressed, and that at the end of those programs the clients were reaching positive outcomes and saving money on medical care and other health needs.

A member noted that she likes that both the STYLE and HIV Care Coordination programs both have outreach components. Members asked how clients were identified and referred to the program, and the PSRA Chair stated that the programs were located at the provider sites in each NYC borough. These clients were drawn from each provider's client list. The Human Services Administrator explained that the potential Broward Part A Program would refer clients from their own caseloads that fit the criteria to become program participants. The committee discussed how to develop criteria to participation: Ryan White Part A, clients who met FPL eligibility, or have some issues with retention, high viral loads, or barriers to care and treatment. A member noted the collaborative effort of the Coordination program, and how it is similar to the ARTAS Program, while another member noted the team effort of the managers/navigators to help the clients. Another member stated concern about the caseload and the time required to assist each participant. The Human Services Administrator addressed the home-based service component of the program, and how if implemented, Broward could streamline case managers making home visits for clients who miss appointments. He explained that research shows if clients who miss appointments are not reached within a certain amount of time then they are more likely to further fall out of care, and that home visits may help reengagement.

The committee briefly discussed the Women of Color Initiative. They discussed the outcomes associated with the program, but noted that the data contained nothing specific to the Miami location. The outcomes presented pertained to all participating locations, both rural and urban. Patients were given a needs assessment, and the information was used to develop an individualized care plan for the client. The committee agreed that they liked the concept but did not think it was suited for Broward clients.

The PSRA committee members identified components that they would like to see in any program developed in Broward:

- Frequent, but flexible, meeting times with formalized health education
- Client Needs Assessment with linkage to services
- Teams designated to find and reengage clients lost to care
- Screening for trauma, domestic violence, mental health, or behavioral health issues with



linkage/referrals to care

- Transportation assistance (bus passes, taxi vouchers)
- Buddy program/ peer educators
- Personnel housed at provider sites that accompany clients to primary care visits
- Teams of flexible case managers, providers and peer educators

The meeting participants discussed how many of these models touch upon components we already have in our current MAI program. They identified that the current model lacked some of the individualized and more flexible care and education components. The PSRA members briefly reviewed the current Broward MAI Service Delivery Model and identified issues: referral mechanisms; clients fallen out of care and not currently in the Ryan White could not be served; program components had rigid time frames and comprised of in-office trainings only; issues with hiring, staffing, and billing. They discussed the need to hire case managers specifically assigned to MAI clients, and how to determine case loads, payments, and time-line for program participants to reach self-sufficiency and be reassigned back to their original case managers. The members discussed the pros and cons of revising the current MAI model or developing an entirely new program. The group discussed barriers to care, and how QMC and the Case Management QI Network are both looking into barriers and access issues affecting the PSRA's target populations.

The members talked about the need to break the model down to see if these components may actually work for the minorities in Broward, and discussed the possibility of bringing in clients, the CEC, and a third party to provide feedback on the new program once it is designed. The Human Services Administrator suggested looking back at the Broward EMA FY16-17 Grant's Special Populations section and designing a matrix to identify specific barriers they may face. Each target population may have a different barrier to care and different gaps that they experience along the Continuum, and the ideal program participant would be clients who are not virally suppressed, not engaged/sporadically in care, never in care, or not medically adherent. People will come into the models at different points and need different level of flexible wrap-around services. A member stated that clients who were linked but never participated in care are not part of the treatment cascade, may be part of the problem, but are an unknown, as the system has no data on those never in care.

ACTION ITEMS FOR NEXT MEETING: Outcomes, cost analysis and provider perspective from HIV Care Coordination Program; any Broward Needs Assessment information regarding barriers/target populations; CM Network/QMC's Black Females data presentation; DIS perspective/case findings; studies regarding barriers to care for target populations in other areas

Plan for MAI rollout: next meeting the PSRA Committee will begin to construct the framework for the model, and after PSRA process is finished the model will then need operationalizing.

- b. **PSRA Timeline:** The PC Manager told the committee that the FY17-18 Timeline is in development, and the PSRA process will begin in the upcoming months. The presentations will consist of data reviews, and will incorporate a "Sense Making" training to help the members understand all of the data in order to rank the Part A services according to the needs of the community. The PSRA Chair stated that there are 3 new members who have never participated in the process who should receive training on how the process will take place. Staff noted that some of the meetings would take up to 4 hours, and members should schedule accordingly.

6. GRANTEE REPORT

- a. **Part A:** The Grantee told the committee that the County is in the process of releasing an RFP sometime in the 2nd or 3rd week of April 2016. The RFP will include a form of integration of primary care and behavioral health elements/linkage.

HIV/AIDS

Epidemiology

Partnership 10

Broward County



Excluding Dept. of Corrections

Created: 12/03/14

Revision: 10/14/15

Florida Department of Health
HIV/AIDS Section
Annual data trends as of 12/31/2014
Living (Prevalence) data as of 06/30/2015



HIV and AIDS Case Data

- Ⓡ AIDS Cases became reportable in Florida in 1981.**
- Ⓡ HIV (not AIDS) became reportable in Florida on July 1, 1997.**
- Ⓡ HIV Infection reporting represents newly Adult HIV Infection Cases, regardless of AIDS status at time of report, that were previously reported.**
- Ⓡ AIDS cases and HIV infection cases by year of report are NOT mutually exclusive and CANNOT be added together.**
- Ⓡ Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida CHARTS and all grant-related data where annual data are included.**
- Ⓡ HIV prevalence data are generated later in the year, usually in July, when most of the “expected” death data are complete.**



HIV and AIDS Case Data (con't)

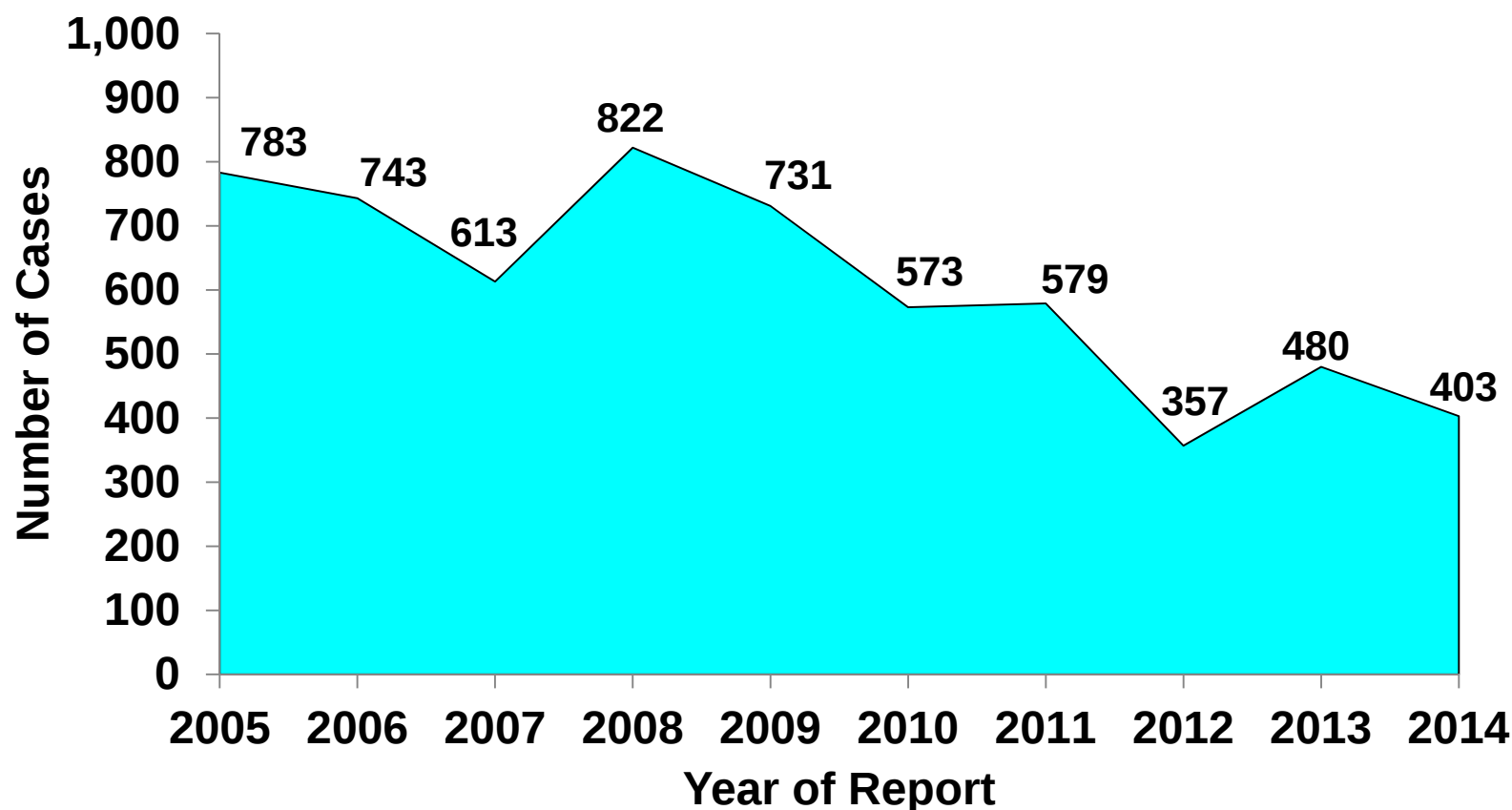
-  **Adult cases represent ages 13 and older, pediatric cases are those under the age of 13. For data by year, the age is by age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.**
-  **Unless otherwise noted, whites are non-Hispanic and blacks are non-Hispanic.**
-  **Unless otherwise noted. Area and county data will exclude DOC cases.**

Snapshot of Persons Reported with HIV Disease, 2014, Partnership 10

Total Population, 2014* 1,796,314	HIV Infection and AIDS Cases Reported in 2014*			
	Adults (Age 13+)	Pediatrics (Age <13)	TOTAL	
	HIV Infection Cases	993	-	993
	AIDS Cases	402	1	403
	*HIV infection cases and AIDS cases by year of report are NOT mutually exclusive and CANNOT be added together.			
	Cumulative HIV/AIDS Cases Reported 1981-2014			
	Adults (Age 13+)	Pediatrics (Age<13)	TOTAL	
	HIV (not AIDS) Cases**	9,329	67	9,396
	AIDS Cases	20,732	271	21,003
	Total	30,061	338	30,399
	*2014 estimate is provisional			
**HIV (not AIDS) cases were NOT reportable until 07/1997				
Persons Living with HIV Disease through 2014, as of 06/30/2015:			19,391	

AIDS Cases and Rates*

By Year of Report, 2005-2014, Partnership 10



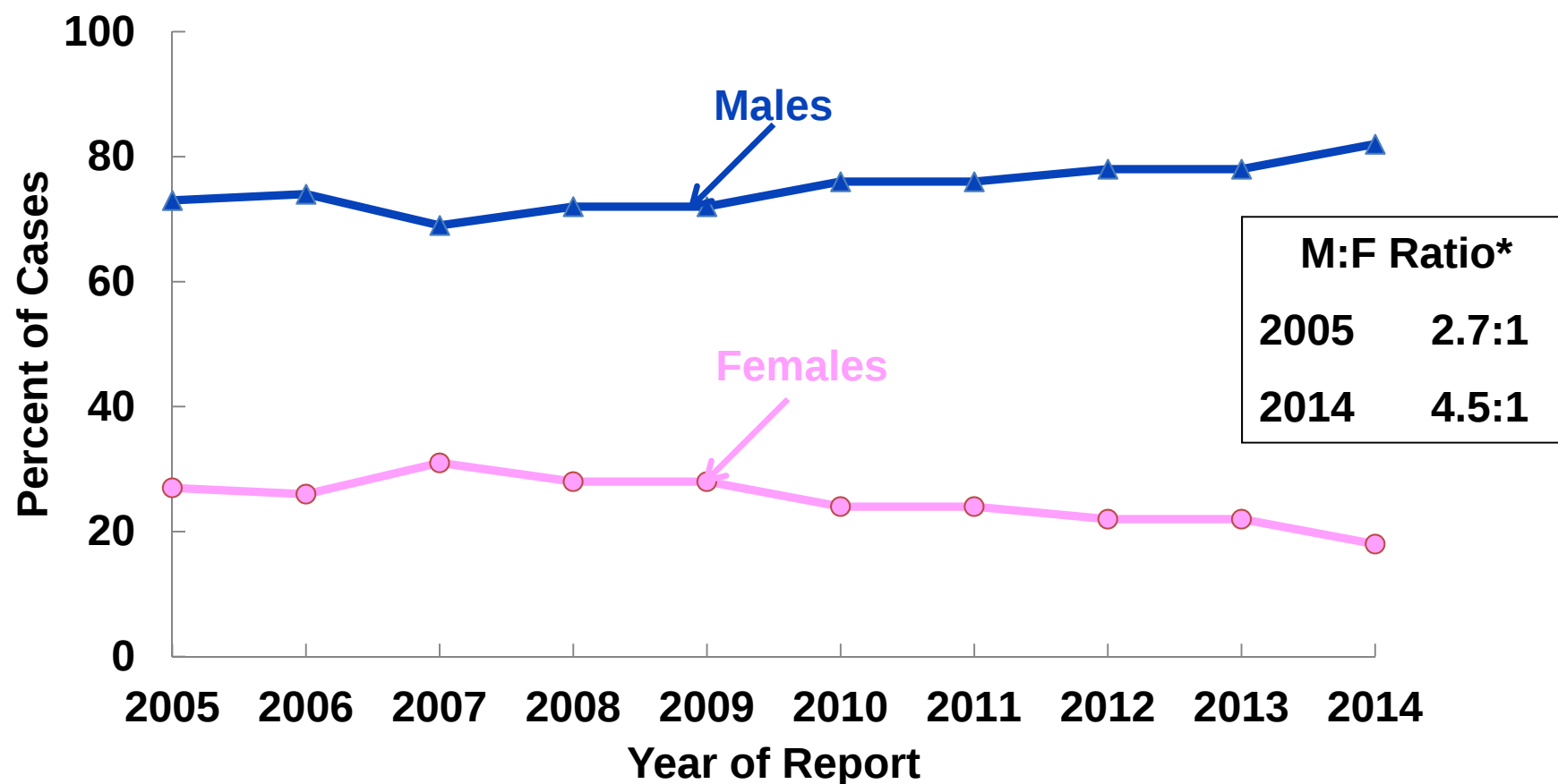
Year	Rate
05	45.1
06	42.7
07	35.4
08	47.3
09	42.1
10	32.8
11	33.1
12	20.3
13	26.9
14	22.5

Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year. This is higher than the 15% decline observed by the state during the same time period.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015. Rates are expressed as per 100,000 population.



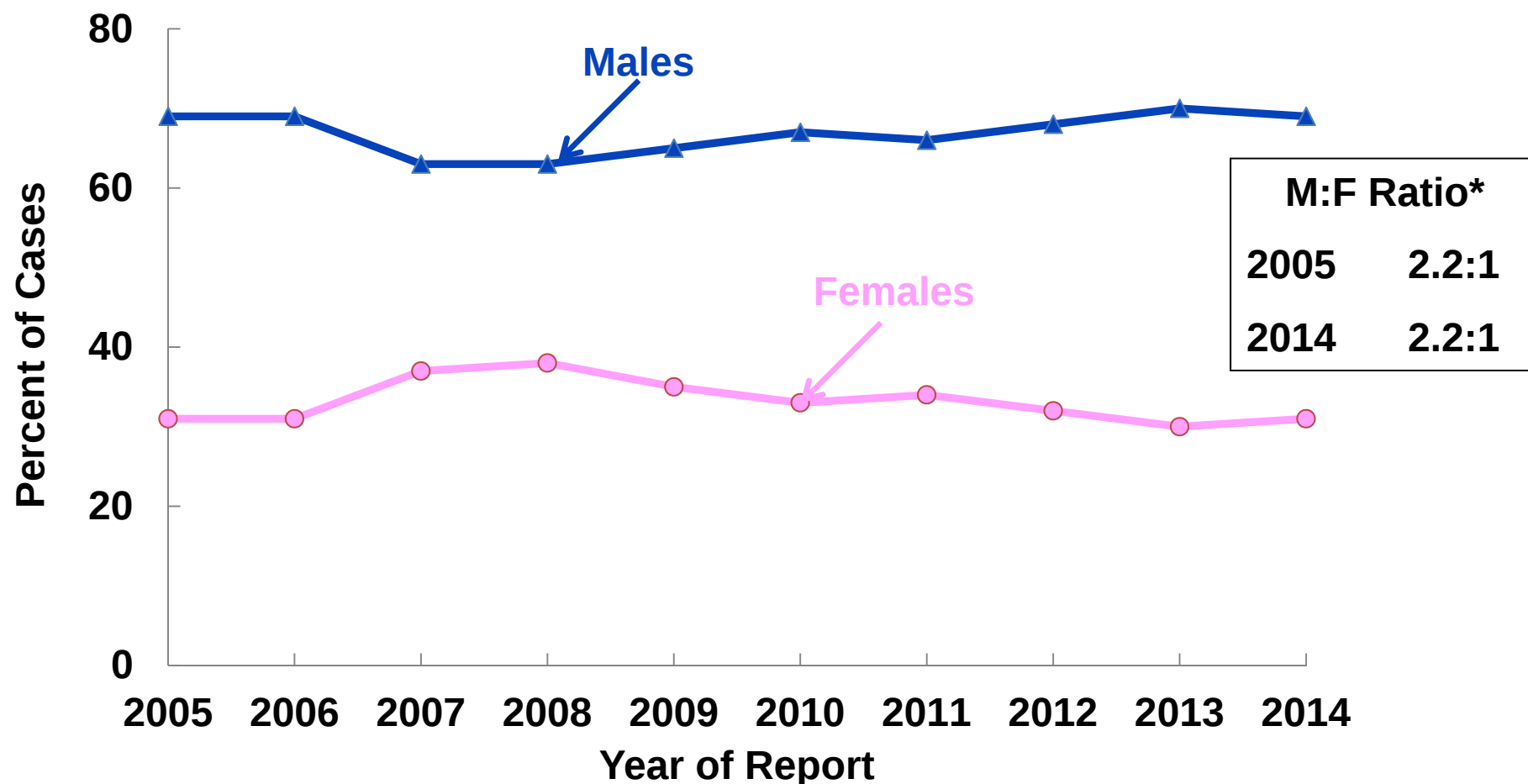
Adult HIV Infection Cases, by Sex and Year of Report, 2005-2014, Partnership 10



Note: Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV Infection Cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

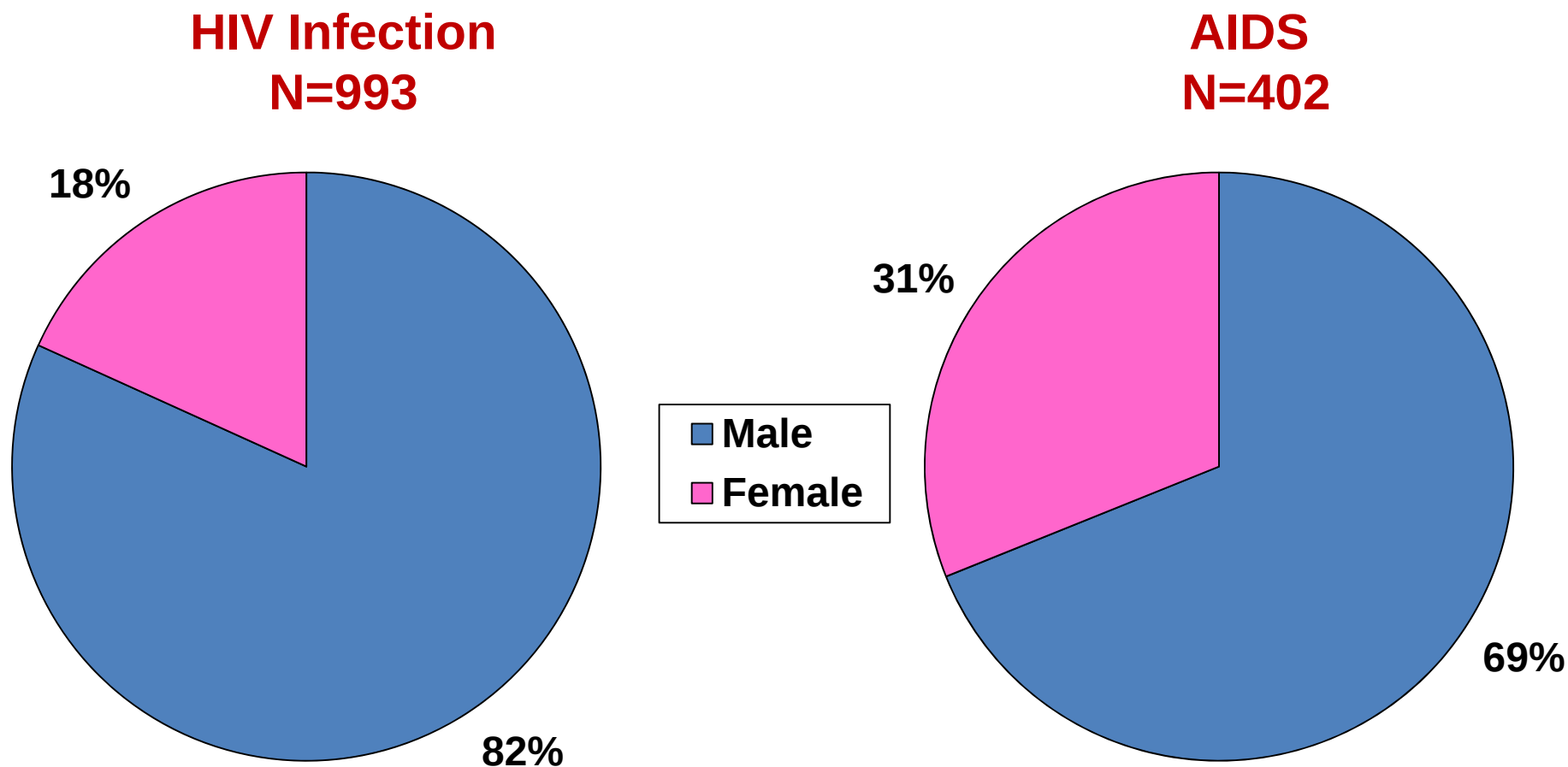


Adult AIDS Cases, by Sex and Year of Report, 2005-2014, Partnership 10



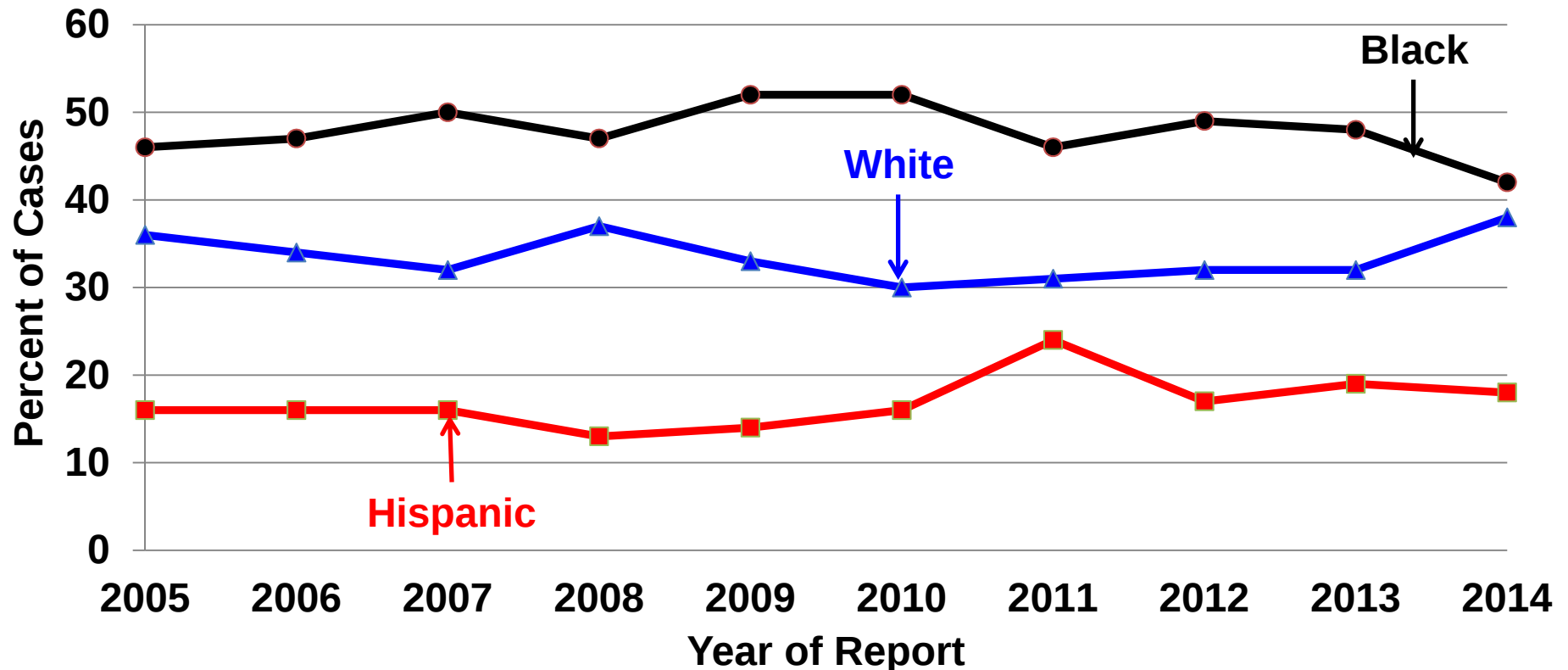
Note: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in males cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

Adult HIV Infection and AIDS Cases by Sex, Reported in 2014, Partnership 10



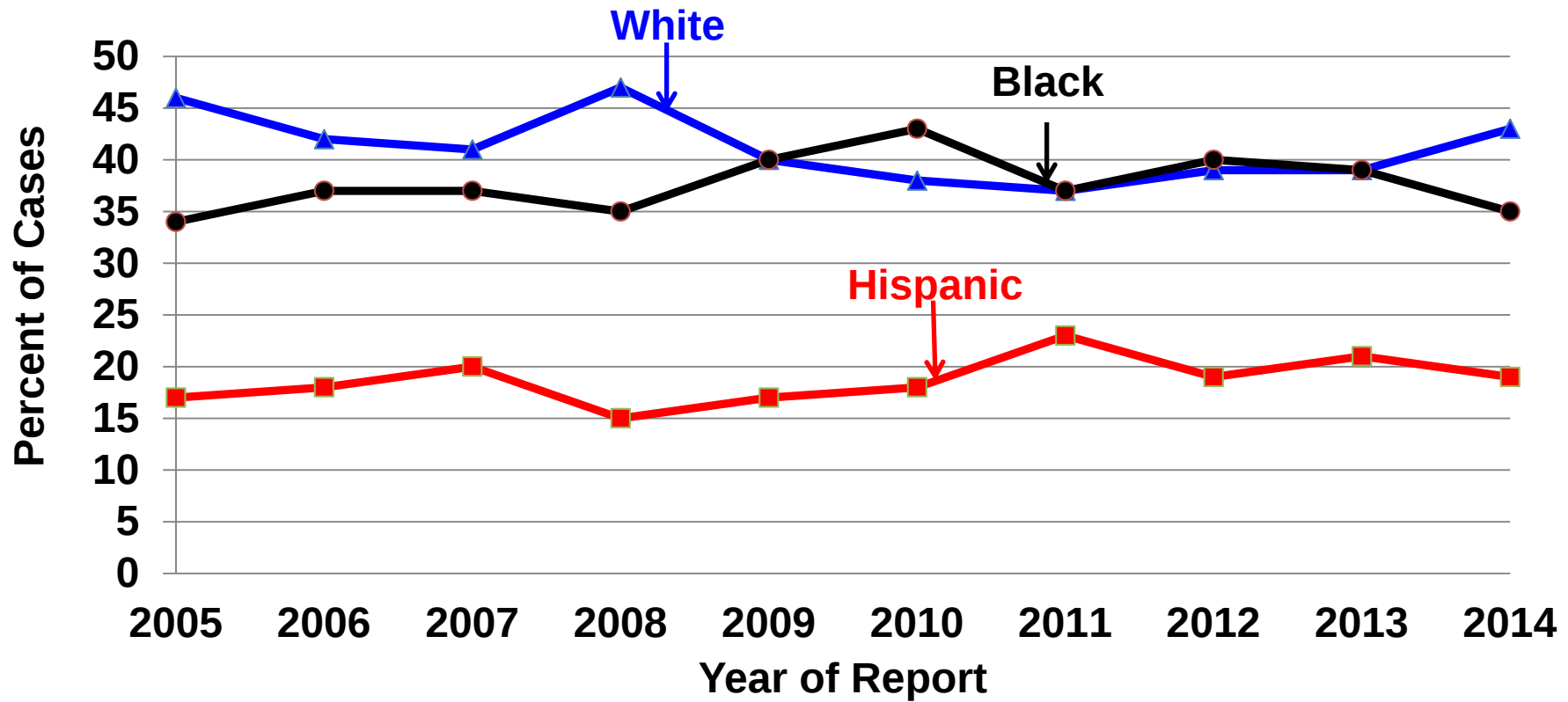
Note: Partnership 10's Adult Population is: 48% Male and 52% Female.

Adult HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



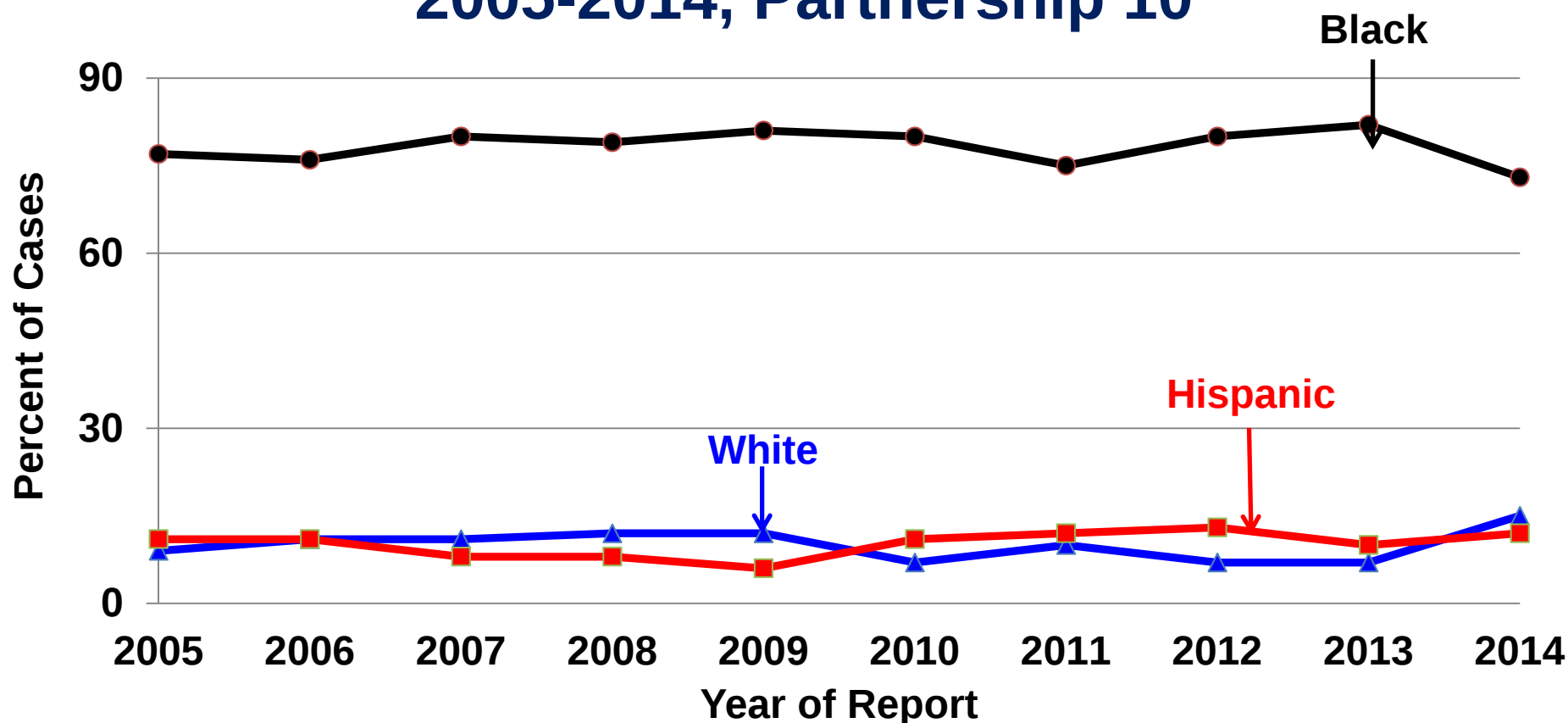
Note: HIV case reporting reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. For the past ten years, blacks represented 42% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among whites and Hispanics increased by 2 percentage points respectively. In contrast, the proportion of HIV infection cases among blacks decreased by 4 percentage points. Other races represent less than 3% of the cases and are not included.

Adult Male HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



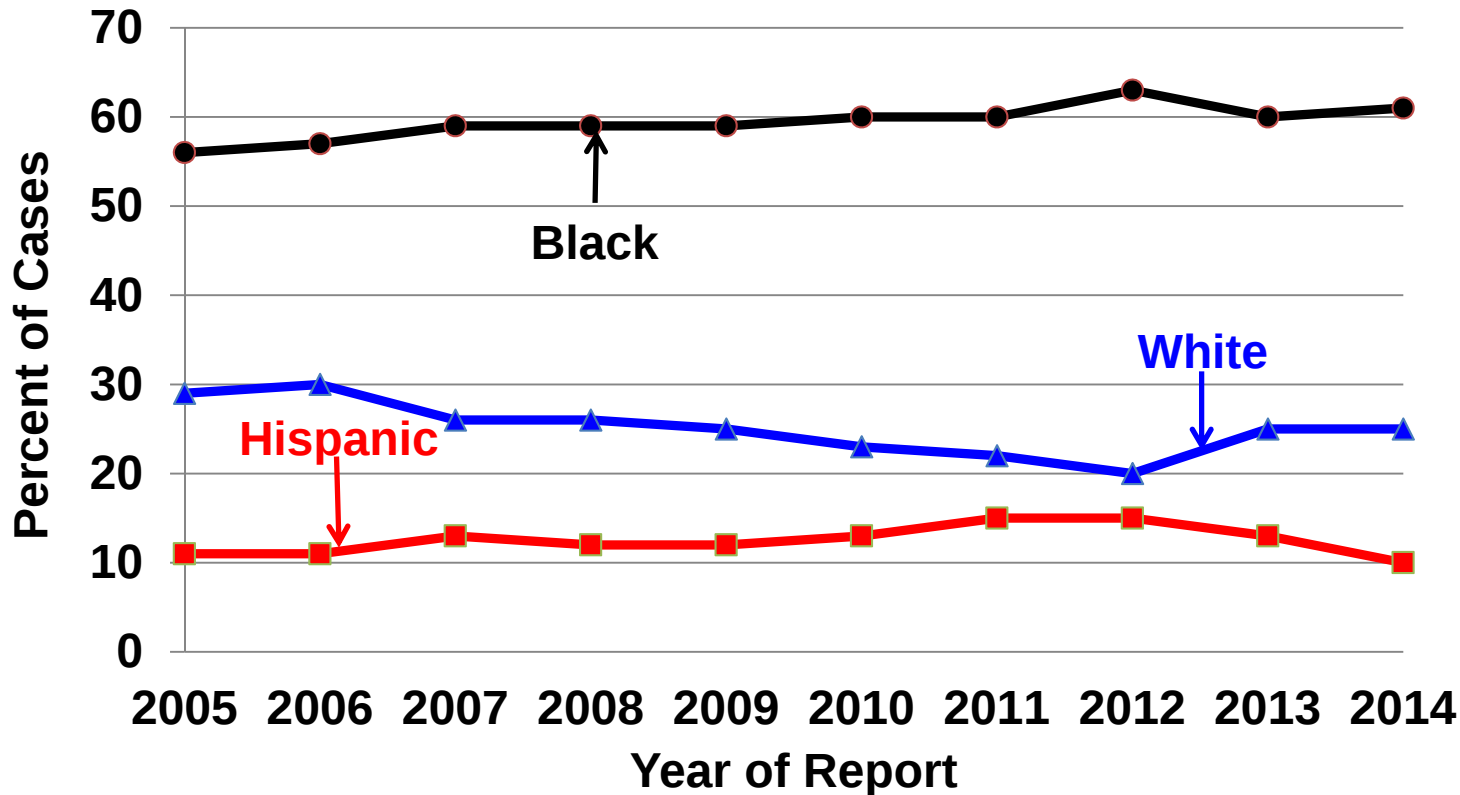
Note: The proportion of adult male HIV infection cases among blacks and whites has shifted up and down over the years, at times, crossing paths. From 2005 to 2014, the proportion of HIV infection cases among black and Hispanic males increased by 1 and 2 percentage points, respectively. In contrast, HIV infection cases among white males decrease by 3 percentage points. Other races represent less than 3% of the cases and are not included.

Adult Female HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case disparities are more evident among women than men. For the past ten years, black women represented 75% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among Hispanic and white females increased by 1 and 6 percentage points, respectively. In contrast, the proportion of HIV infection cases among black females decreased by 4 percentage points. Other races represent less than 5% of the cases and are not included.

Adult AIDS Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10

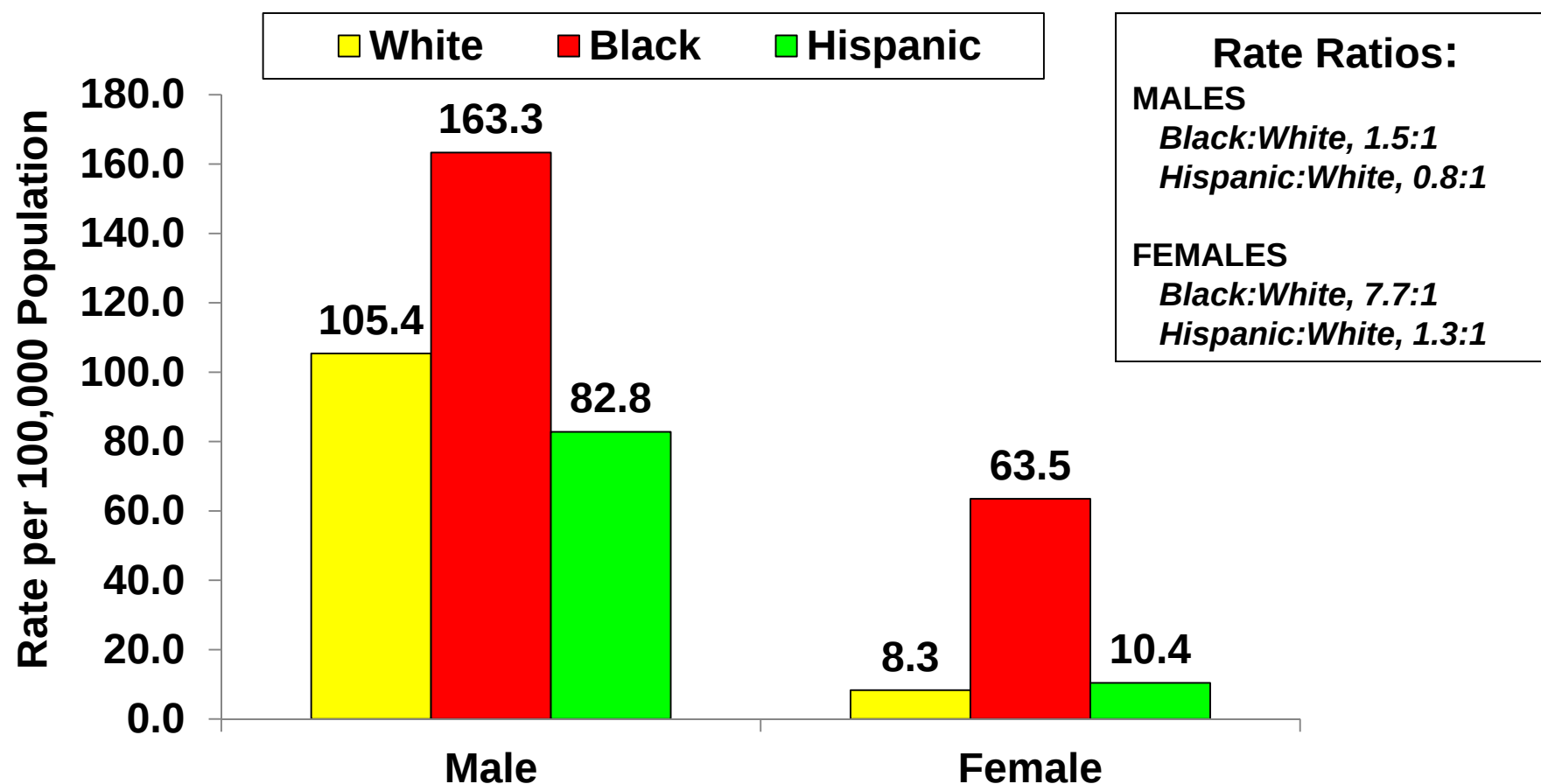


Factors Affecting Disparities

- Late diagnosis of HIV.
- Access to/ acceptance of care.
- Delayed prevention messages.
- Stigma.
- Non-HIV STD's in the community.
- Prevalence of injection drug use.
- Complex matrix of factors related to socioeconomic status

Note: In 2014, blacks accounted for 61% of adult AIDS cases, but only 25% of the population. From 2005 to 2014, the proportion of AIDS cases among blacks increased by 5 percentage points. In contrast, the proportion of AIDS cases among Hispanics and whites decreased by 1 and 4 percentage points, respectively. Numerous disparities can affect the increases of HIV disease in a given population. Other races represent less than 4% of the cases and are not included.

Adult HIV Infection Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10

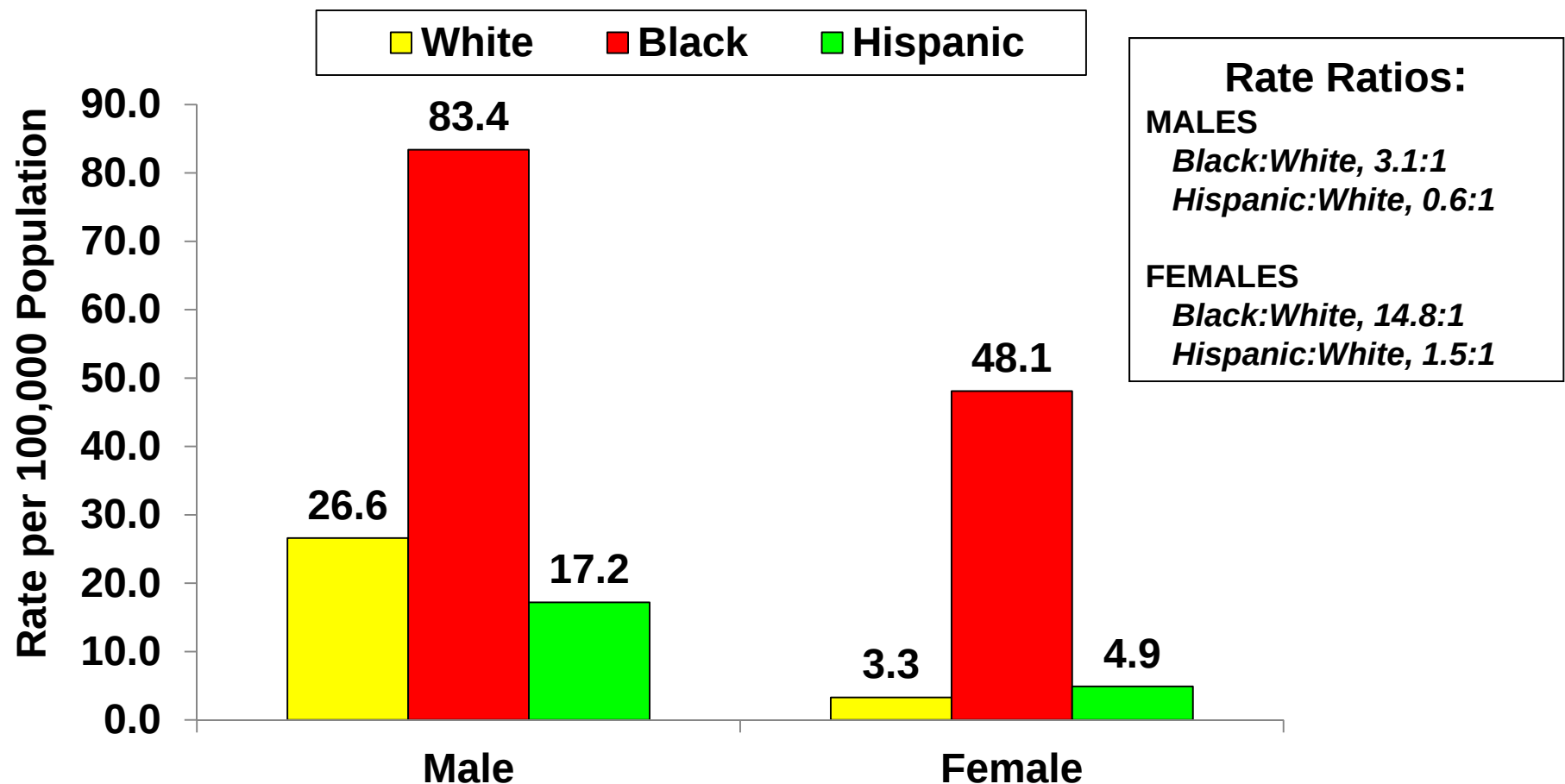


Note: Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males. Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females. In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.



Adult AIDS Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10

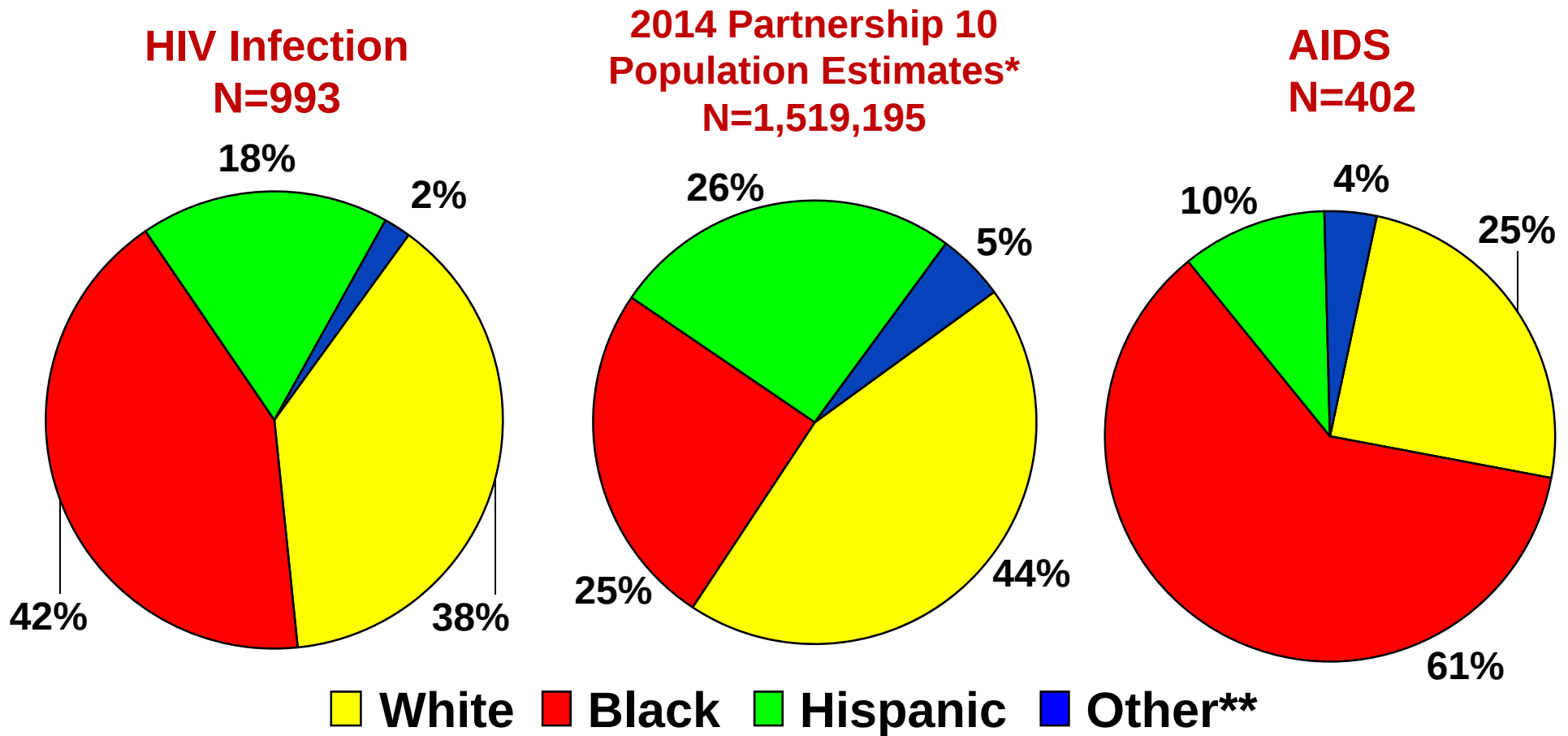


Note: Among black males, the AIDS case rate is 3 times higher than the rate among white males. Among black females, the AIDS case rate is nearly 15-fold greater than the rate among white females. Hispanic males have an AIDS case rate that is lower than the rate among white males. In contrast, the AIDS case rate among Hispanic females is nearly 2 times higher than the rate among white females.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.



Adult HIV and AIDS Cases Reported in 2014 and Population Data, by Race/Ethnicity, Partnership 10



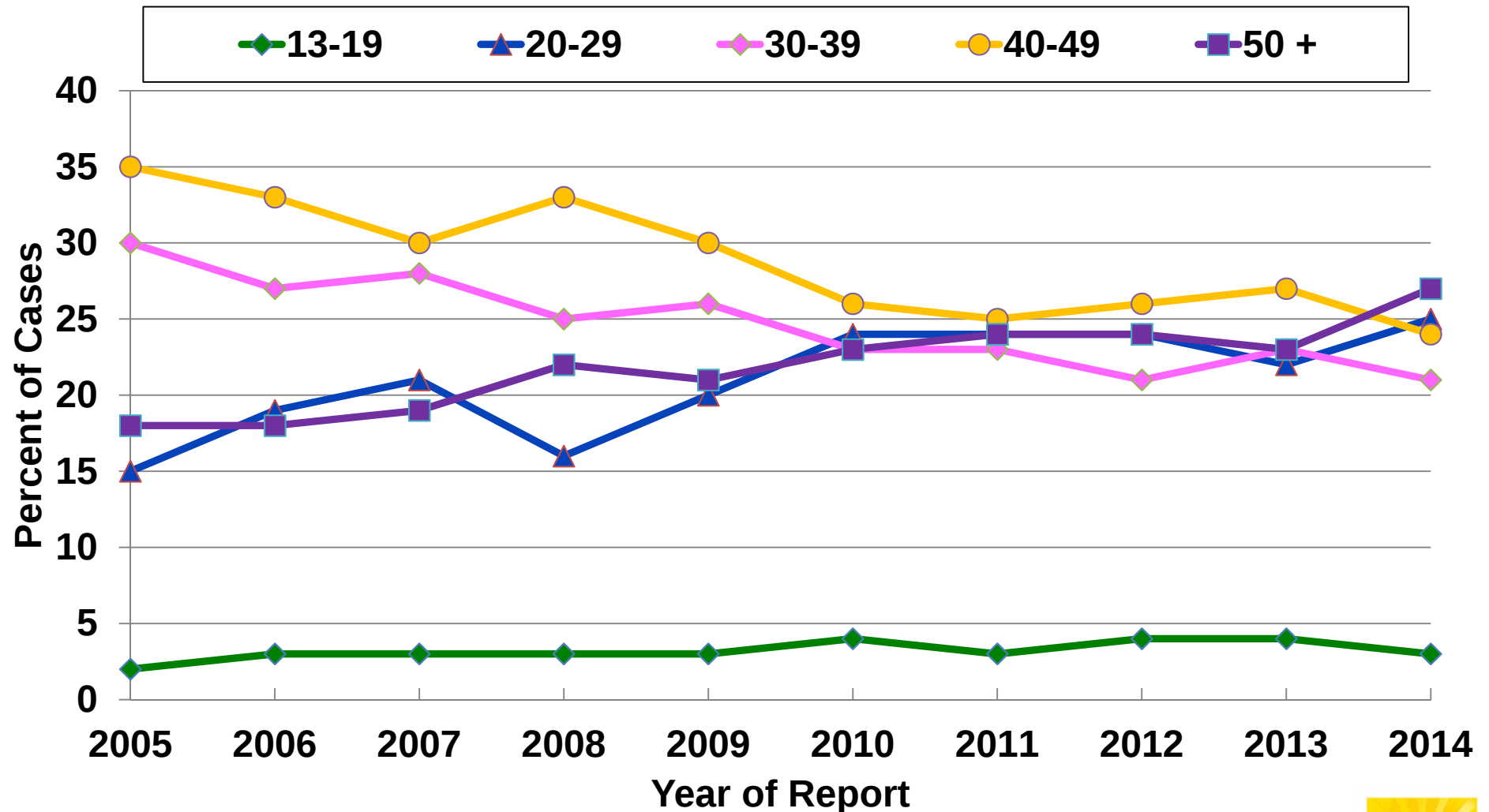
Note: In this snapshot for 2014, blacks are over-represented among the HIV and AIDS cases, accounting for 42% of adult HIV cases and 61% of adult AIDS cases, but only 25% of the adult population. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of the population.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.

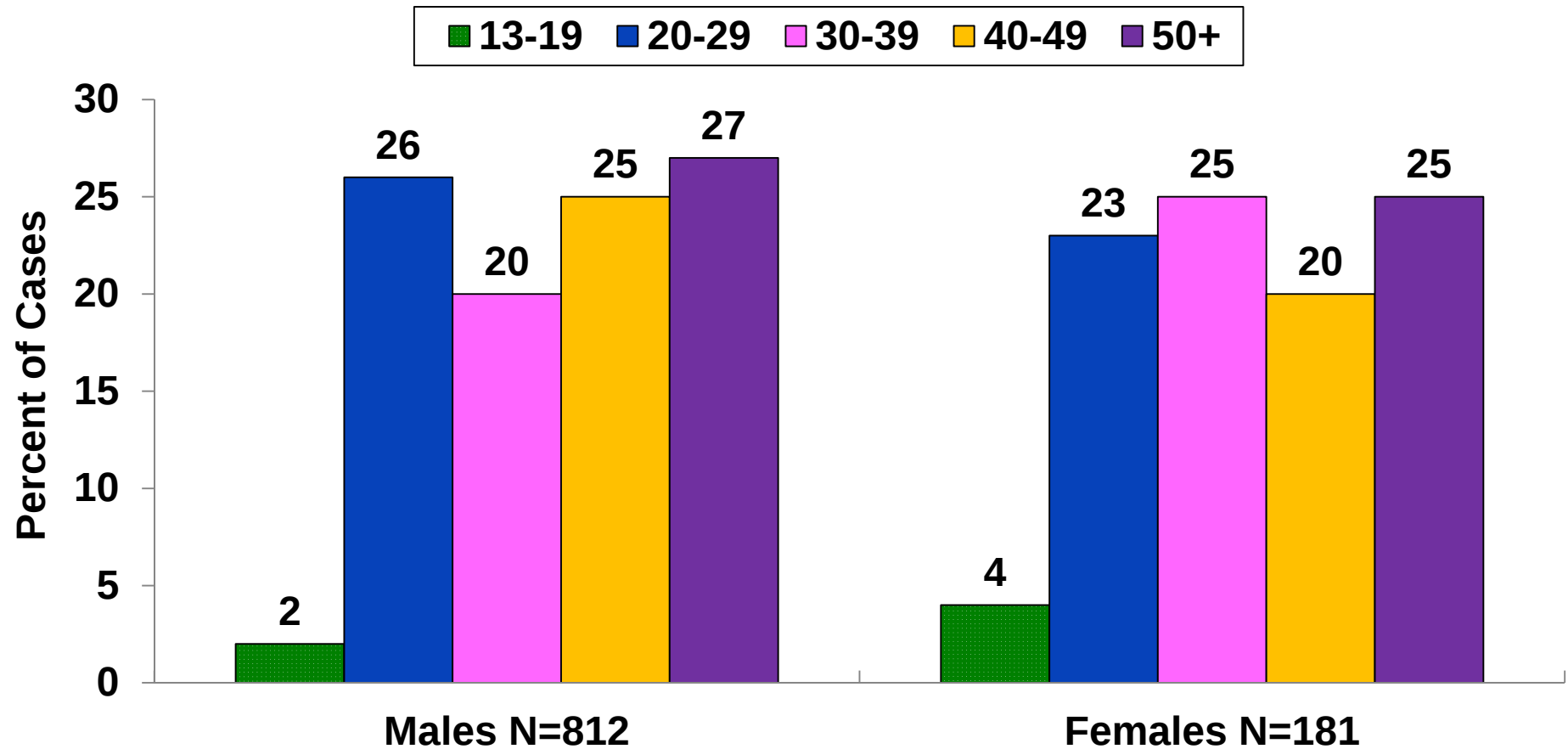


Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005–2014, Partnership 10



Note: From 2005 to 2014, the proportion of adult HIV infection cases among those aged 20-29 and those aged 50+ increased by 10 and 9 percentage points, respectively.

Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Reported in 2014, Partnership 10

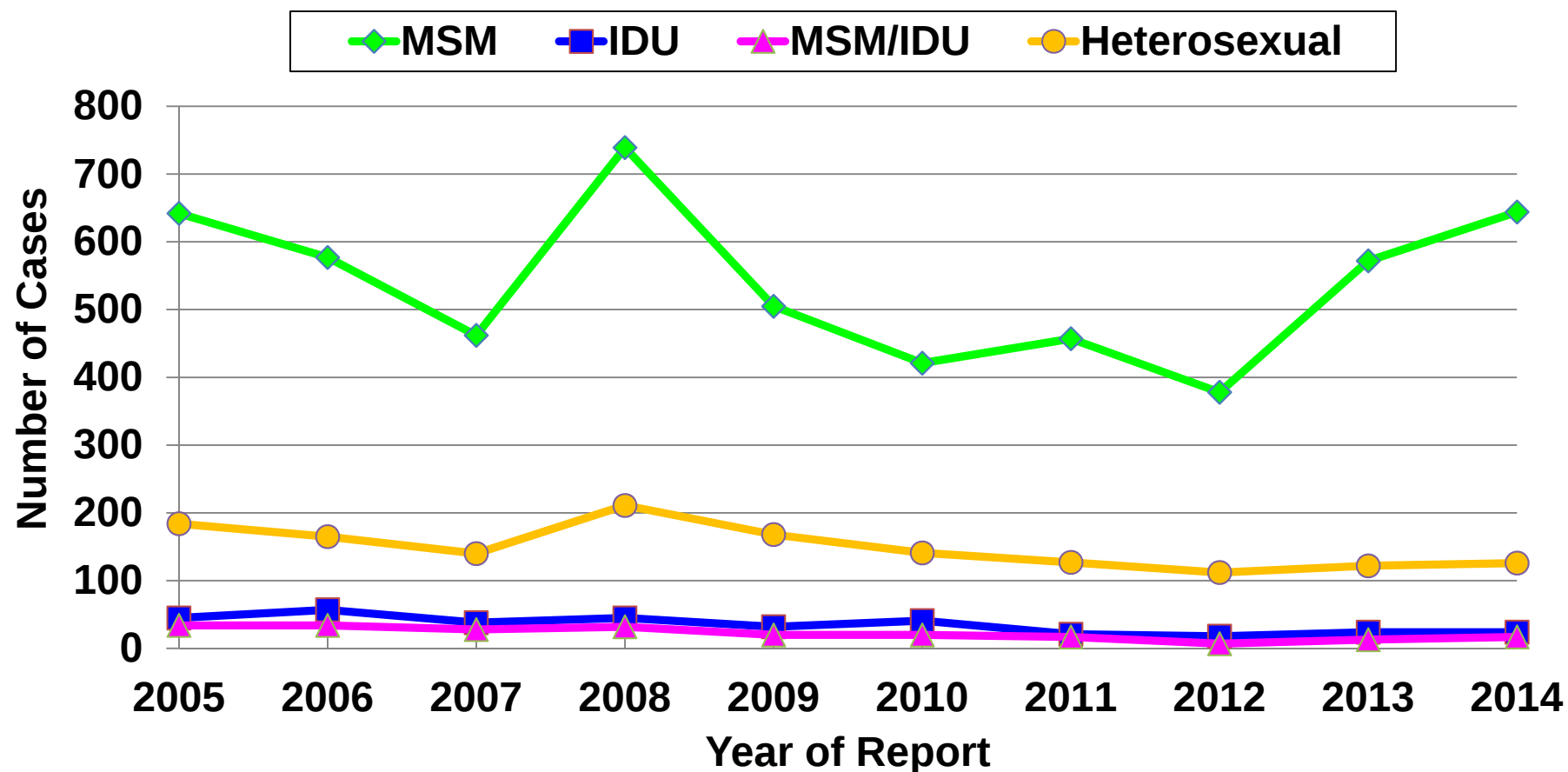


Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age groups with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and those aged 50 or older.

Definitions of Mode of Exposure Categories

- ◆ **MSM** = Men who have sex with men or Male-to-male sexual contact with person with HIV/AIDS or known HIV risk
- ◆ **IDU** = Injection Drug User
- ◆ **MSM/IDU** = Men who have sex with men or Male-to-male sexual contact & Injection Drug User
- ◆ **Heterosexual** = Heterosexual contact with person with HIV/AIDS or known HIV risk
- ◆ **OTHER** = includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.
- ◆ **NIR** = Cases reported with No Identified Risk
- ◆ **Redistribution of NIRs** = This illustrates the effect of statistically assigning (redistributing) the NIRs to recognized exposure (risk) categories by applying the proportions of historically reclassified NIRs to the unresolved NIRs.

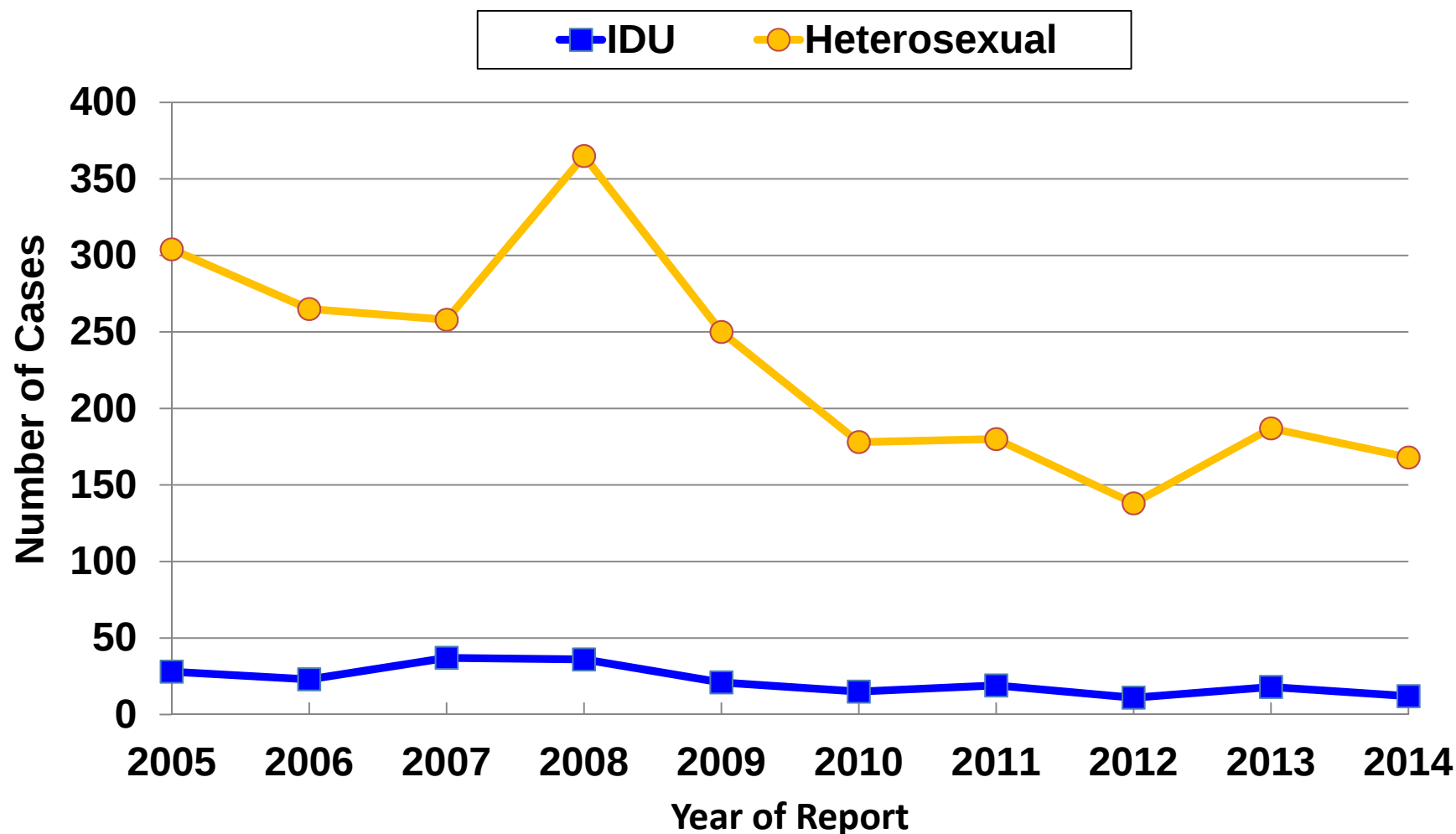
Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005–2014, Partnership 10



Note: NIRs redistributed. Male-to-male sexual contact (MSM) remains as the primary mode of exposure among male HIV cases in Partnership 10, followed by heterosexual contact.



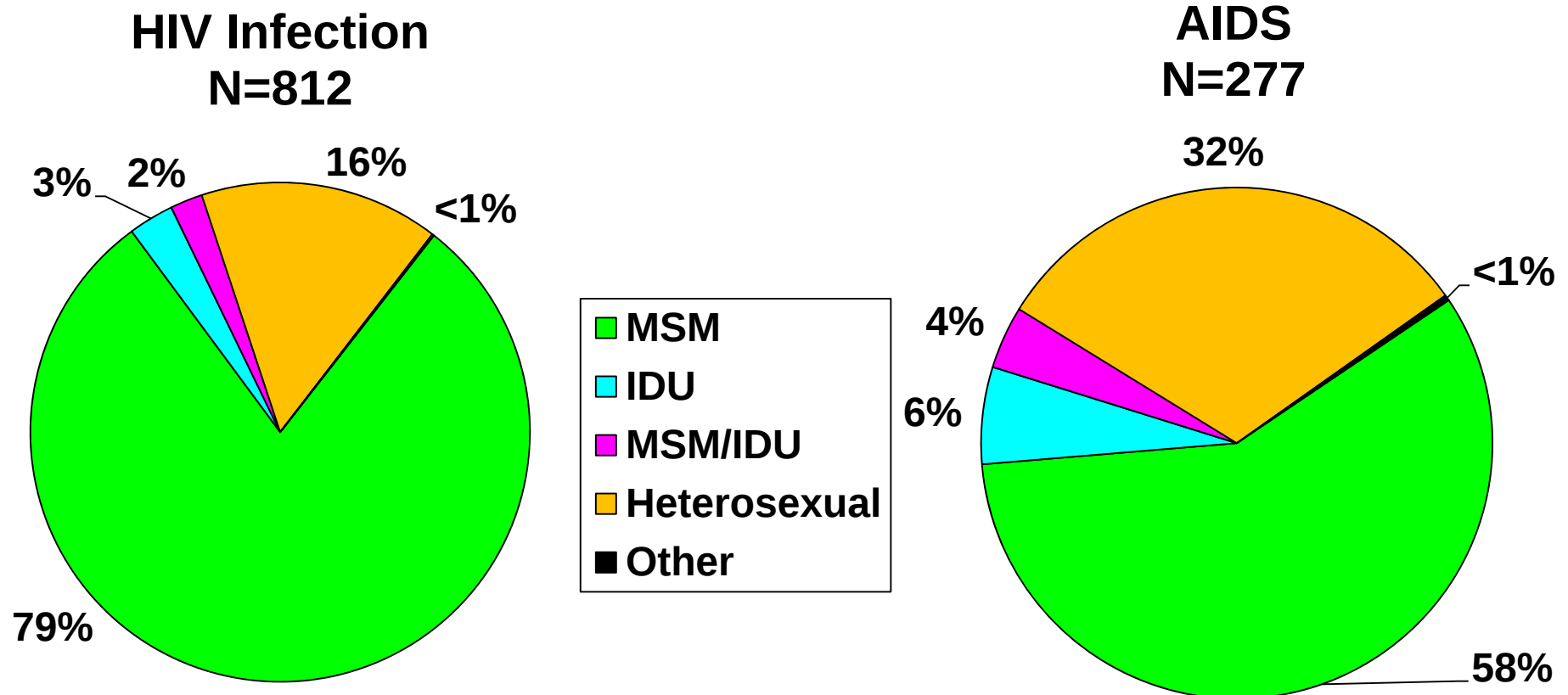
Adult Female HIV Infection Cases by Exposure Category and Year of Report, 2005-2014, Partnership 10



Note: NIRs redistributed. The heterosexual risk continues to be the dominant mode of exposure among females.

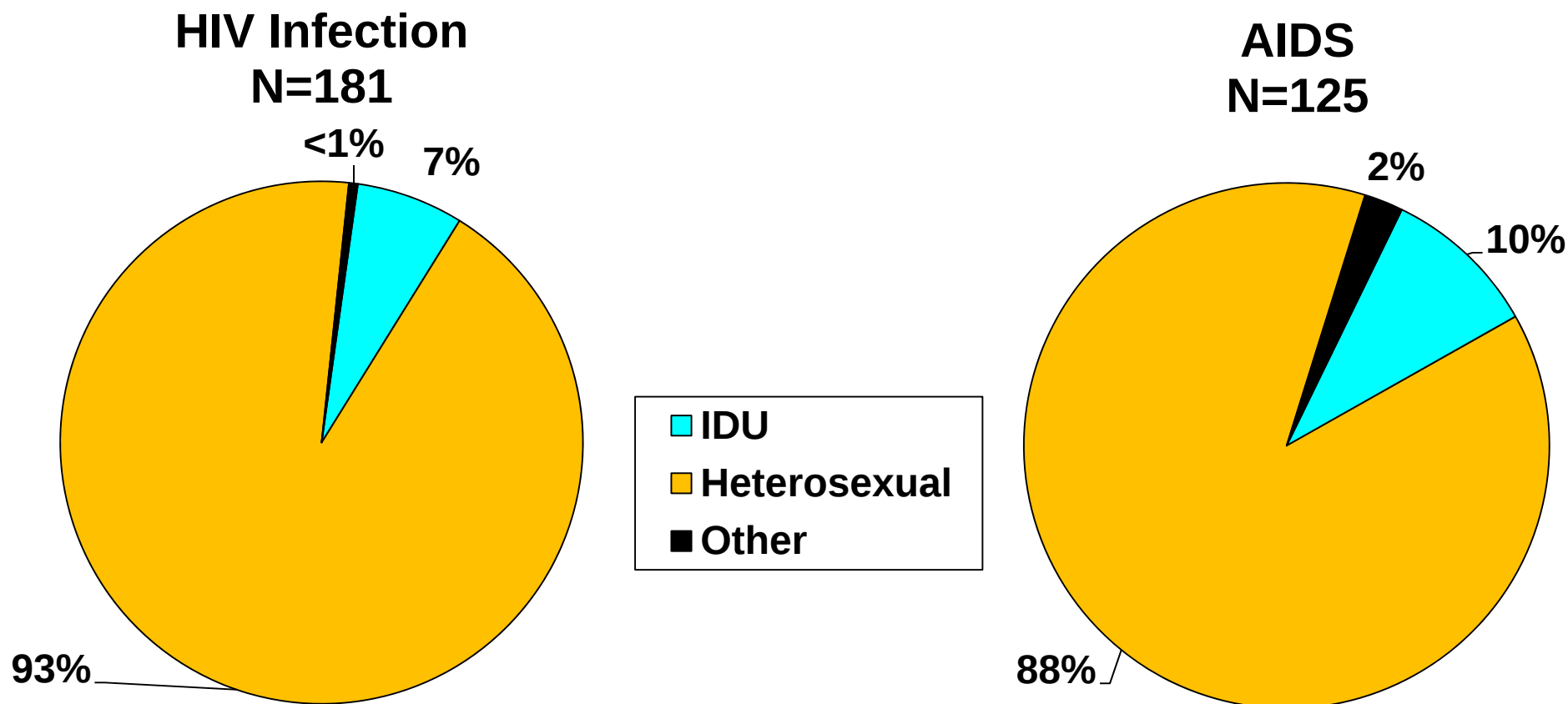


Adult Male HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, male-to-male sexual contact (MSM) was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS). The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic.

Adult Female HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



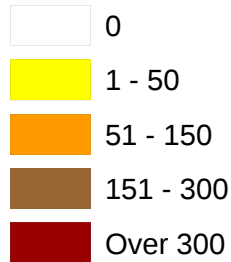
Note: NIRs redistributed. Among the female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively).

Cases Living with HIV Disease

Unless otherwise noted, data in the following slides represent persons living with HIV/AIDS (PLWHAs), who were living in Florida (regardless where diagnosed) through the most recent calendar year. Living data are also referred to as prevalence cases or living with HIV disease.



By Zip Code, Diagnosed through 2014, Partnership 10



00053

00041

33076 33067 33433 33442 33441

33065 33073 33064

33071 33063 33066 33062

33321 33068 33069 33060

33351 33319 33309 33308

33323 33322 33313 33334 33306

33327 33326 33325 33324 33317 33305 33304

33332 33331 33330 33328 33314 33311 33301

33312 33315 33316 33300

33029 33028 33026 33024 33021 33020 33019

33018 33027 33025 33023 33009 33169 33179 33180

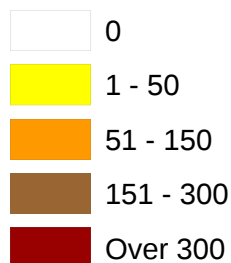
BALTIMORE

**NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zip.
Data as of 06/30/2015**

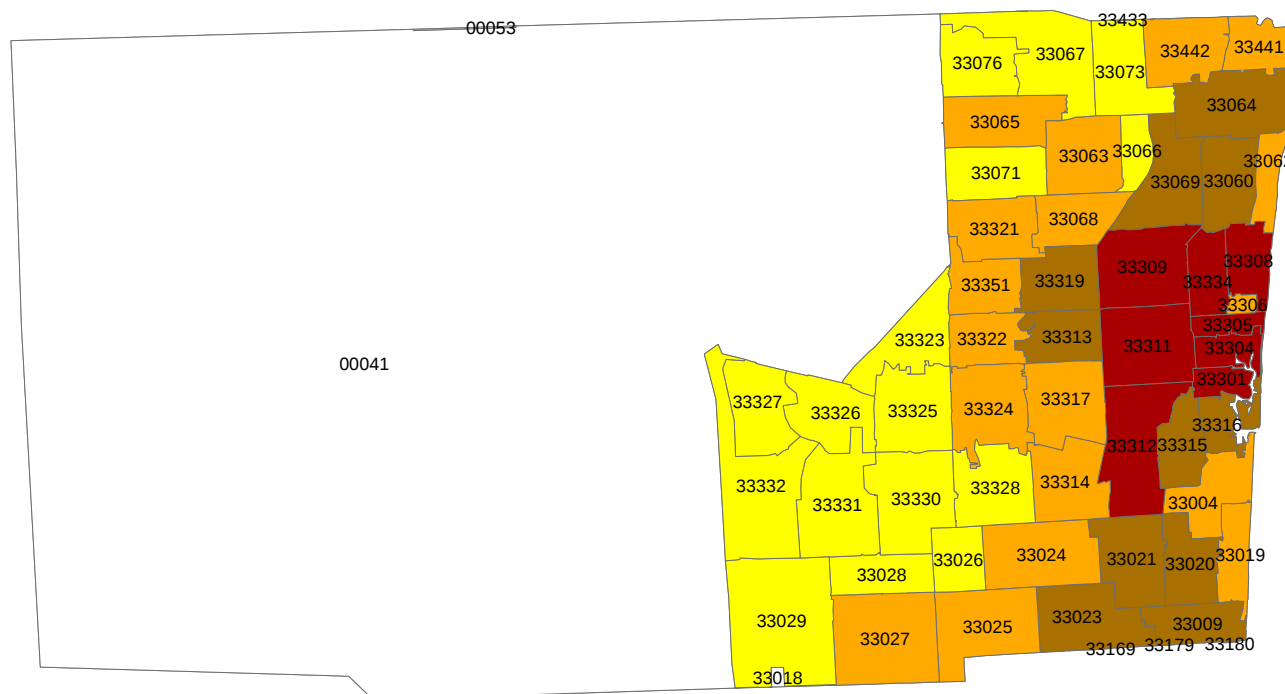


Men who have Sex with Men (MSM)* Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 10

Presumed Living MSM HIV/AIDS Cases



N=10,841



NIRs are not redistributed.

Excludes DOC, homeless, and cases with unknown zips.

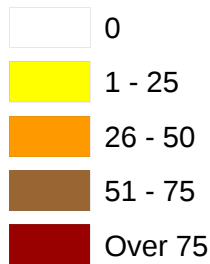
*Includes MSM/IDU cases.

Data as of 06/30/2015

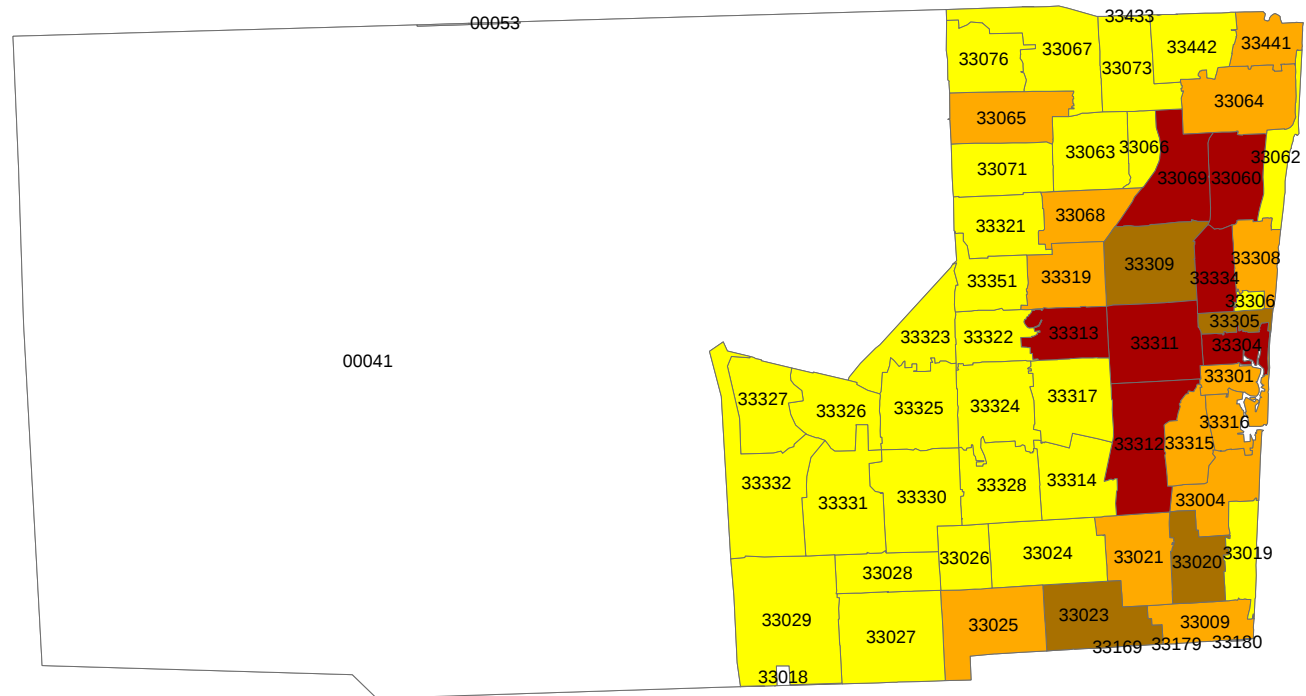


Injection Drug Users (IDUs)* Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 10

Presumed Living IDU HIV/AIDS Cases



N=1,780

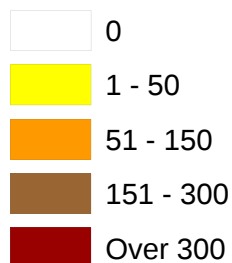


NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
*Includes MSM/IDU cases.
Data as of 06/30/2015

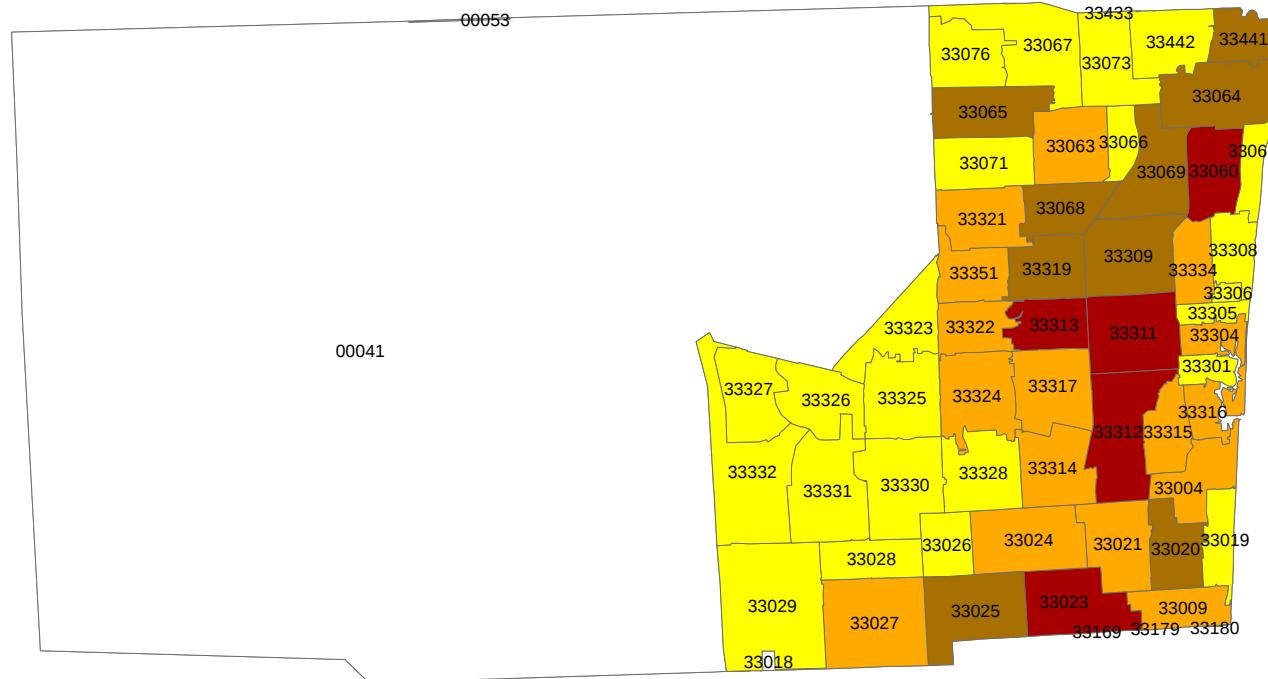


Adult Heterosexuals Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 10

Presumed Living Heterosexual HIV/AIDS Cases



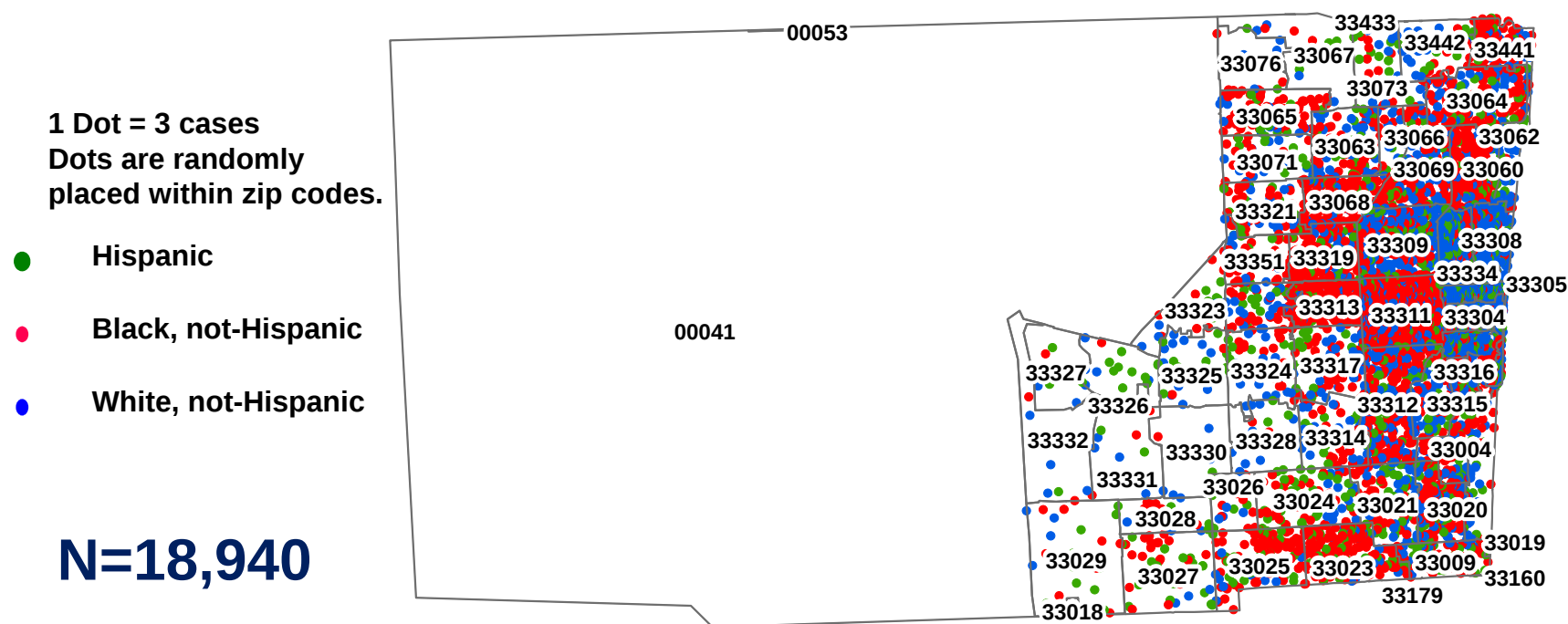
N=7,105



NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zip.
Data as of 06/30/2015



Adults Living with HIV Disease By Zip Code and Race/Ethnicity, Diagnosed through 2014, Partnership 10



Total includes all races, some which are not on map.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

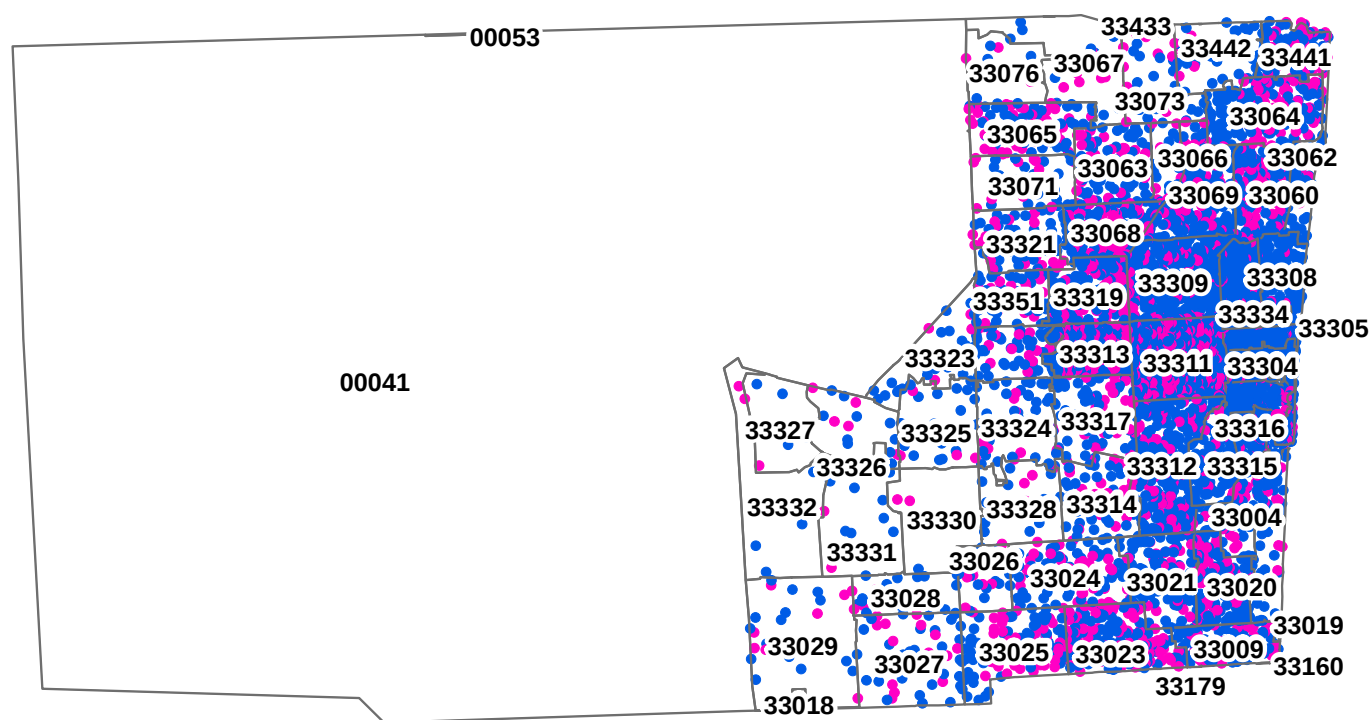


Adults Living with HIV Disease By Zip Code and Sex, Diagnosed through 2014, Partnership 10

1 Dot = 3 cases
Dots are randomly
placed within zip codes.

- Male
- Female

N=19,386

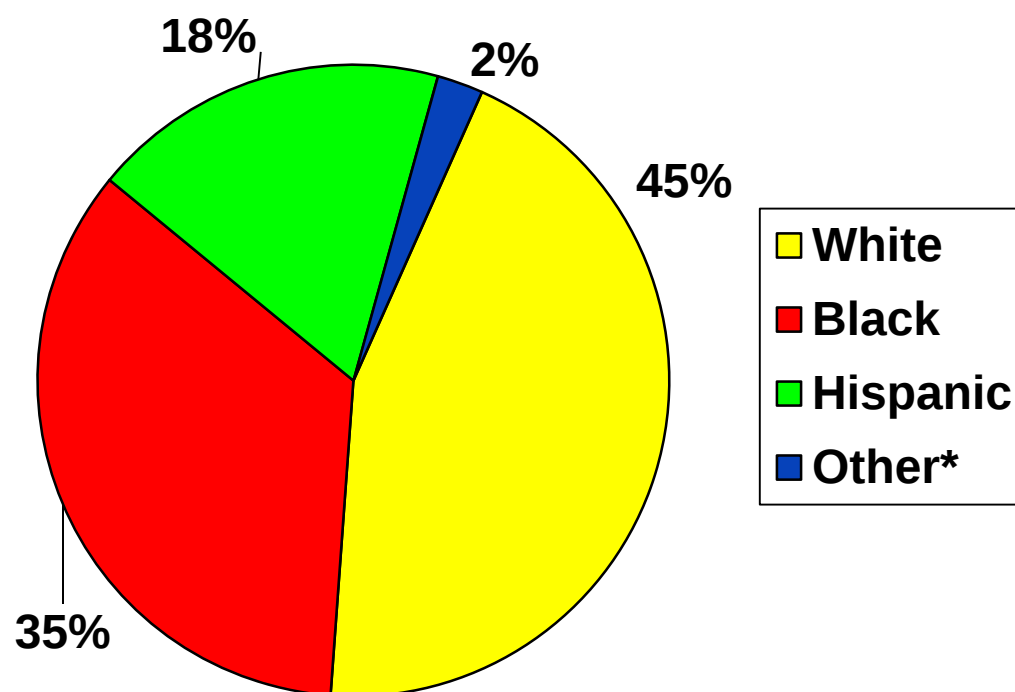


Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

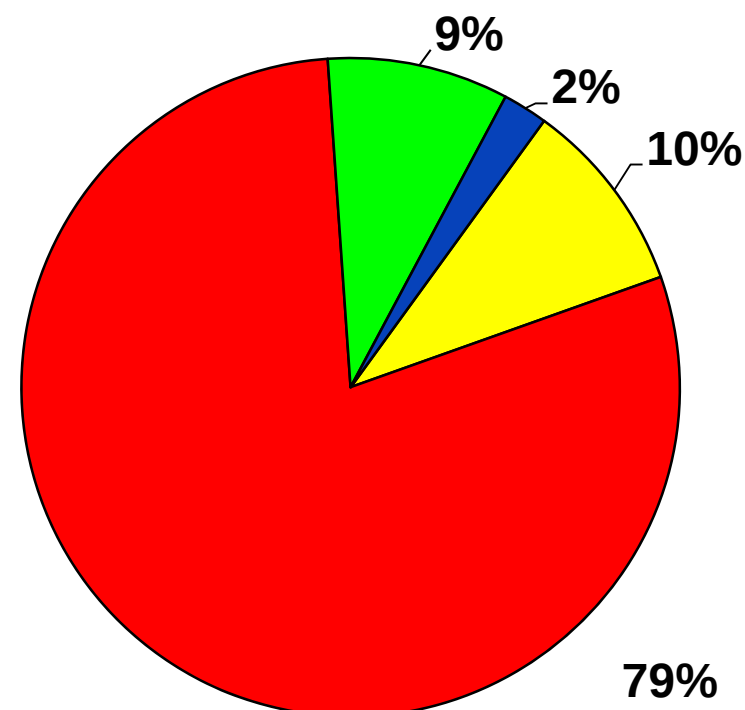


Adults Living with HIV Disease, by Sex and Race/Ethnicity Diagnosed through 2014, Partnership 10

Males
N=14,193

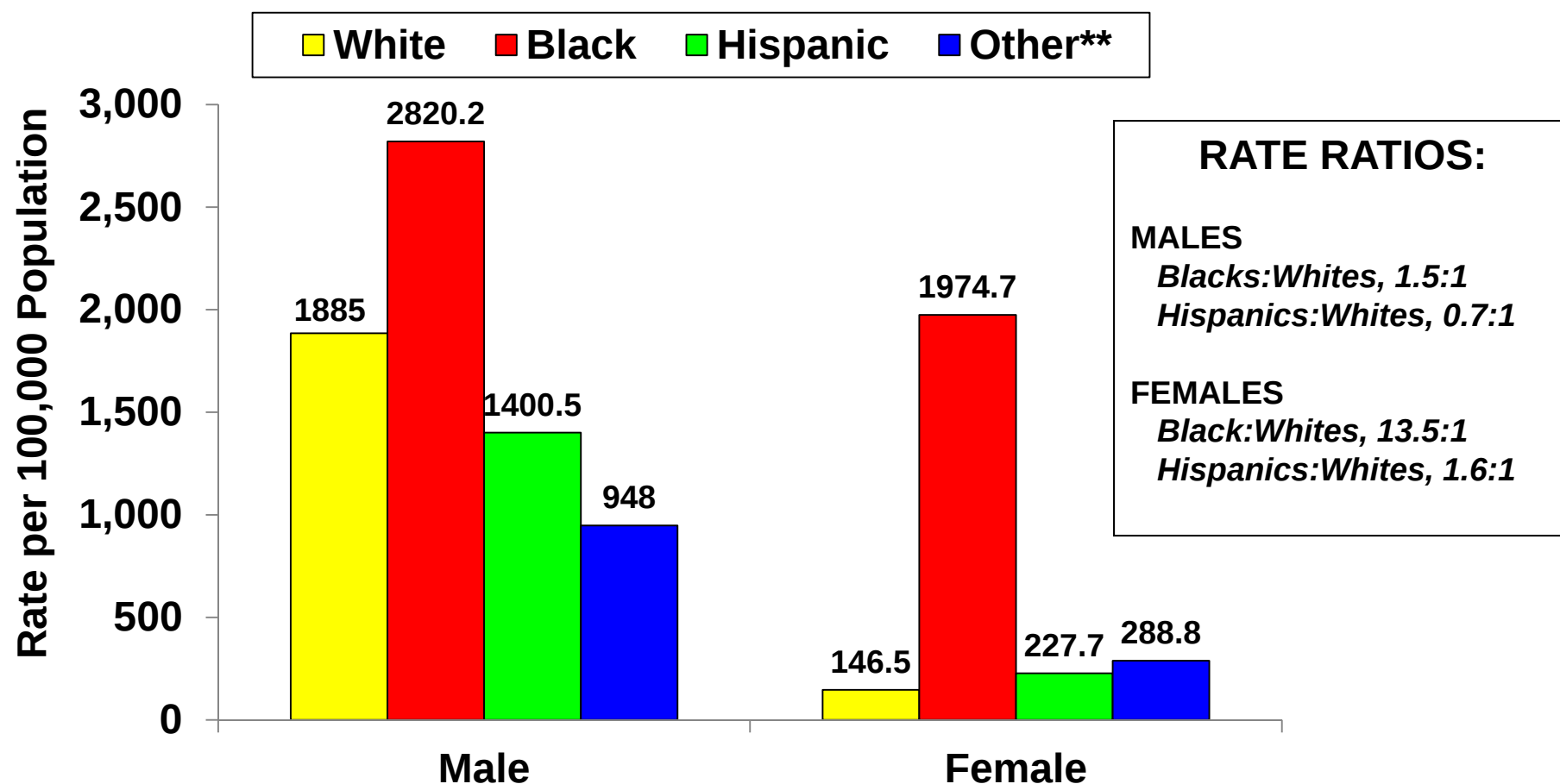


Females
N=5,176



Note: Among adult males living HIV disease, whites represent the race most affected (45%).
Among adult females, blacks represent the race most affected (79%).
*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

Case Rates* of Adults Living with HIV Disease, by Sex and Race/Ethnicity, Diagnosed through 2014, Partnership 10



Note: Among black males living with HIV disease Diagnosed through 2014, the case rate is nearly 2 times higher than the rate among white males. Among black females living with HIV disease, the case rate is nearly 14 times higher than the rate among white females. The Hispanic male rate is less than the rate among their white counterpart, whereas the Hispanic female rate is slightly higher than the rate among their white counterpart. Data excludes Department of Corrections cases.

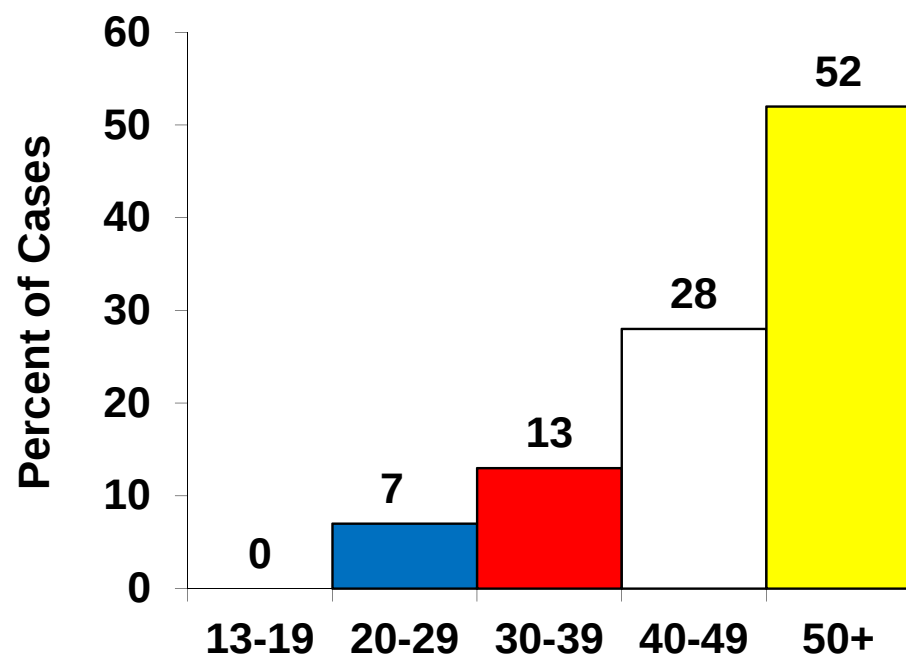
*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

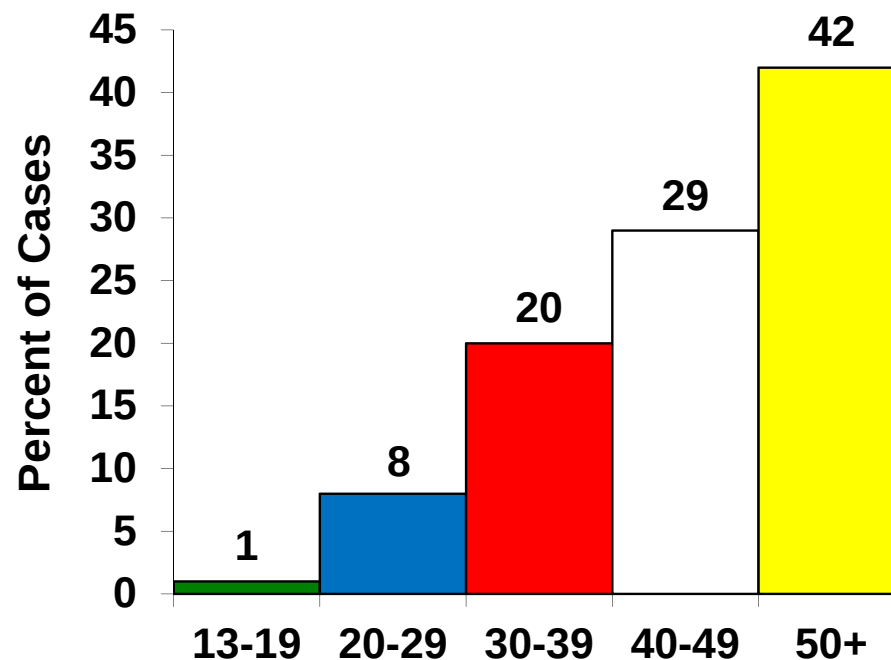


Adults Living with HIV Disease, by Sex and Current Age Group, Diagnosed through 2014, Partnership 10

Males
N=14,193



Females
N=5,176

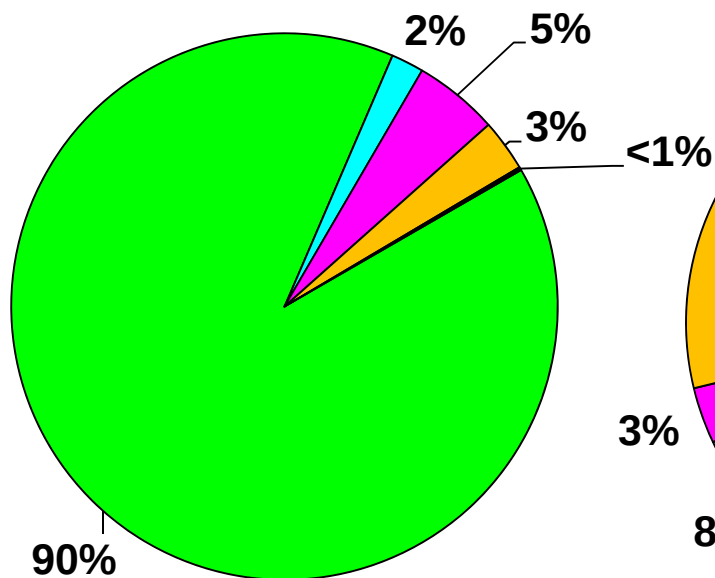


Note: Males living with HIV disease have a higher proportion of cases who are currently 40 years of age or older (80%), compared with females who are currently 40 years of age or older living with HIV disease (71%).

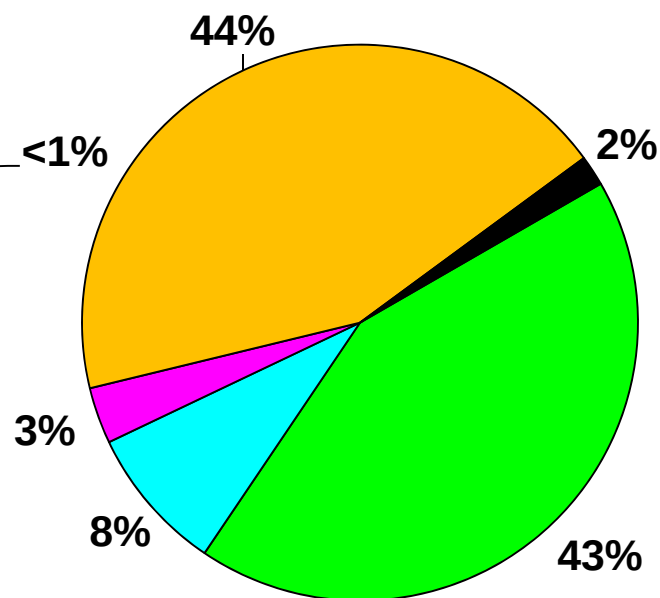


Adult Males Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 10

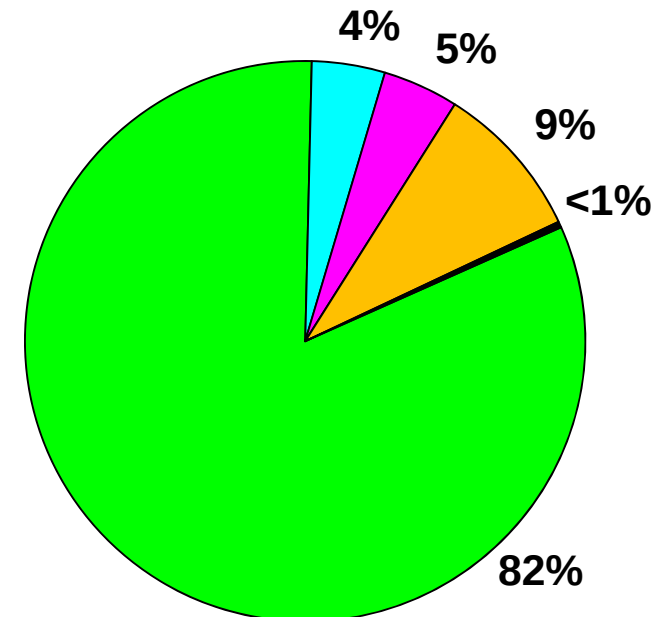
**White, Non-Hispanic
N=6,314**



**Black, Non-Hispanic
N=4,939**



**Hispanic
N=2,606**



■ MSM ■ IDU ■ MSM/IDU ■ Heterosexual ■ Other*

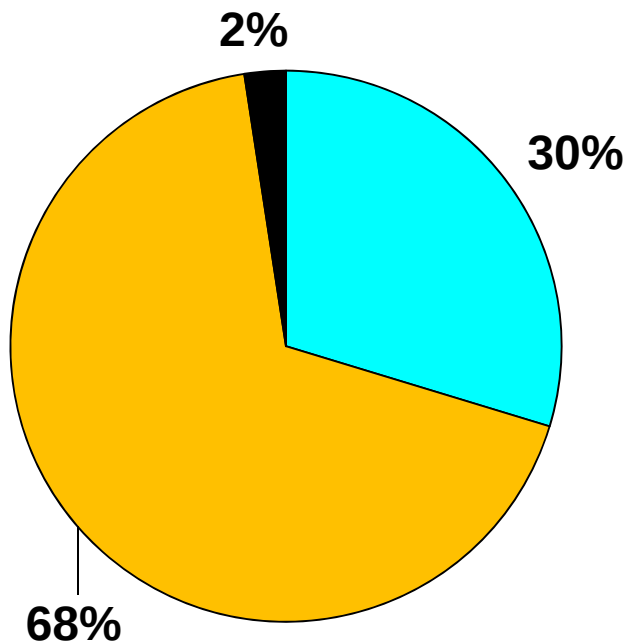
Note: NIRs redistributed. Male-to-male sexual contact (MSM) represents the highest risk for all races. White males have the smallest proportion of heterosexual contact risk.

* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

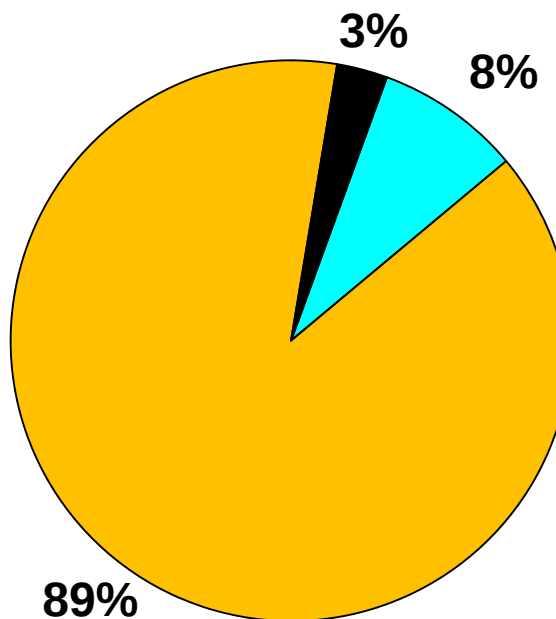


Adult Females Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 10

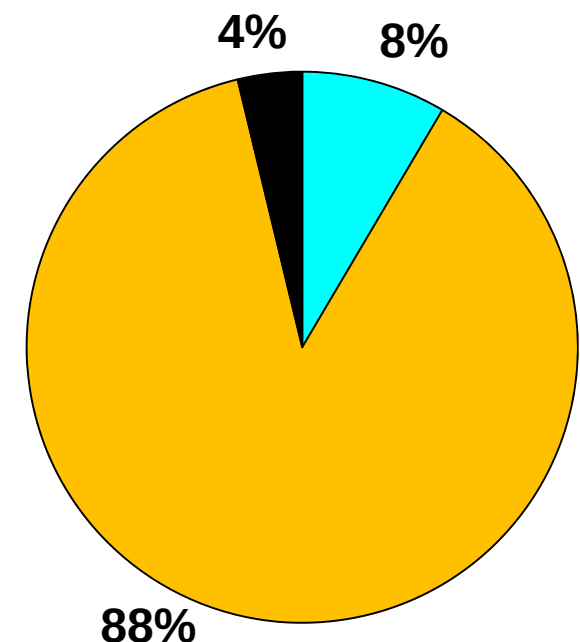
White, Non-Hispanic
N=495



Black, Non-Hispanic
N=4,106



Hispanic
N=424

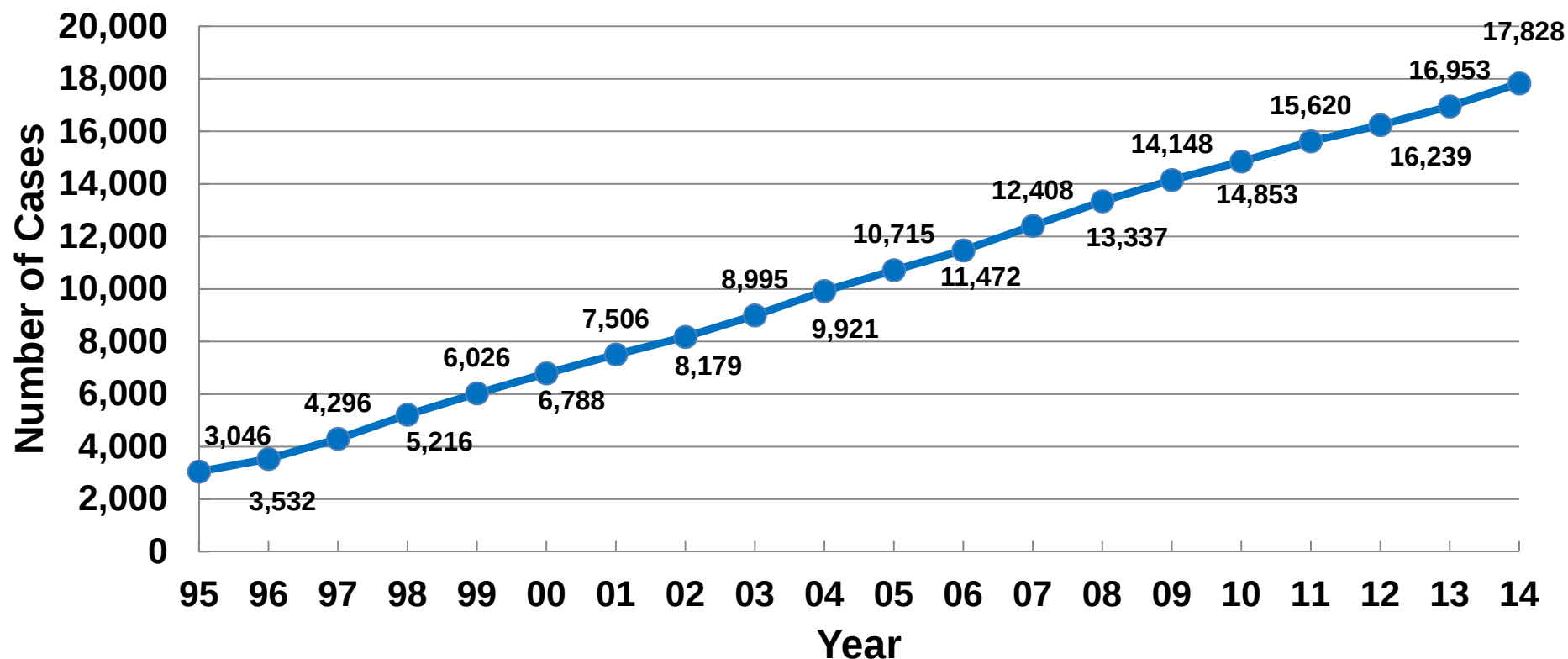


■ IDU ■ Heterosexual ■ Other*

Note: NIRs redistributed. Heterosexual contact is the majority risk for all races. However, whites have the largest proportion of IDU risk.

* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

Annual Prevalence of Adults Living with HIV Disease, 1995-2014, Partnership 10



As a result of declining deaths, annual HIV/AIDS diagnoses have exceeded deaths since 1995, and the number of persons reported with HIV/AIDS who are presumed to be alive have been increasing. Since 1995, the number of persons reported living with HIV/AIDS have increased over 460%. In 2014, the prevalence increased by 5% since the previous year.

Note: These data represent adults living with HIV disease diagnosed in Florida regardless of their current residence.



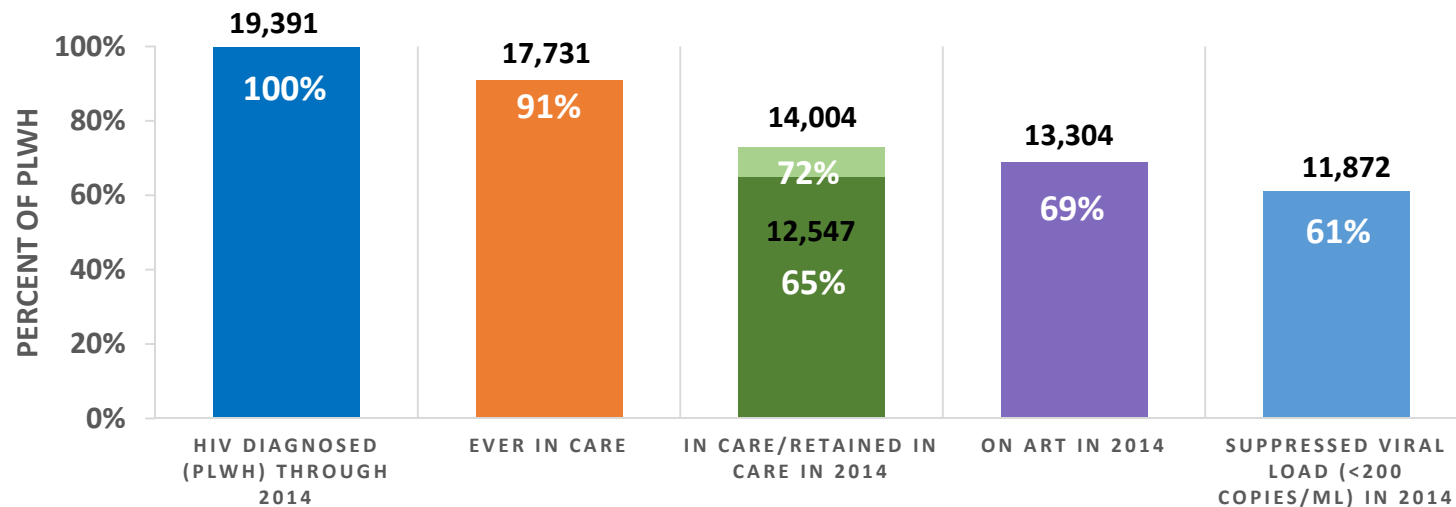
Partnership 10's Top-9 Priority Populations in 2014 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease

- 1. White Men who have sex with Men**
- 2. Black Heterosexual men and women**
- 3. Black Men who have sex with men**
- 4. Hispanic Men who have sex with Men**
- 5. Black Injection Drug User**
- 6. Hispanic Heterosexual men and women**
- 7. White Heterosexual men and women**
- 8. White Injection Drug User**
- 9. Hispanic Injection Drug User**

This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.



Number and Percentage of Persons Diagnosed and Living with HIV (PLWH) Engaged in Selected Stages of the Continuum of HIV Care Partnership 10 (excl. DOC), 2014



- 86% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis
- 85% of PLWH in care had a suppressed viral load in 2014

(1) **HIV Diagnosed:** Persons diagnosed and living with HIV (PLWH) in Florida through the end of 2014.

(2) **Ever in Care:** PLWH with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.

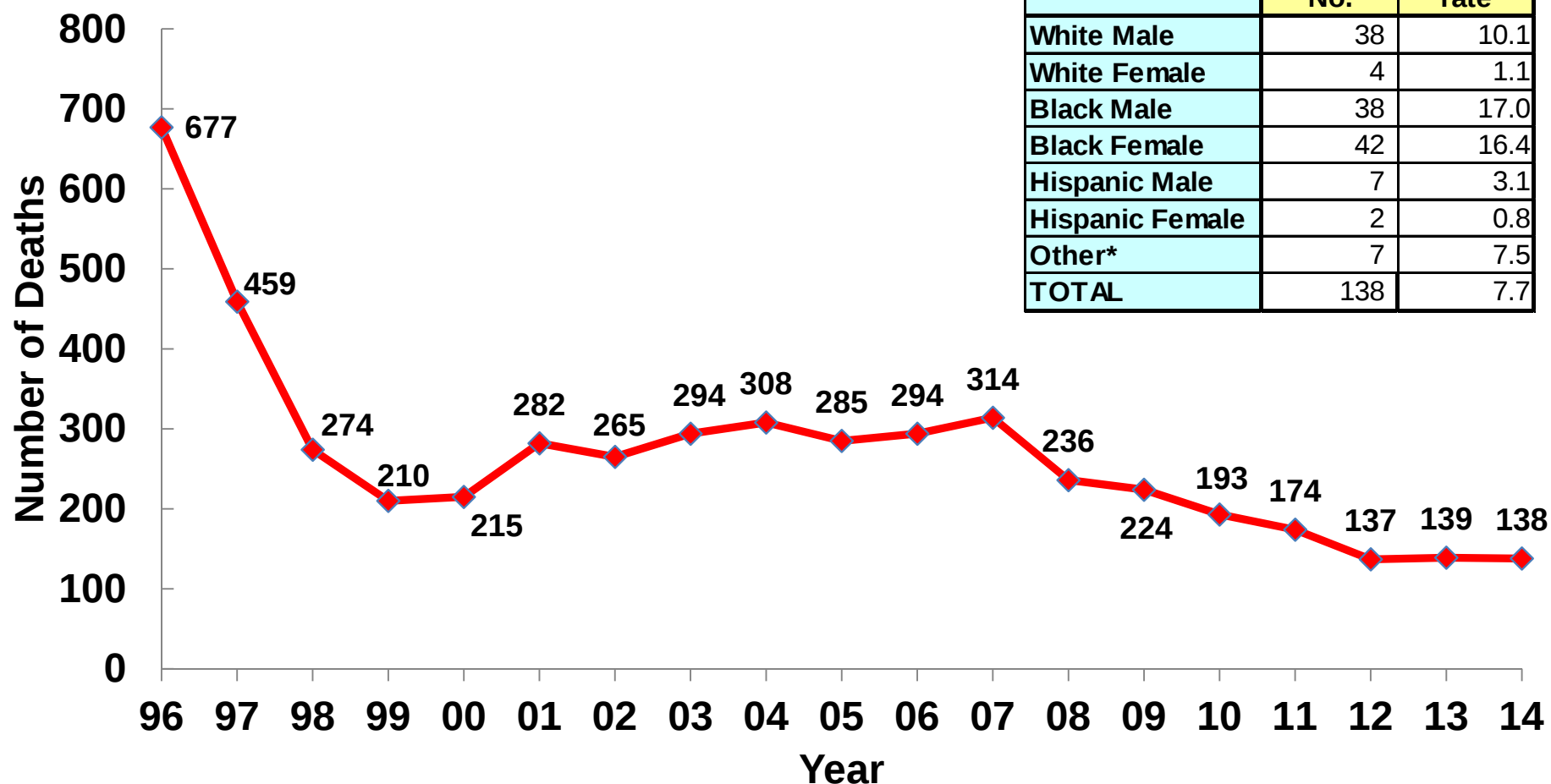
(3) **In Care:** PLWH with at least 1 documented VL or CD4 lab, medical visit or prescription in 2014.

Retained in Care: PLWH with 2 or more documented VL or CD4 labs, medical visits or prescriptions (at least 3 months apart) in 2014.

(4) **On ART:** Estimated PLWH on antiretroviral therapy (ART) in 2014 (estimated from 2013 FL MMP data).

(5) **Suppressed Viral Load:** PLWH with a suppressed VL (<200 copies/mL) on last VL in 2014.

Resident Deaths due to HIV Disease, by Year of Death, 1995-2014, Partnership 10



Race/Ethnicity	2014	
	No.	rate
White Male	38	10.1
White Female	4	1.1
Black Male	38	17.0
Black Female	42	16.4
Hispanic Male	7	3.1
Hispanic Female	2	0.8
Other*	7	7.5
TOTAL	138	7.7

These data represent a 80% decline in HIV resident deaths due to HIV disease from the peak year of 1995 to 2014. This is higher than the 79% decline observed by the state.

Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 05/31/2015).

Population data are provided by Florida CHARTS as of 7/9/2015.

*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



Some Useful Links

- ⌘ CDC HIV/AIDS Surveillance Reports
(State and Metro Data):
<http://www.cdc.gov/hiv/stats/hasrlink.htm>
- ⌘ MMWR (Special Articles on Diseases, Including HIV/AIDS):
<http://www.cdc.gov/mmwr/>
- ⌘ U.S. Census Data (Available by State, County):
<http://www.census.gov>
- ⌘ Partnership 10 Dept. of Health, HIV/AIDS Section Website
(Slide sets, Facts Sheets, Monthly Surveillance Report, Counseling & Testing Data, etc.):
<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>



**“The reason for collecting,
analyzing and disseminating
information on a disease is to
control that disease.
Collection and analysis should
not be allowed to consume
resources if action does not
follow.”**

--Foege WH et al. Int. J of Epidemiology 1976; 5:29-37



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For Florida HIV/AIDS Surveillance Data

Contact: (850) 245-4444



Lorene Maddox, MPH

Ext. 2613

Tracina Bush, BSW

Ext. 2612

Madgene Moise, MPH

Ext. 2373

Visit Florida's internet site for:
Monthly Surveillance Reports
Slide Sets and Fact Sheets
Annual Reports and Epi Profiles

<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>

Visit CDC's HIV/AIDS internet site for:
Surveillance Reports, fact sheets and slide sets

<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm>

FY 2016-2017 PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) TIMELINE

TASK	DATA ELEMENTS	RESPONSIBLE PARTY	DATE
Broward County Data Review: Epidemiology, Unmet Need, EIIHA	- Epidemiology Terms, Importance and Uses Handout - FLDOH Partnership Slides Area 10 - Unmet Need Data, Terms, Importance and Uses Handout - EIIHA Data, Terms, Importance and Uses Handout	DOH Staff	PSRA: 4/20/2016
Part A Data Review: Service Categories Sense Making Training Priority Setting*	- Service Category Scorecard Presentations: FY 11-15 allocations; FY 11-15 expenditures; client demographics and utilization; service eligibility criteria; viral load data; outcomes and indicators; HIV Care Continuum data - Client Projections based on Utilization and Expenditures - Impact of the ACA on Ryan White: Part A and ADAP clients enrolled in the ACA Marketplace; HICP and ACA covered services expenditures; average co-pay, premium, deductible and OOP costs; future ADAP Premium Plus client eligibility criteria - QMC Recommendations regarding minority populations - Sense Making: Group discussions about notable data elements to identify bias and trends - PSRA Data Review: Overview of Broward and Part A data presentations - Needs Assessment Data Presentation: Client Survey and Focus Group Results - Part A and MAI service category ranking	Support Staff Grantee NA Consultant Support Staff PSRA	PSRA: 5/25/2016 (4 hour meeting) CEC: 5/3/2016 PSRA: 6/15/2016 6/29/2016*
Allocations for FY 2017-2018	- Allocations table - FY 16-17 Allocations approval	Support Staff PSRA HIVPC	PSRA: 6/15/2016 6/29/2016* HIVPC: 6/23/2016

HIV/AIDS Epidemiology Partnership 10



Broward County

Excluding Dept. of Corrections

Created: 12/03/14
Revision: 10/14/15

Florida Department of Health
HIV/AIDS Section
Annual data trends as of 12/31/2014
Living (Prevalence) data as of 06/30/2015



HIV and AIDS Case Data

- ⚡ AIDS Cases became reportable in Florida in 1981.
- ⚡ HIV (not AIDS) became reportable in Florida on July 1, 1997.
- ⚡ HIV Infection reporting represents newly Adult HIV Infection Cases, regardless of AIDS status at time of report, that were previously reported.
- ⚡ AIDS cases and HIV infection cases by year of report are NOT mutually exclusive and CANNOT be added together.
- ⚡ Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida CHARTS and all grant-related data where annual data are included.
- ⚡ HIV prevalence data are generated later in the year, usually in July, when most of the “expected” death data are complete.



HIV and AIDS Case Data (con't)

- ⚡ Adult cases represent ages 13 and older, pediatric cases are those under the age of 13. For data by year, the age is by age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.
- ⚡ Unless otherwise noted, whites are non-Hispanic and blacks are non-Hispanic.
- ⚡ Unless otherwise noted. Area and county data will exclude DOC cases.

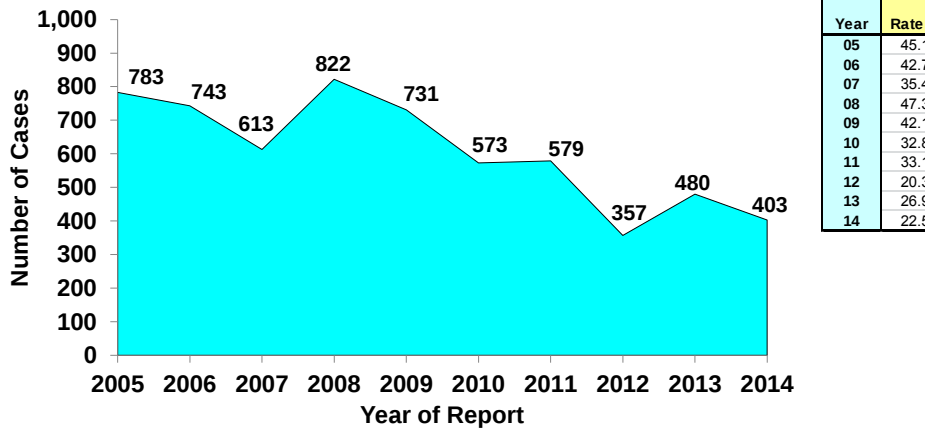


Snapshot of Persons Reported with HIV Disease, 2014, Partnership 10

	HIV Infection and AIDS Cases Reported in 2014*		
	Adults (Age 13+)	Pediatrics (Age <13)	TOTAL
HIV Infection Cases	993	-	993
AIDS Cases	402	1	403
*HIV infection cases and AIDS cases by year of report are NOT mutually exclusive and CANNOT be added together.			
Total Population, 2014* 1,796,314	Cumulative HIV/AIDS Cases Reported 1981-2014		
	Adults (Age 13+)	Pediatrics (Age <13)	TOTAL
HIV (not AIDS) Cases**	9,329	67	9,396
AIDS Cases	20,732	271	21,003
Total	30,061	338	30,399
*2014 estimate is provisional **HIV (not AIDS) cases were NOT reportable until 07/1997			
Persons Living with HIV Disease through 2014, as of 06/30/2015:			19,391



AIDS Cases and Rates* By Year of Report, 2005-2014, Partnership 10

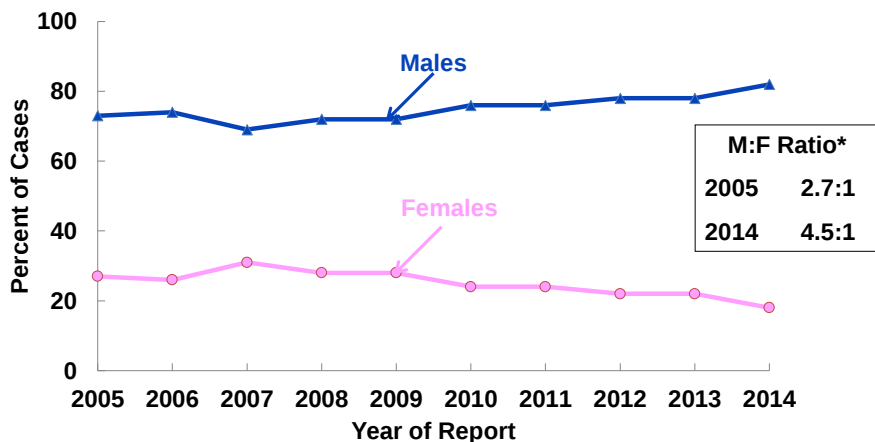


Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year. This is higher than the 15% decline observed by the state during the same time period.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015. Rates are expressed as per 100,000 population.



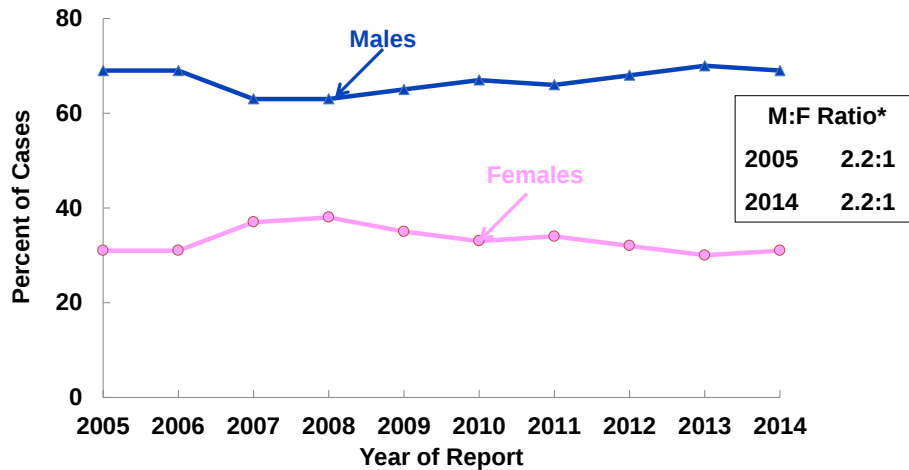
Adult HIV Infection Cases, by Sex and Year of Report, 2005-2014, Partnership 10



Note: Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV Infection Cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.



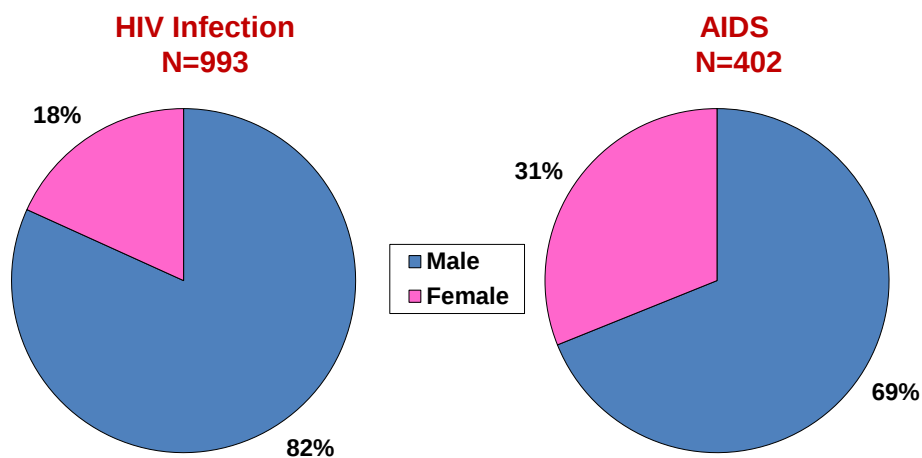
Adult AIDS Cases, by Sex and Year of Report, 2005-2014, Partnership 10



Note: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in males cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.



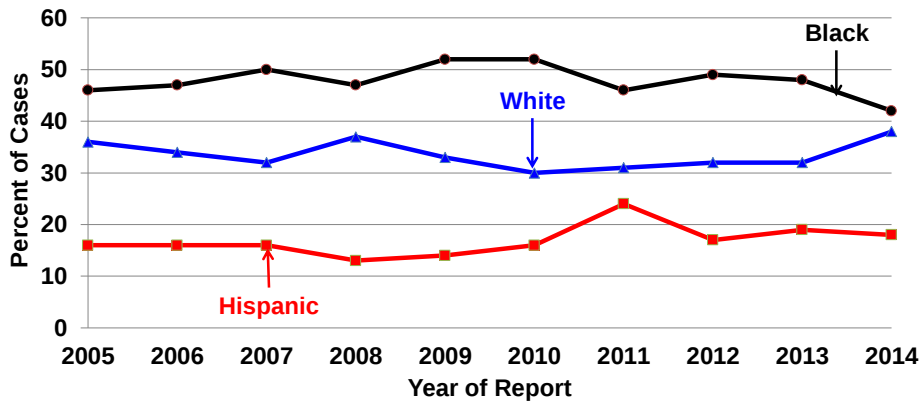
Adult HIV Infection and AIDS Cases by Sex, Reported in 2014, Partnership 10



Note: Partnership 10's Adult Population is: 48% Male and 52% Female.



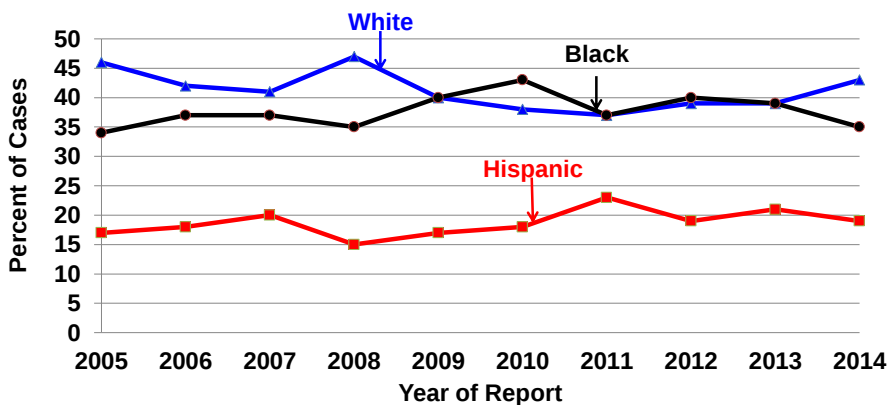
Adult HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case reporting reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. For the past ten years, blacks represented 42% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among whites and Hispanics increased by 2 percentage points respectively. In contrast, the proportion of HIV infection cases among blacks decreased by 4 percentage points. Other races represent less than 3% of the cases and are not included.



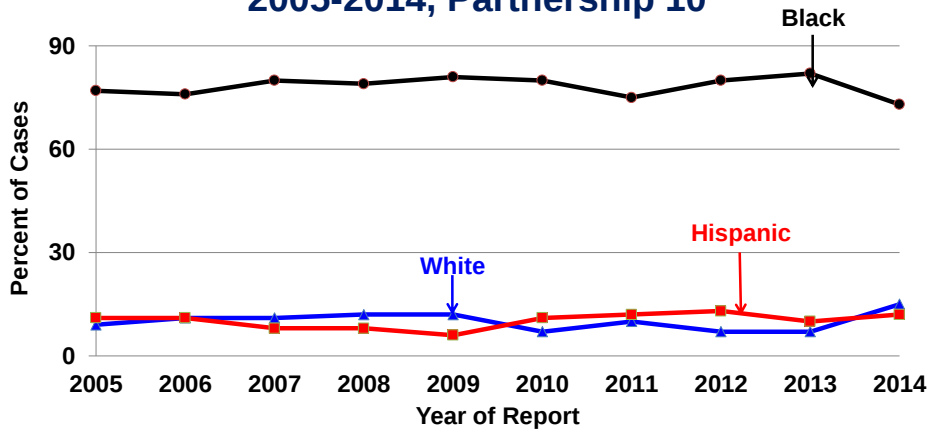
Adult Male HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: The proportion of adult male HIV infection cases among blacks and whites has shifted up and down over the years, at times, crossing paths. From 2005 to 2014, the proportion of HIV infection cases among black and Hispanic males increased by 1 and 2 percentage points, respectively. In contrast, HIV infection cases among white males decrease by 3 percentage points. Other races represent less than 3% of the cases and are not included.



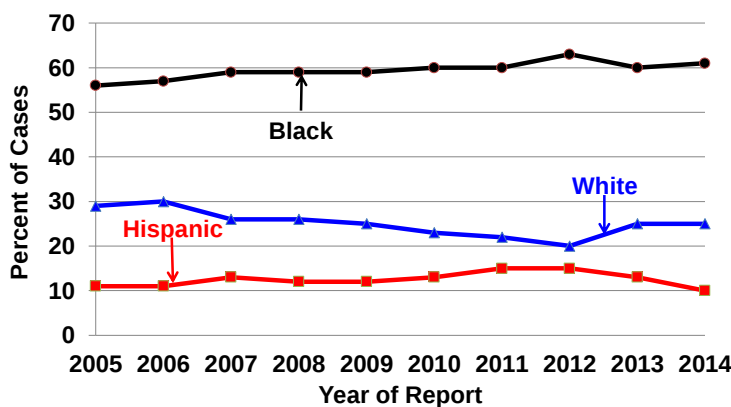
Adult Female HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case disparities are more evident among women than men. For the past ten years, black women represented 75% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among Hispanic and white females increased by 1 and 6 percentage points, respectively. In contrast, the proportion of HIV infection cases among black females decreased by 4 percentage points. Other races represent less than 5% of the cases and are not included.



Adult AIDS Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



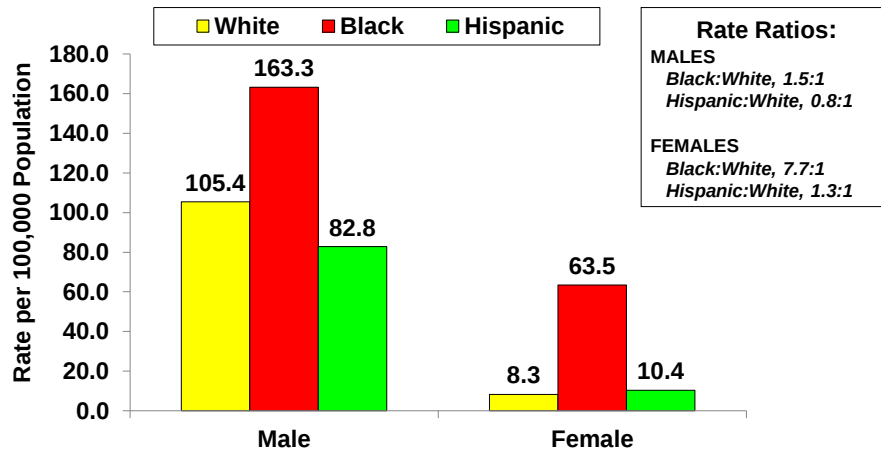
Factors Affecting Disparities

- Late diagnosis of HIV.
- Access to/ acceptance of care.
- Delayed prevention messages.
- Stigma.
- Non-HIV STD's in the community.
- Prevalence of injection drug use.
- Complex matrix of factors related to socioeconomic status

Note: In 2014, blacks accounted for 61% of adult AIDS cases, but only 25% of the population. From 2005 to 2014, the proportion of AIDS cases among blacks increased by 5 percentage points. In contrast, the proportion of AIDS cases among Hispanics and whites decreased by 1 and 4 percentage points, respectively. Numerous disparities can affect the increases of HIV disease in a given population. Other races represent less than 4% of the cases and are not included.



Adult HIV Infection Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10

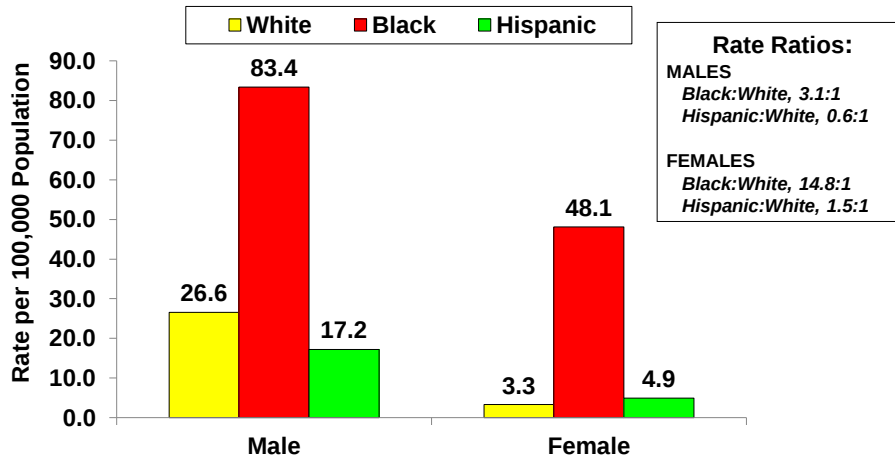


Note: Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males. Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females. In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.



Adult AIDS Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10

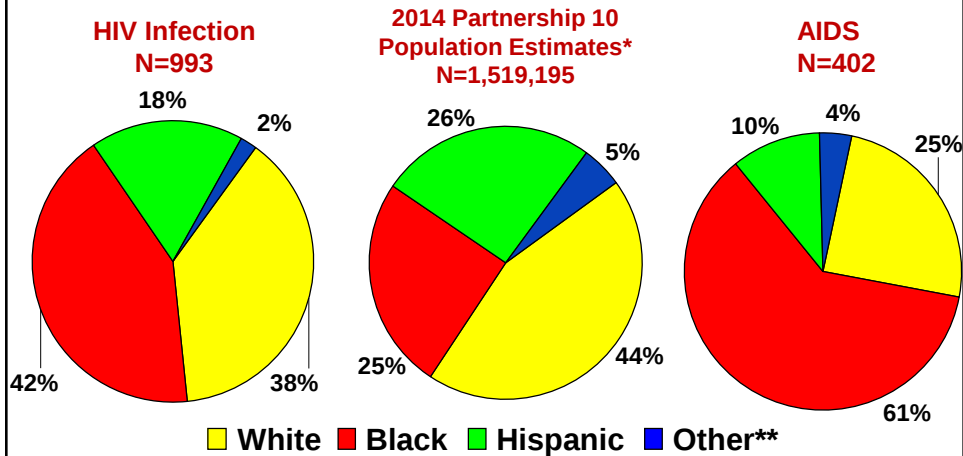


Note: Among black males, the AIDS case rate is 3 times higher than the rate among white males. Among black females, the AIDS case rate is nearly 15-fold greater than the rate among white females. Hispanic males have an AIDS case rate that is lower than the rate among white males. In contrast, the AIDS case rate among Hispanic females is nearly 2 times higher than the rate among white females.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.



Adult HIV and AIDS Cases Reported in 2014 and Population Data, by Race/Ethnicity, Partnership 10



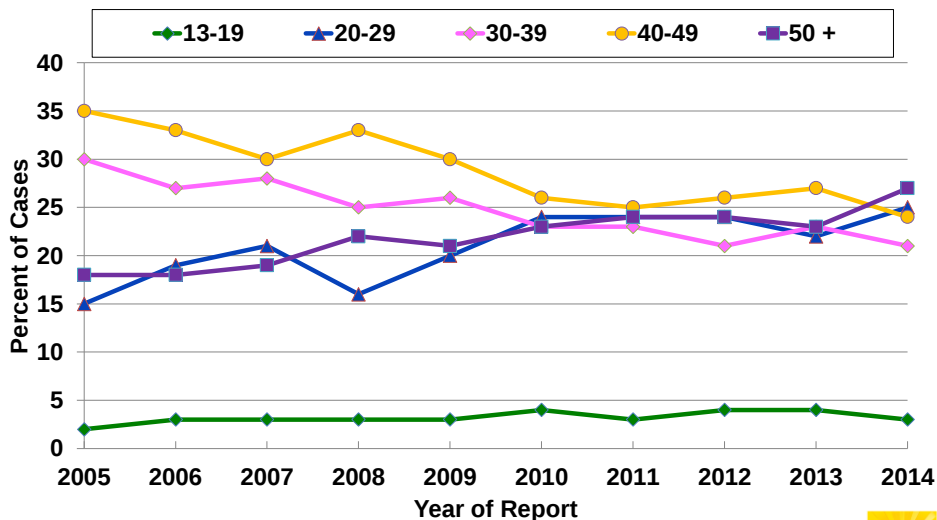
Note: In this snapshot for 2014, blacks are over-represented among the HIV and AIDS cases, accounting for 42% of adult HIV cases and 61% of adult AIDS cases, but only 25% of the adult population. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of the population.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.



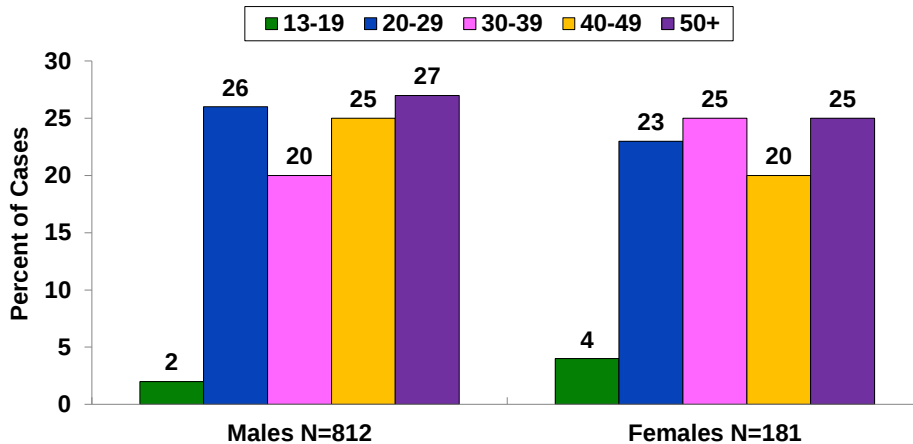
Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005–2014, Partnership 10



Note: From 2005 to 2014, the proportion of adult HIV infection cases among those aged 20-29 and those aged 50+ increased by 10 and 9 percentage points, respectively.



Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Reported in 2014, Partnership 10



Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age groups with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and those aged 50 or older.

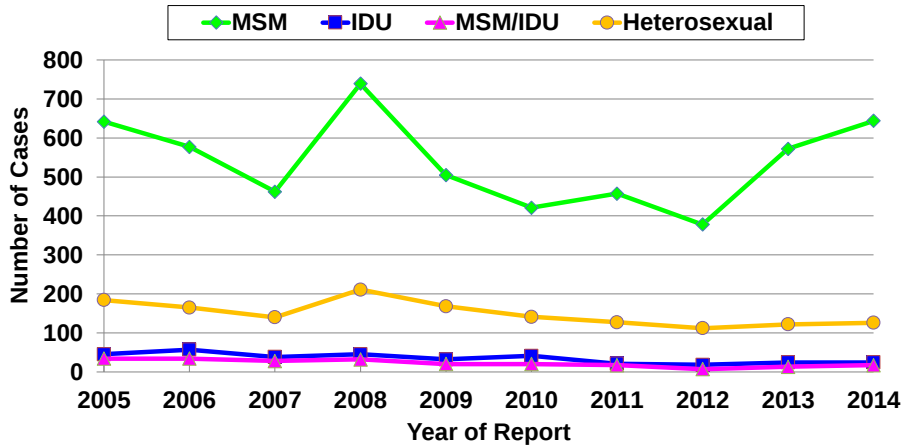


Definitions of Mode of Exposure Categories

- ◆ **MSM** = Men who have sex with men or Male-to-male sexual contact with person with HIV/AIDS or known HIV risk
- ◆ **IDU** = Injection Drug User
- ◆ **MSM/IDU** = Men who have sex with men or Male-to-male sexual contact & Injection Drug User
- ◆ **Heterosexual** = Heterosexual contact with person with HIV/AIDS or known HIV risk
- ◆ **OTHER** = includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.
- ◆ **NIR** = Cases reported with No Identified Risk
- ◆ **Redistribution of NIRs** = This illustrates the effect of statistically assigning (redistributing) the NIRs to recognized exposure (risk) categories by applying the proportions of historically reclassified NIRs to the unresolved NIRs.



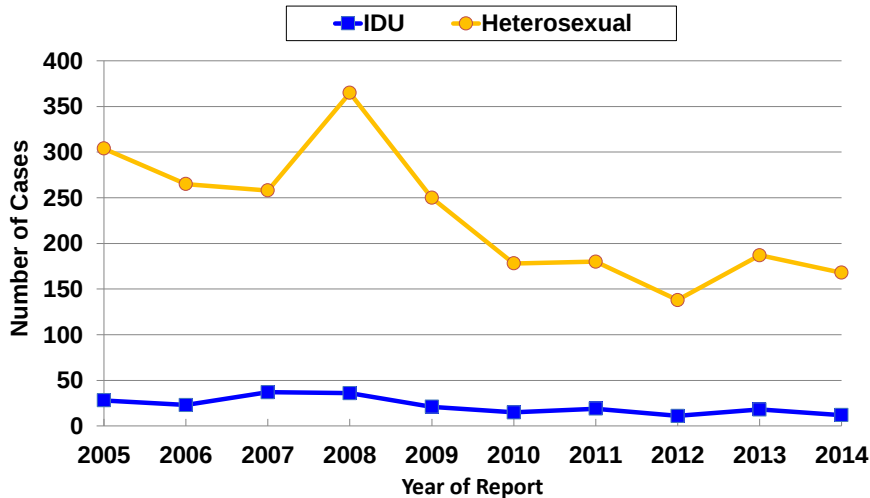
Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005–2014, Partnership 10



Note: NIRs redistributed. Male-to-male sexual contact (MSM) remains as the primary mode of exposure among male HIV cases in Partnership 10, followed by heterosexual contact.



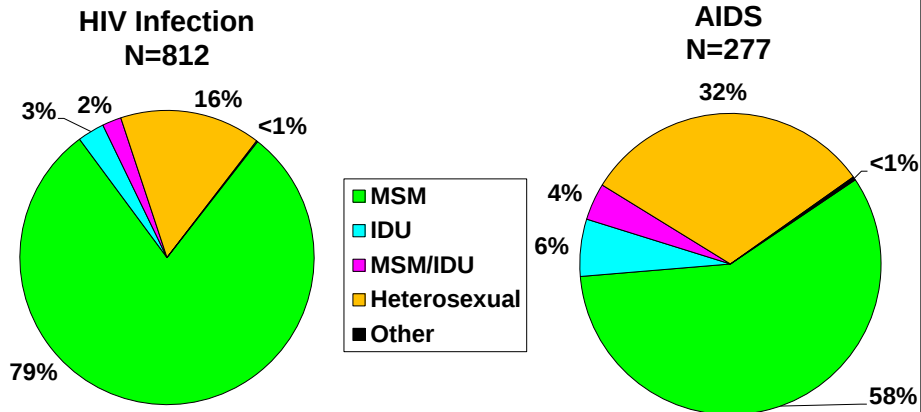
Adult Female HIV Infection Cases by Exposure Category and Year of Report, 2005-2014, Partnership 10



Note: NIRs redistributed. The heterosexual risk continues to be the dominant mode of exposure among females.



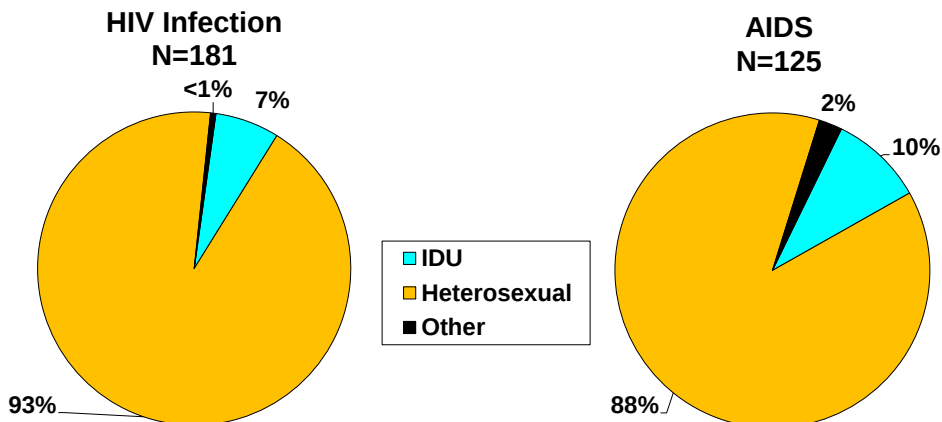
Adult Male HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, male-to-male sexual contact (MSM) was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS). The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic.



Adult Female HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively).



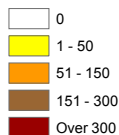
Cases Living with HIV Disease

Unless otherwise noted, data in the following slides represent persons living with HIV/AIDS (PLWHAs), who were living in Florida (regardless where diagnosed) through the most recent calendar year. Living data are also referred to as prevalence cases or living with HIV disease.

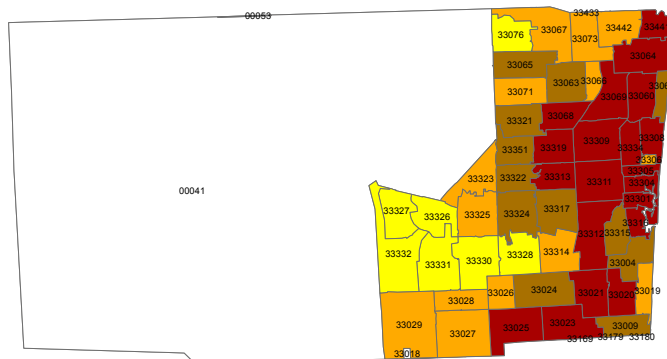


Adults Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 10

Total Living
HIV/AIDS Cases



N=19,386

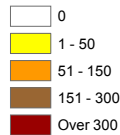


NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

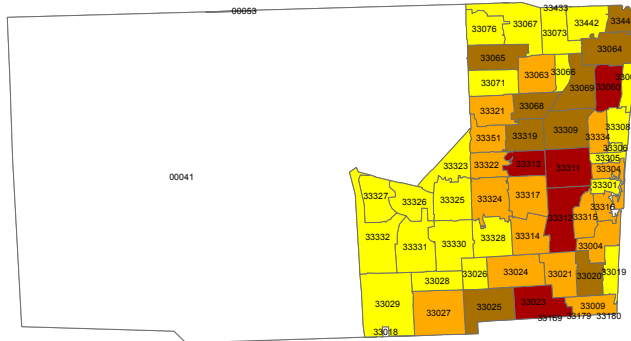


Adult Heterosexuals Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 10

Presumed Living Heterosexual HIV/AIDS Cases



N=7,105



NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

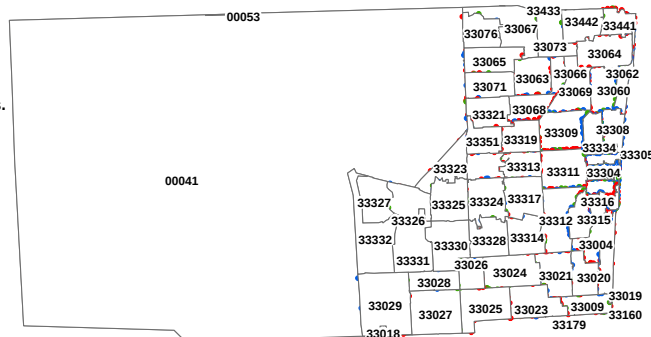


Adults Living with HIV Disease By Zip Code and Race/Ethnicity, Diagnosed through 2014, Partnership 10

1 Dot = 3 cases
Dots are randomly
placed within zip codes.

- Hispanic
- Black, not-Hispanic
- White, not-Hispanic

N=18,940



Total includes all races, some which are not on map.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

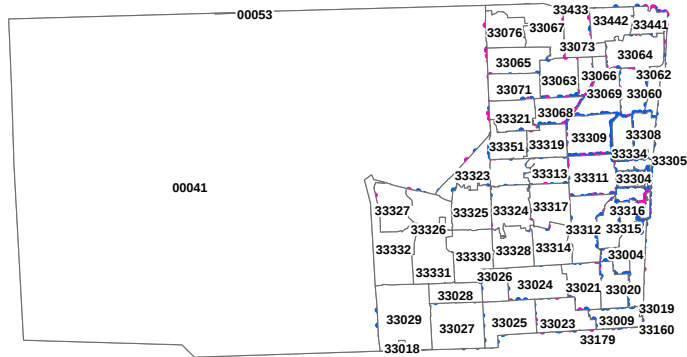


Adults Living with HIV Disease By Zip Code and Sex, Diagnosed through 2014, Partnership 10

1 Dot = 3 cases
Dots are randomly
placed within zip codes.

- Male
- Female

N=19,386

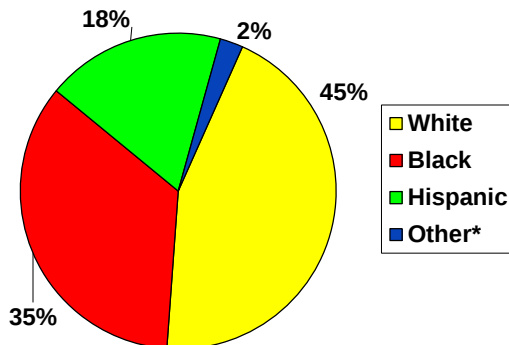


Excludes DOC, homeless, and cases with unknown zips.
Data as of 06/30/2015

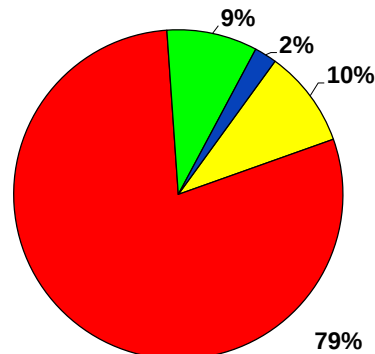


Adults Living with HIV Disease, by Sex and Race/Ethnicity Diagnosed through 2014, Partnership 10

**Males
N=14,193**



**Females
N=5,176**

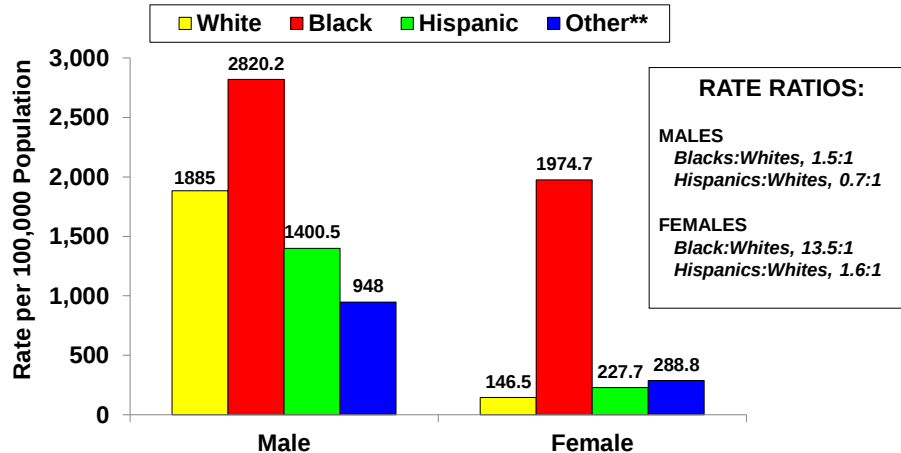


Note: Among adult males living HIV disease, whites represent the race most affected (45%).
Among adult females, blacks represent the race most affected (79%).

*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



Case Rates* of Adults Living with HIV Disease, by Sex and Race/Ethnicity, Diagnosed through 2014, Partnership 10



Note: Among black males living with HIV disease Diagnosed through 2014, the case rate is nearly 2 times higher than the rate among white males. Among black females living with HIV disease, the case rate is nearly 14 times higher than the rate among white females. The Hispanic male rate is less than the rate among their white counterpart, whereas the Hispanic female rate is slightly higher than the rate among their white counterpart. Data excludes Department of Corrections cases.

*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

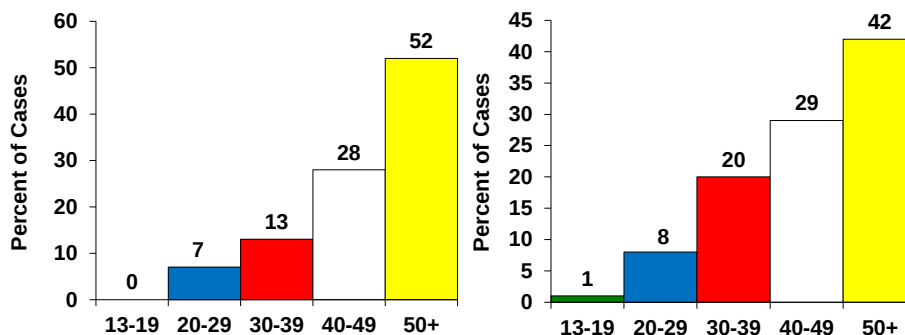
**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



Adults Living with HIV Disease, by Sex and Current Age Group, Diagnosed through 2014, Partnership 10

Males
N=14,193

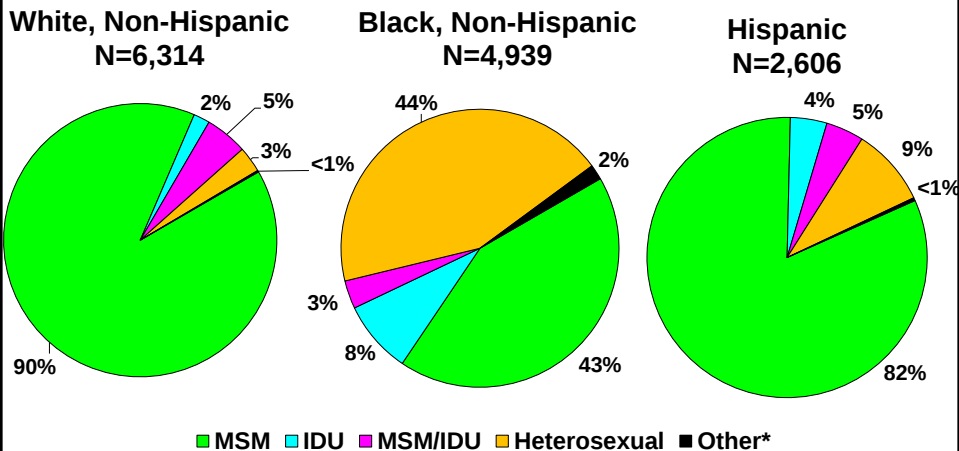
Females
N=5,176



Note: Males living with HIV disease have a higher proportion of cases who are currently 40 years of age or older (80%), compared with females who are currently 40 years of age or older living with HIV disease (71%).



Adult Males Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 10

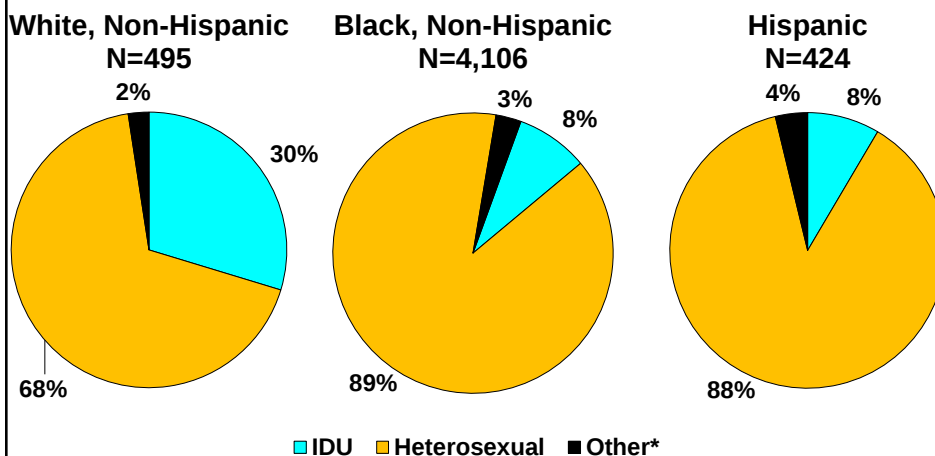


Note: NIRs redistributed. Male-to-male sexual contact (MSM) represents the highest risk for all races. White males have the smallest proportion of heterosexual contact risk.

* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.



Adult Females Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 10

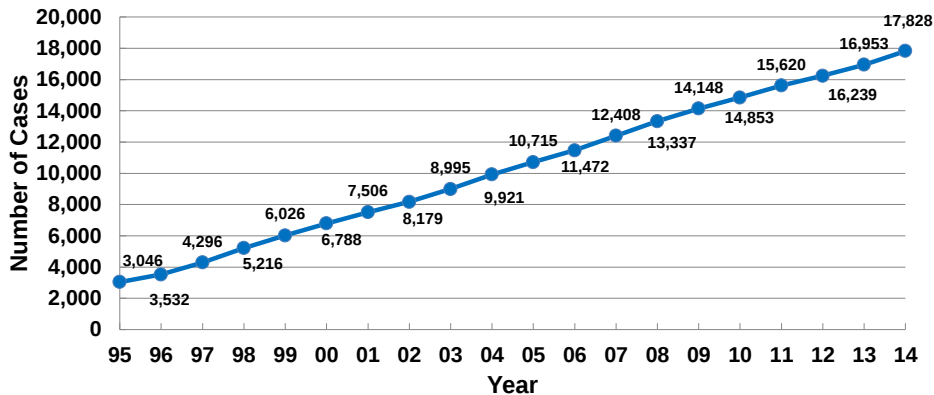


Note: NIRs redistributed. Heterosexual contact is the majority risk for all races. However, whites have the largest proportion of IDU risk.

* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.



Annual Prevalence of Adults Living with HIV Disease, 1995-2014, Partnership 10



As a result of declining deaths, annual HIV/AIDS diagnoses have exceeded deaths since 1995, and the number of persons reported with HIV/AIDS who are presumed to be alive have been increasing. Since 1995, the number of persons reported living with HIV/AIDS have increased over 460%. In 2014, the prevalence increased by 5% since the previous year.

Note: These data represent adults living with HIV disease diagnosed in Florida regardless of their current residence.



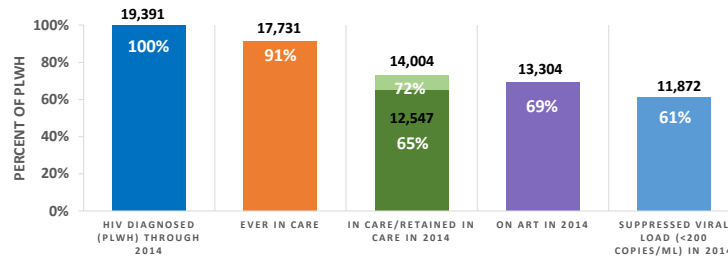
Partnership 10's Top-9 Priority Populations in 2014 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease

1. White Men who have sex with Men
2. Black Heterosexual men and women
3. Black Men who have sex with men
4. Hispanic Men who have sex with Men
5. Black Injection Drug User
6. Hispanic Heterosexual men and women
7. White Heterosexual men and women
8. White Injection Drug User
9. Hispanic Injection Drug User

This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.



Number and Percentage of Persons Diagnosed and Living with HIV (PLWH) Engaged in Selected Stages of the Continuum of HIV Care Partnership 10 (excl. DOC), 2014



- > 86% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis
- > 85% of PLWH in care had a suppressed viral load in 2014

(1) **HIV Diagnosed:** Persons diagnosed and living with HIV (PLWH) in Florida through the end of 2014.

(2) **Ever in Care:** PLWH with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.

(3) **In Care:** PLWH with at least 1 documented VL or CD4 lab, medical visit or prescription in 2014.

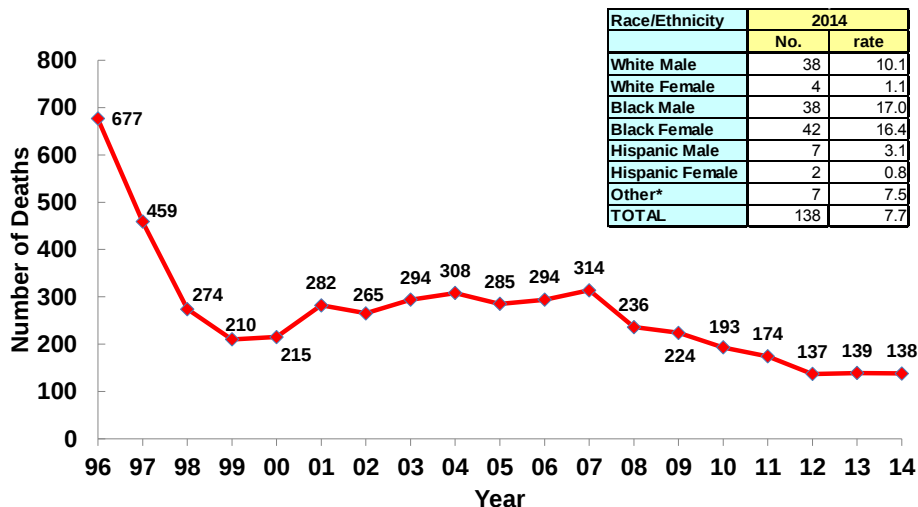
Retained in Care: PLWH with 2 or more documented VL or CD4 labs, medical visits or prescriptions (at least 3 months apart) in 2014.

(4) **On ART:** Estimated PLWH on antiretroviral therapy (ART) in 2014 (estimated from 2013 FL MMP data).

(5) **Suppressed Viral Load:** PLWH with a suppressed VL (<200 copies/mL) on last VL in 2014.



Resident Deaths due to HIV Disease, by Year of Death, 1995-2014, Partnership 10



These data represent a 80% decline in HIV resident deaths due to HIV disease from the peak year of 1995 to 2014. This is higher than the 79% decline observed by the state.

Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 05/31/2015).

Population data are provided by Florida CHARTS as of 7/9/2015.

*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



Some Useful Links

- ✂ CDC HIV/AIDS Surveillance Reports
(State and Metro Data):
<http://www.cdc.gov/hiv/stats/hasrlink.htm>
- ✂ MMWR (Special Articles on Diseases, Including HIV/AIDS):
<http://www.cdc.gov/mmwr/>
- ✂ U.S. Census Data (Available by State, County):
<http://www.census.gov>
- ✂ Partnership 10 Dept. of Health, HIV/AIDS Section Website
(Slide sets, Facts Sheets, Monthly Surveillance
Report, Counseling & Testing Data, etc.):
<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>



**"The reason for collecting,
analyzing and disseminating
information on a disease is to
control that disease.
Collection and analysis should
not be allowed to consume
resources if action does not
follow."**

--Foege WH et al. Int. J of Epidemiology 1976; 5:29-37



Partnership 10 Surveillance Contact

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For Florida HIV/AIDS Surveillance Data Contact: (850) 245-4444



Lorene Maddox, MPH

Ext. 2613

Tracina Bush, BSW

Ext. 2612

Madgene Moise, MPH

Ext. 2373

Visit Florida's internet site for:
Monthly Surveillance Reports
Slide Sets and Fact Sheets
Annual Reports and Epi Profiles

<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>

Visit CDC's HIV/AIDS internet site for:
Surveillance Reports, fact sheets and slide sets

<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm>

Barriers to Care for Women Living with HIV

PSRA COMMITTEE

APRIL 20, 2016

Outline

1. Breaking Down Barriers to Care: What Women Living with HIV Need to Stay Healthy by the Positive Woman's Network – USA (PWN –USA)
2. Barriers to Care Quality Improvement Project Summary by the Ryan White Part A Case Management Quality Improvement Network



Breaking Down Barriers to Care: What Women Living with HIV Need to Stay Healthy

FINDINGS FROM A COMMUNITY-BASED PARTICIPATORY RESEARCH
PROJECT LED BY WOMEN LIVING WITH HIV

Project Findings

To inform the future of medical care and service delivery for women with HIV, Positive Women's Network – USA (PWN-USA) facilitated a community-based participatory research project led by women living with HIV.

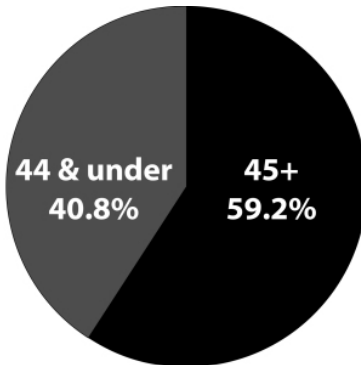
180 women living with HIV in 7 geographic regions were surveyed to find out what was working, what wasn't, and which services would help women stay in care.

Significant numbers of the women surveyed:

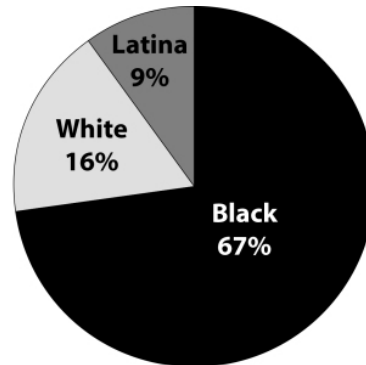
- were low-income (89.7% below 138% of the Federal Poverty Level [FPL])
- were unstably housed and/or reliant on subsidized housing
- had family responsibilities (regardless of reproductive age)
- relied on subsidized health care for primary medical coverage

Demographics of Project Participants

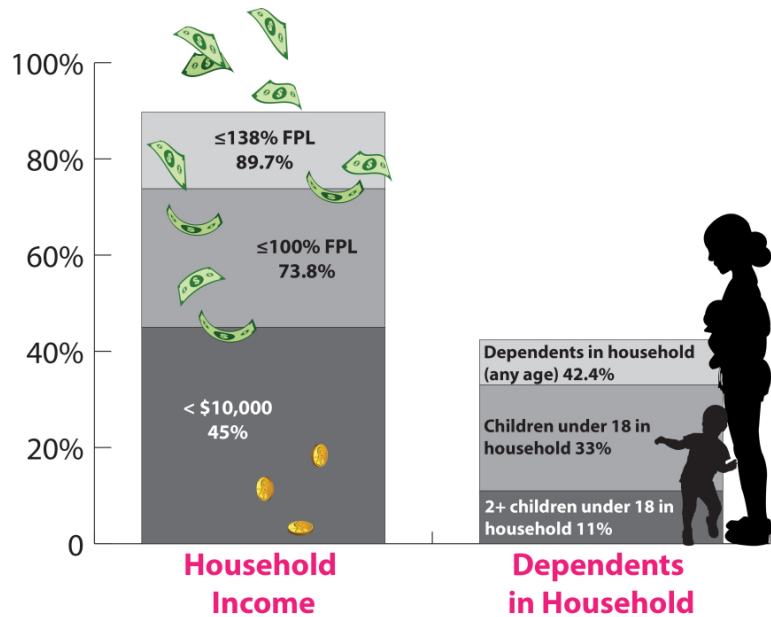
AGE



RACE

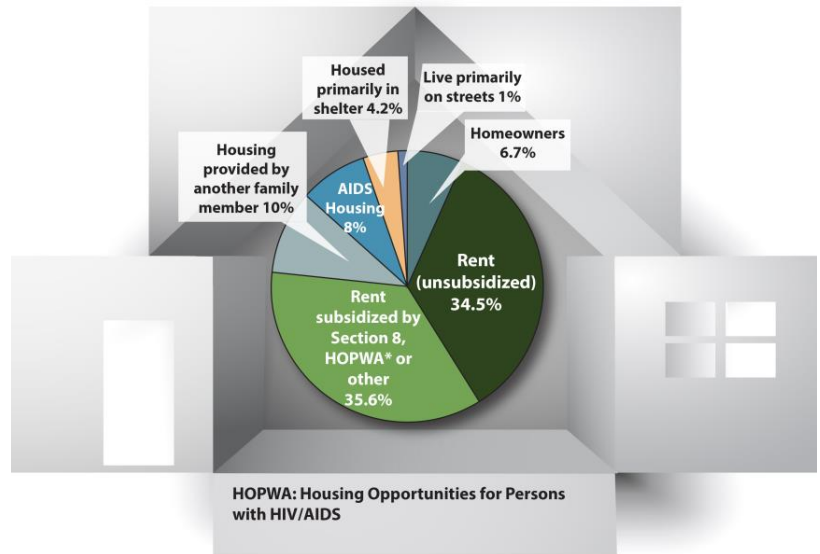


Household Income and Number of Dependents in Household

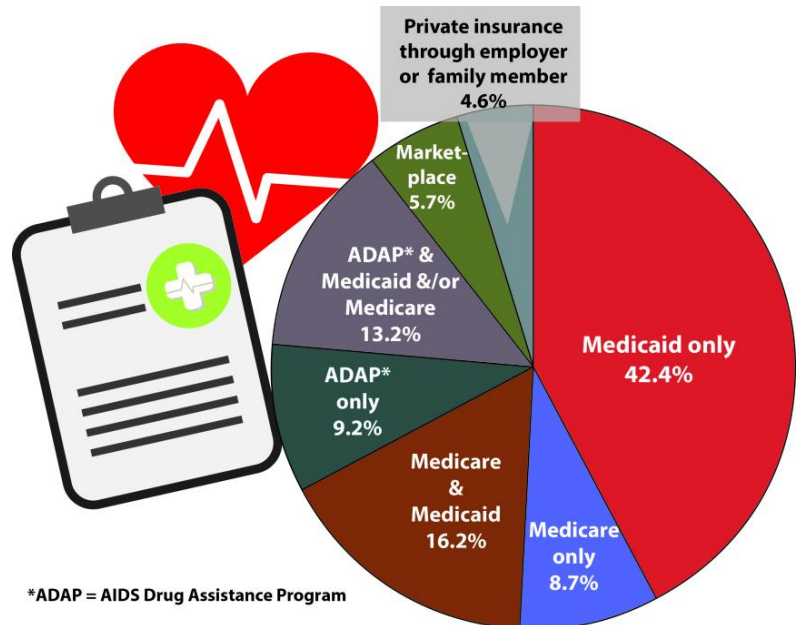


HANDOUT D

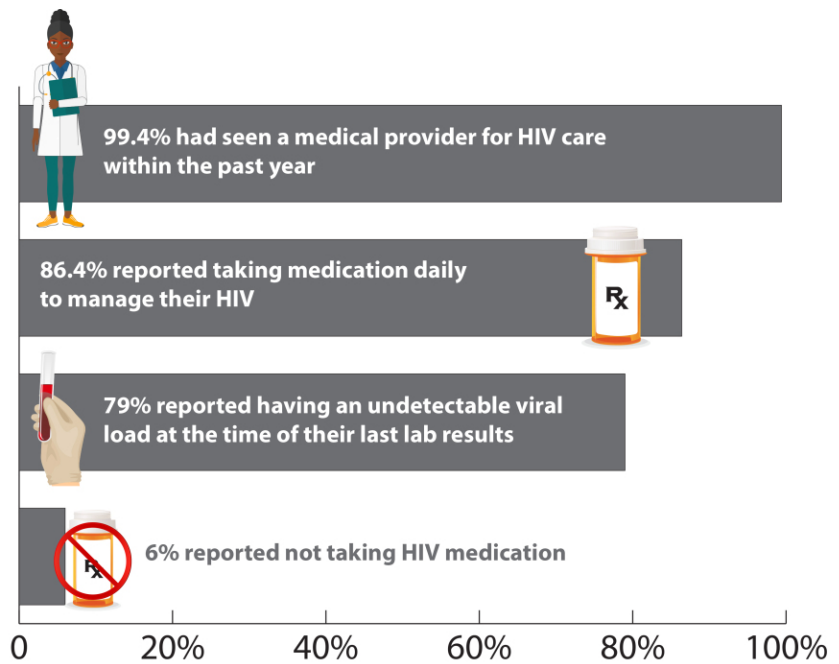
Housing Status



Healthcare Coverage



Engagement in Care



What do women with HIV need to stay in care?

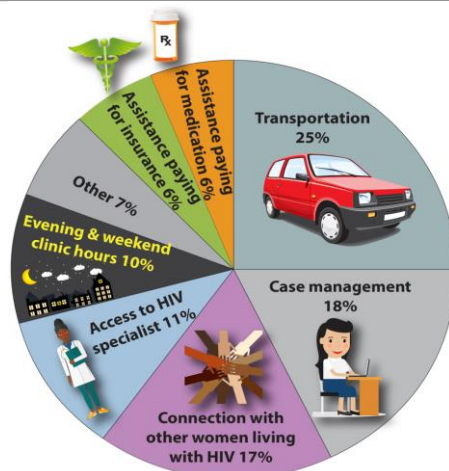
While most participants were consistently in care, many faced significant barriers.

50% of respondents who had **missed a medical appointment** in the past year cited transportation as the reason.

32% of respondents had **missed filling a prescription for HIV medications** in the past year. Primary reasons were: lack of transportation (24%), copay cost (15%), and pharmacy hours (11%).

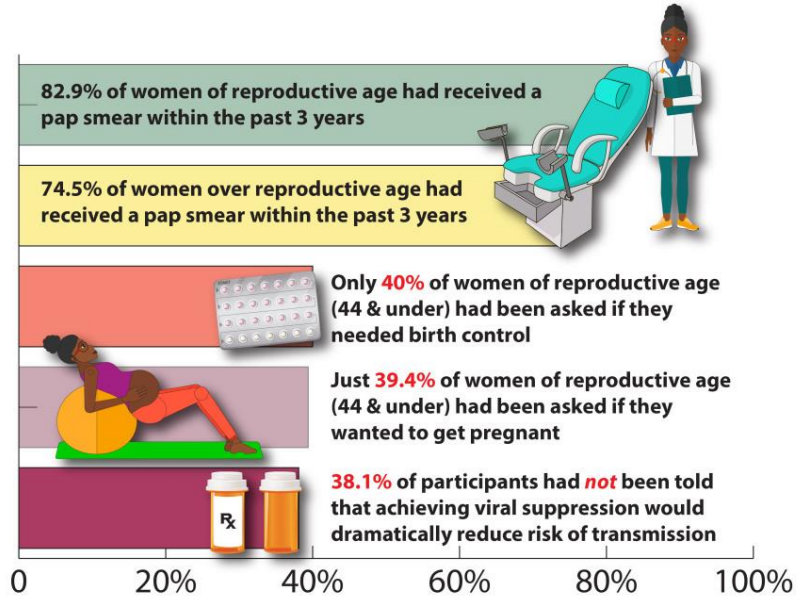
50% of participants who reported **needing child care services** on site at their medical provider did not receive those services.

Financial and structural barriers were interrelated. All respondents who reported they had **missed filling a prescription due to copay cost** in the past year also reported that they had **missed a medical appointment due to lack of transportation**.



Sexual and Reproductive Healthcare

While providers appeared to be doing a fairly good job at screening for cervical cancer (for which women with HIV are at high risk), lack of attentiveness to sexual and reproductive needs and desires may be related to stigmatizing attitudes toward sexuality of women living with HIV.



Gaps in Mental Health Services

17% of respondents had been diagnosed with post-traumatic stress disorder (PTSD). An alarming 64.9% had been diagnosed with depression.

Nearly two-thirds (64.6%) of respondents reported that they would like to see someone for counseling or therapy. Of those, 59% were able to access therapy as needed. Others reported that **cost, lack of coverage, lack of available services or waitlists for services** presented a barrier.

87% of Project participants reported interest in attending an HIV support group, yet of those, **nearly 20% were unable to access one.**

Recommendations

1. Improve the **quality of care** provided by:
 - a. expanding the availability of **high-quality sexual and reproductive health care (SRH) services** through all parts of the Ryan White Program; and
 - b. instituting trauma-informed practices and enhancing the availability of mental health services for people living with HIV.
2. Implement interventions that **improve the fundamental economic conditions** of women's lives.
3. Institutionalize mechanisms to **strengthen navigation between HIV care and other systems**.
4. Invest in **services that support access to care**, with an emphasis on addressing transportation, copayments, child care for adults of all ages with dependents, and other structural and cost-related barriers.
5. **Address stigma** by expanding availability of peer support, psychosocial support, and stigma reduction interventions and ending HIV-related criminalization.

Barriers to Care QIP Summary

CASE MANAGEMENT QUALITY IMPROVEMENT NETWORK

1 IDENTIFY PATIENTS WHO ARE NOT RETAINED

Compile a list of patients who have not been seen during the time period used to define retention. Remove those from the list who meet the exclusion criteria.

EXAMPLE:

EXCLUSION CRITERIA: The patient has died, transferred care, is incarcerated, or has been admitted to a long-term or residential care facility. These patients should be removed from your denominator.

1012	➔	56	➔	19	➔	37
Total patient case load		Original list of not-retained patients		Excluded: known status (e.g., died, transferred care, incarcerated)		Remaining list to drill down

The remaining group of patients are those to include in the drill down process.

2 ASSESS REASONS FOR NON-RETENTION

For those patients not retained, conduct an assessment of the factors causing absences from care. Multidisciplinary provider teams should review all available information from patient records as needed to identify any barriers to care, competing patient concerns, and other reasons for non-retention.

EXAMPLE:

MULTIDISCIPLINARY TEAM MEMBERS:
Case managers, patient navigators, pharmacists, nurses, physicians, others involved.

PATIENT RECORDS:
Medical records, case manager or patient navigator notes, emergency room records, correctional facility records.

4 DEVELOP A TARGETED FOLLOW-UP PLAN

Using the data from steps 2 and 3, identify the barriers that are most critical to patient health and that affect the most patients. Develop a plan to address these issues. Consider personalizing your follow-up strategies by examining the needs of key populations or by looking at health indicators such as average viral load (see *Prioritization Strategies*).

EXAMPLE:

1. One clinic identified incorrect contact information as a major barrier to retention among its patient population. Staff searched Medicaid and pharmacy records for updated contact information and visited the patient's home if they were unable to locate the individual through other means.
2. This clinic also identified transportation as a barrier to retention for one patient with a very high viral load. Staff members arranged transportation to the clinic for this patient, which proved important in engaging the patient in care (see HNQUAL Brief 11, *Improving Patient Retention in Western New York* for more information).

3 CREATE A TABLE

Compile all the identified reasons for non-retention and tally the number of patients experiencing each. This table will be used to prioritize areas in need of improvement and to develop targeted interventions.

EXAMPLE:

KEEP IN MIND: Patients grouped in the same category may have different reasons for experiencing that difficulty. For example, patients experiencing issues with transportation may not be able to pay for fares, may live too far from available transit, etc. Individualized solutions will likely be required for each patient.

BARRIER	NUMBER OF PATIENTS
TRANSPORTATION	35
HOUSING INSTABILITY	11
INSURANCE	2
DISCLOSURE ISSUES	15
REFUSES TREATMENT	2

Barriers to Care QIP: Rationale

- The Case Management Quality Improvement (QI) Network determined that Black females had significantly low rates of viral suppression compared to other populations.
- The Case Management QI Network was interested in learning why this population was not achieving viral suppression and what barriers to care exist for Black females.
- This information will be useful because when the barriers to care are understood because the Network will be better equipped to address the issues and implement changes to assist Black female clients in achieving viral load suppression.

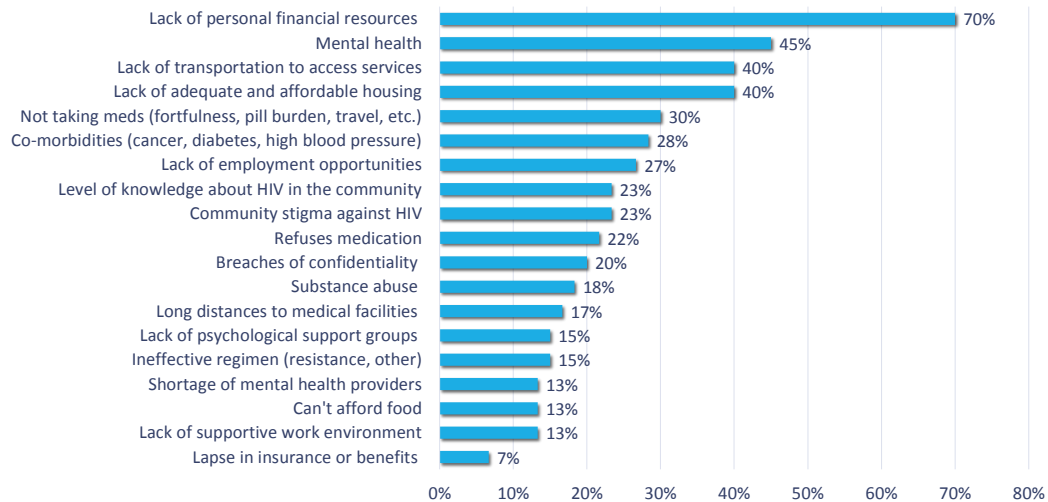
Barriers to Care QIP: Methods

- Each agency identified barriers to care for unsuppressed Black non-Hispanic females receiving case management services at their respective agency.
- Case managers assessed the extent to which a given medical or social service barrier makes it difficult for the client to obtain medical care, specifically HIV clinic appointments and mental health services.
 - Barriers were rated using the following scale: "No Problem at all," "Very Slight Problem," "Somewhat of a Problem," or "Major Problem."
- The case managers utilized a modified version of the Barriers to Care Scale with the following categories: demographics, medication, other illnesses, financial/economic concerns, stigma, and service availability.

Barriers to Care Reported by Black Females in Case Management Services (N=60)

Barrier	Very Slight Problem	Somewhat of a Problem	Major Problem	Total # of Patients
Lack of personal financial resources	6	13	23	42
Mental health	6	11	10	27
Lack of adequate and affordable housing	5	7	12	24
Lack of transportation to access services	13	5	6	24
Not taking meds (forgetfulness, pill burden, travel, etc.)	5	4	9	18
Co-morbidities (cancer, diabetes, high blood pressure)	2	6	9	17
Lack of employment opportunities	3	7	6	16
Community stigma against HIV	3	5	6	14
Level of knowledge about HIV in the community	7	5	2	14
Refuses medication	5	5	3	13
Breaches of confidentiality	4	7	1	12
Substance abuse	5	0	6	11
Long distances to medical facilities	8	1	1	10
Ineffective regimen (resistance, other)	4	2	3	9
Lack of psychological support groups	4	2	3	9
Lack of supportive work environment	8	0	0	8
Can't afford food	5	0	3	8
Shortage of mental health providers	5	3	0	8
Lapse in insurance or benefits	1	2	1	4

Barriers to Care Reported by Black Females in Case Management Services (N=60)



Barriers to Care QIP: Findings

- The most commonly reported barriers to care were mental health issues including depression and anxiety and lack of personal financial resources.
- Over 50% of the clients report a mental health issue but utilization of mental health services among black females is as low as 1-2%.
 - There are a lot of cultural issues when addressing the topic of mental health.
- The following two most common were not taking medications and unstable housing.
 - One member said some clients view taking medications as an option, not a necessity.
 - A common issue was stigma and clients stressing about family or friends noticing they were taking medication.

Barriers to Care QIP: Next Steps

- The Case Management QI Network members are interested in addressing the issue of mental health and looking more closely at clients that report these issues.
- The information obtained from the Case Management QI Network could aid PSRA in their allocation process.

NYC HIV Care Coordination A Client Centered Team Approach

PRESENTED BY:

JULIE L BARNES, LMHC

SAME BOAT CONSULTING

JULIE RWAN, MPH

JILL WILLIAMS

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE

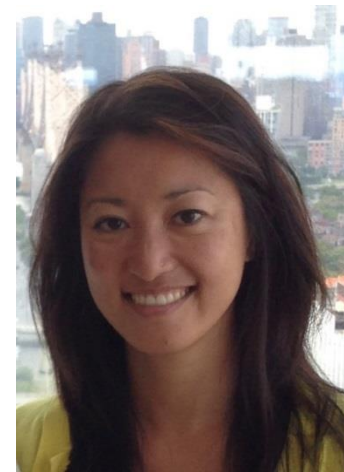
Introductions



Julie Barnes



Jill Williams



Julie Rwan

Our Time Together

- ▶ Introduction to the evidence-informed Care Coordination Model from NYC
- ▶ Overview of Care Coordination Team Members
- ▶ Overview of Patient Navigator (PN) role in helping people living with HIV
- ▶ Tools
- ▶ Outcomes
- ▶ Q&A about Care Coordination
- ▶ Opportunity to request further information or training

Why Is This Relevant to You?

- ▶ Care Coordination aligns with the National HIV/AIDS Strategy's (NHAS) viral load suppression (VLS) goals
- ▶ Linkage to care and medication adherence is key to improve health outcomes for HIV+ people
- ▶ This model can be an essential part of HIV treatment as prevention programming

Who Benefits From HIV Care Coordination?

▶ PLWHA who:

- ▶ Are newly-diagnosed with HIV
- ▶ Struggle to stay in care
- ▶ Have challenges with med adherence or unsuppressed viral load
- ▶ Have many psycho-social barriers to health
- ▶ Have co-occurring behavioral health issues
- ▶ Have other chronic conditions (Diabetes, Hep C, Kidney Disease)

Addressing Barriers

NYC HIV Care Coordination plays a role in addressing barriers through:

- ▶ Cultural interpretation
- ▶ Bridging the gap between clients & providers
- ▶ Helping the client ask real questions
- ▶ Encouraging the client to communicate openly & honestly with her team
- ▶ Modeling a non-judgmental attitude towards the client's behaviors
- ▶ Providing assistance with housing, transportation, childcare, missed appointments and referrals

Founding of PACT:

- ▶ A response to health inequalities among at-risk HIV+ populations in Boston
- ▶ To improve the well-being of individuals and communities burdened by the HIV epidemic through collaborative, educational, supportive home, and community-based services in the context of a harm reduction philosophy.
 - ▶ Health Promotion
 - ▶ Directly Observed Therapy (DOT)

History of Care Coordination



Seguin, Haiti



Mission Hill, Roxbury, Boston



Brigham and Women's Hospital, Boston



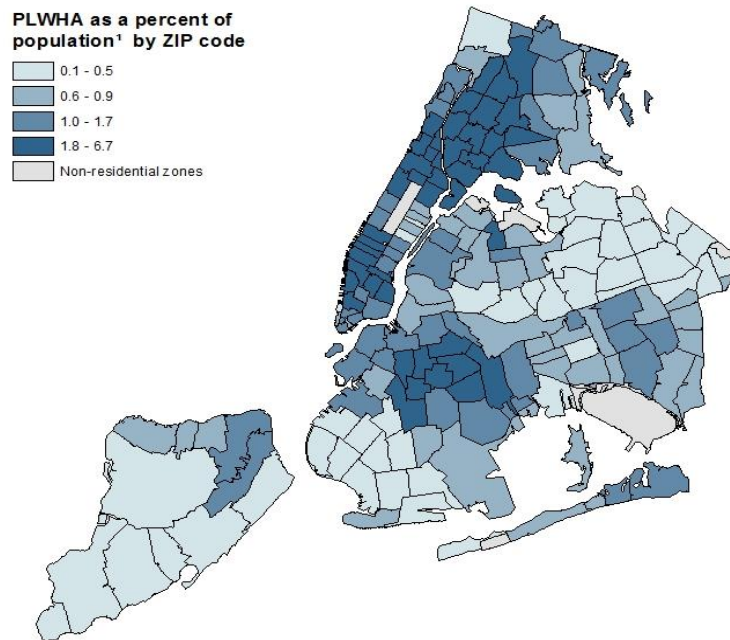
New York City

Care Coordination Around The World

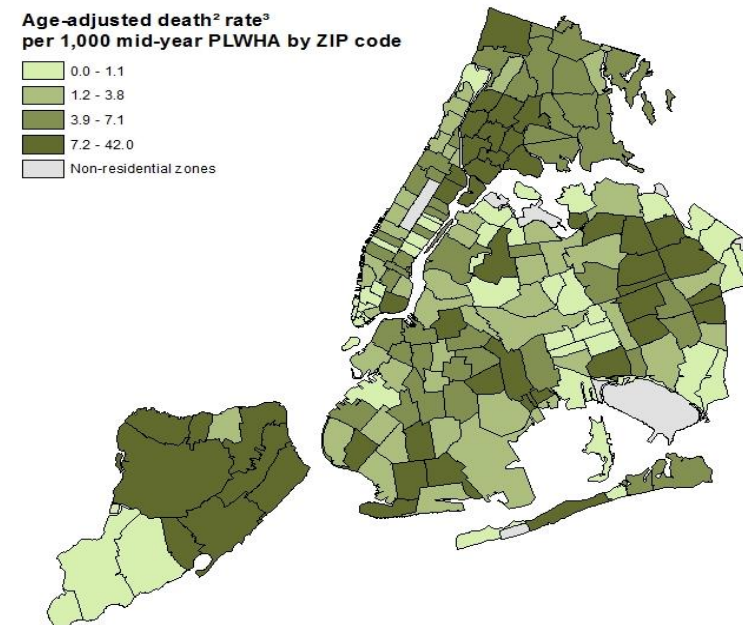


Geographic Distribution of HIV

HIV prevalence, NYC 2014



Age-adjusted death rates among people with HIV/AIDS, NYC 2014



PLWHA=People living with HIV/AIDS

¹Rates calculated using the intercensal 2014 NYC population.

²2014 death data are incomplete.

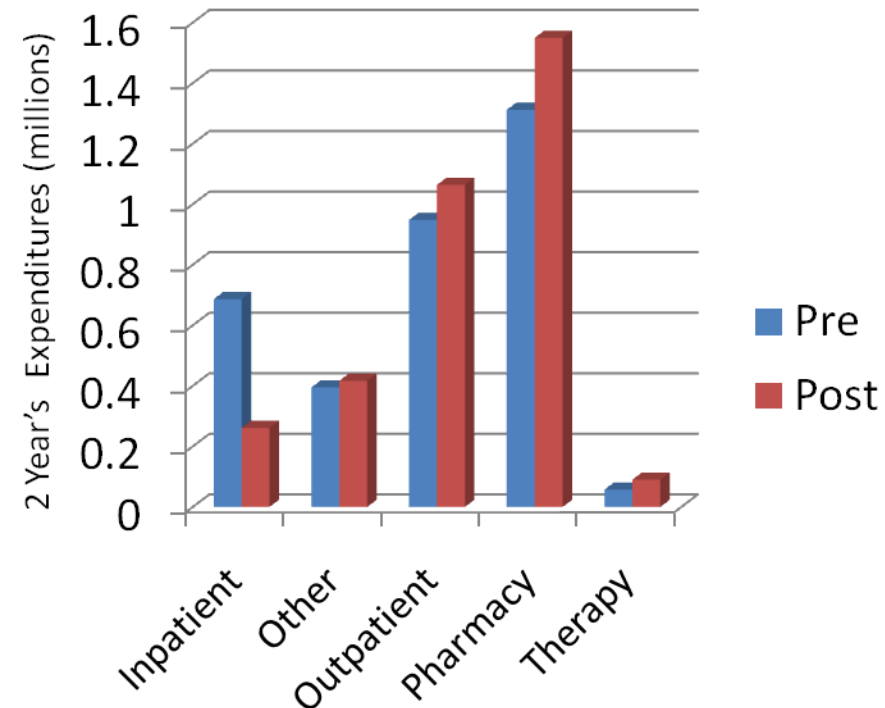
³Age-adjusted to the NYC Census 2010 population. People newly diagnosed with HIV at death were excluded from the numerator.

HIV Epidemiology and Field Services Program. HIV Surveillance Annual Report, 2014. New York City Department of Health and Mental Hygiene: New York, NY. December 2015.

PACT's Accomplishments

- ▶ MassHealth claims analysis reveals 16% net savings
- ▶ 35% reduction in length of stay
- ▶ 60% reduction in inpatient costs
- ▶ 70% of HIV participants w/ significant clinical improvement

Medicaid Costs 2 years Pre- and Post-PACT Enrollment



What is the NYC Care Coordination Model?

Why this Care Coordination Model?

- ▶ Structured Intervention
- ▶ Flexible tiers to meet different levels of need
- ▶ Skill-building curriculum that's practical & client-centered
- ▶ Effective with “hardest to reach” clients, including CDC priority populations
- ▶ Reduces health disparities
- ▶ Promotes whole health in an integrated way in partnership with medical teams

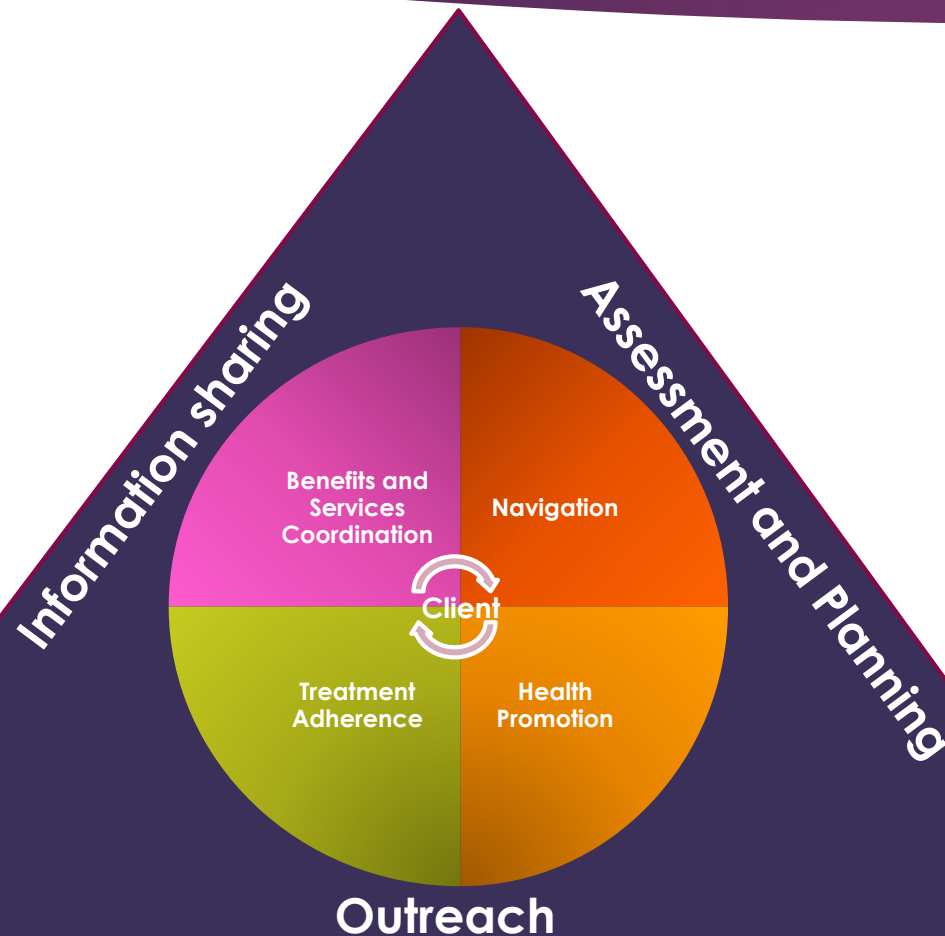
Care Coordination

- ▶ Is an evidence-informed medical model that improves HIV treatment, retention in care and VLS while improving the client's health.
- ▶ A team approach that includes the union of various professional roles to coordinate care and facilitate the appropriate delivery of health care services for persons living with HIV.

Care Coordination in NYC

- ▶ Funded programs include:
 - ▶ Hospitals
 - ▶ Community Health Centers
 - ▶ Community Based Organizations
- ▶ Services are provided at HIV clinics operated by hospitals and community-based organizations that are co-located with or have formal partnerships with clinical facilities; services are also provided in client's home and other field-based settings

The NYC Care Coordination Model



➤ Four components of Care Coordination

- ▶ Benefits and Services Coordination
- ▶ Navigation
- ▶ Treatment Adherence
- ▶ Health Promotion

➤ Shared across all four components

- ▶ Information Sharing
- ▶ Assessment and Planning
- ▶ Outreach

Underlying Principle of Care Coordination

- ▶ Persons with HIV have a medical home to coordinate client care activities.
- ▶ Being able to effectively coordinate & communicate between the primary care physician and other members of the team (Social Worker, Patient Navigator and others) supports the client's engagement in care and improves adherence.

How Care Coordination Works

- ▶ The deliberate integration of client care activities includes:
 - ▶ Medical and social services & benefits assessment
 - ▶ Outreach and lost to care activities
 - ▶ Patient Navigation (appointment reminders, assistance with scheduling appointments and accompaniment to doctors visits)
 - ▶ Case Conferences to facilitate communication among team members
(i.e. Doctors, Social Workers, Patient Navigators)



How Care Coordination Works

- ▶ Patient care activities continued:
 - ▶ Home Visits
 - ▶ Health Promotion – Delivery of specific education topics
 - ▶ ART Adherence Support
 - ▶ Directly Observed Therapy (DOT) for patients with greatest need



Patient Navigators (PNs) visit clients in their homes daily to observe the taking of HIV meds, provide social support and education around pill-taking.



Directly Observed Therapy (DOT)

Helpful for clients experiencing:

- ▶ Difficulty adhering to ART regimen independently
- ▶ New ART regimen
- ▶ Clinical deterioration while on ART
- ▶ Difficulty achieving viral load suppression
- ▶ Viral load > 10,000 without any detectable resistance or if any clinical or social complications are present
- ▶ No lab results for > 6 months due to not attending medical appointments
- ▶ New opportunistic infection
- ▶ Changes in mental health, substance use, housing, social support, income, job, benefits and entitlements, etc.

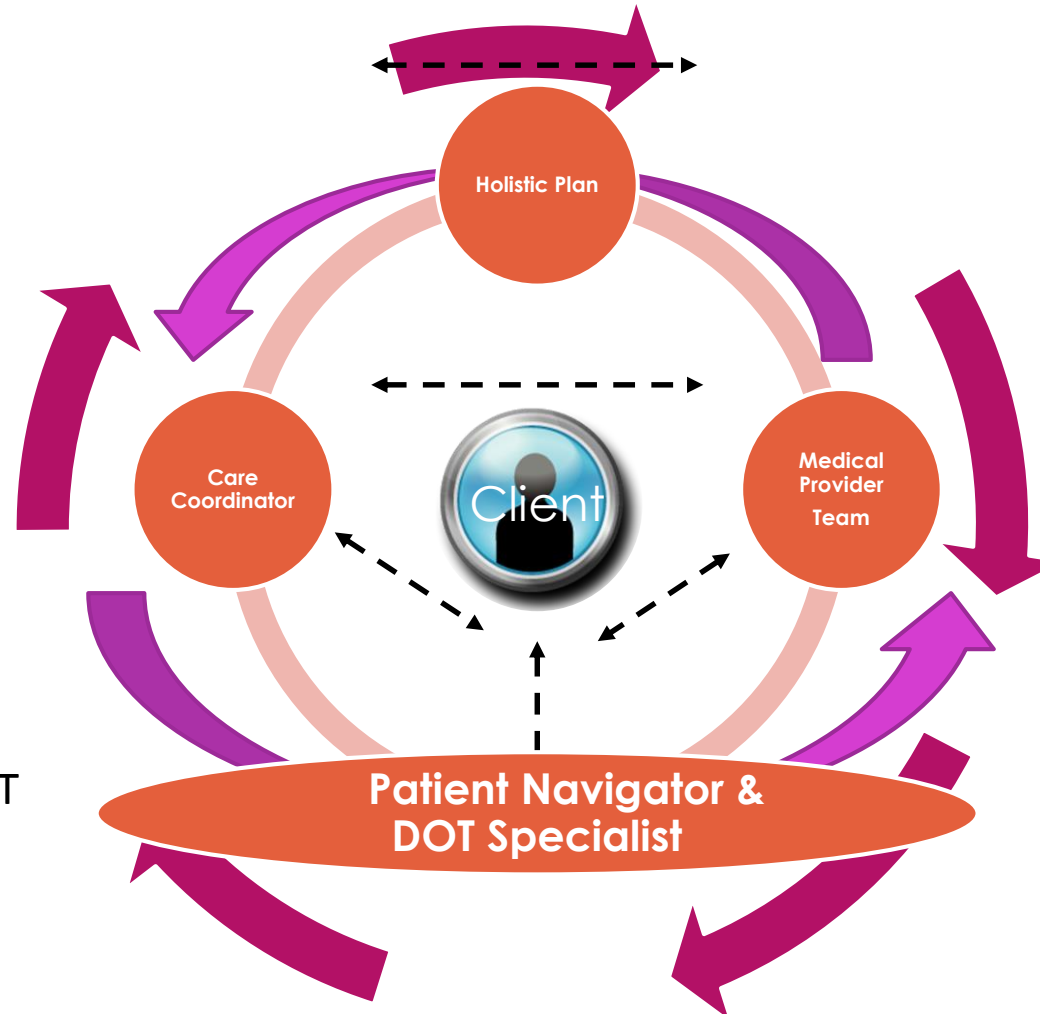
The NYC Care Coordination Team

The Program Director:

- Recruits, hires and supervises key personnel
- Monitors reporting and quality management

Care Coordinator:

- Incorporates medical treatment plan into the Care Plan
- Facilitates the interdisciplinary conversation with the HIV care team
- Provides programmatic supervision to Navigators and DOT Specialists



Medical Provider:

- Provides medical care
- Participates in referral and case conferences
- Relays clinical concerns to Care Coordination Staff
- Creates medical treatment plan to be combined with the Care Plan

Patient Navigator:

- Provides services in the client home or out in the field
- Conducts health promotion sessions for client health education and skills building
- Accompanies clients to appointments
- Provides critical feedback to other members of the team
- May provide Directly Observed Therapy (DOT) services

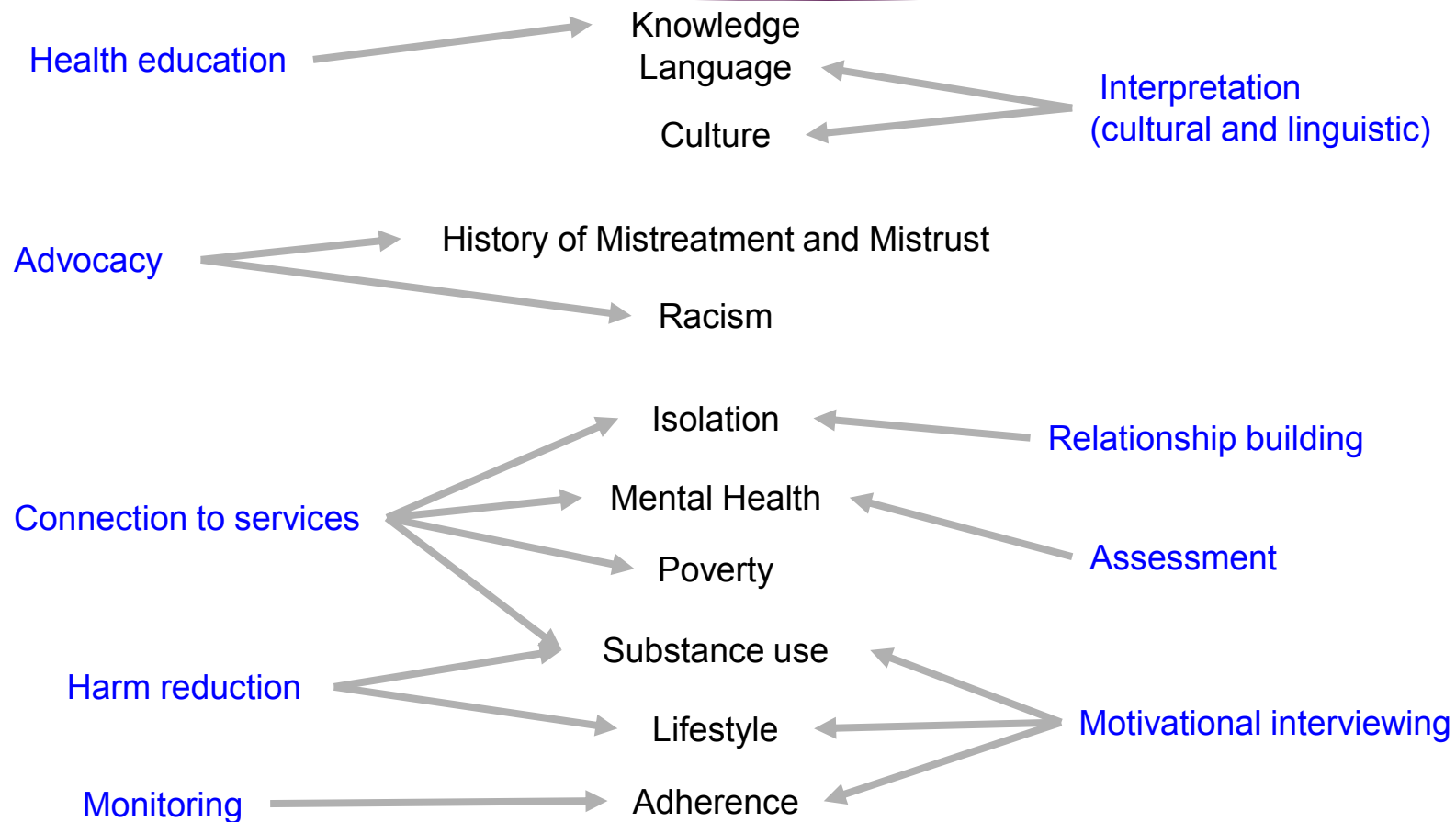
Polling Question!

Based on your experience, what is the most important function of a patient navigator?

So Who is a Patient Navigator?

- ▶ A patient navigator (PN) is...
 - ▶ a community member, educator, advocate, coach, supporter, listener, ally, cultural interpreter, skilled professional.
- ▶ A patient navigator (PN) is not...
 - ▶ friend, family member, therapist, nurse, healer, rescuer, administrative assistant, extra pair of hands.

How We Support Our Clients



Patient Navigator (PN) Role

- ▶ Helps engage and retain clients in care
- ▶ New & evolving role in health care
- ▶ Varies greatly across sites/programs
- ▶ Is flexible & can become ambiguous
- ▶ Ideal= job description is clear across the team from the beginning
- ▶ Goal= create & communicate shared expectations ongoing so PN is not misused or under-utilized

Patient Navigators Strengthen HIV Care!

- ▶ Extend the reach of the care team to the clients' home and community
- ▶ Support care team's accountability to client
- ▶ Assess medical and behavioral health issues in the home, as the eyes and ears of clinic-based staff
- ▶ Frees up medical providers time to focus on what they do best & uses PNs skills where they are most impactful (supporting client engagement, buy-in, behavior change, and follow-up)



“I help my patients learn to love themselves again.”

– Cristina, Patient Navigator

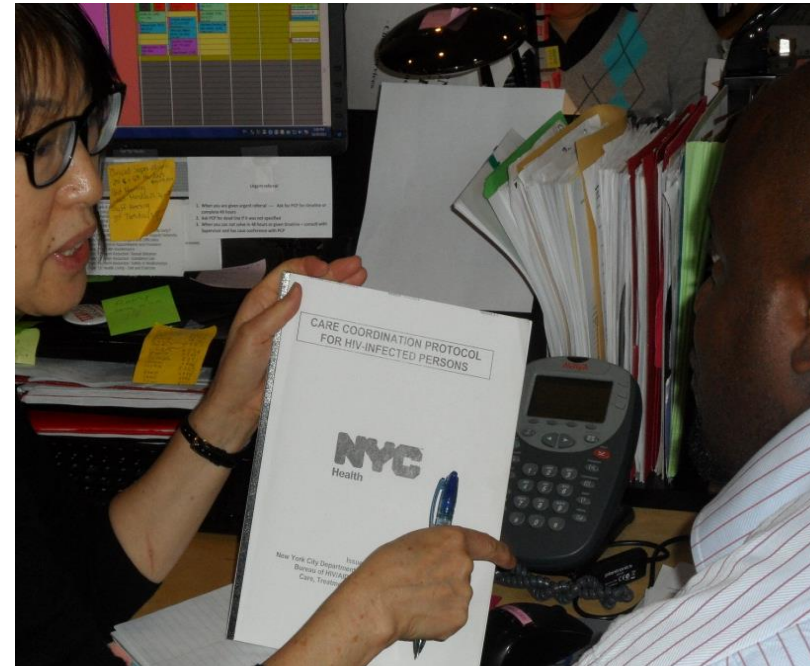
Polling Question!

What are the key barriers to optimal patient engagement in care that you see in your program/community? In your response, please include the city/state where you work.

What kind of tools do you wish you had to support patient adherence & engagement in care?

Care Coordination Tools

- ▶ Program Manual
 - ▶ Recommended staffing plan
 - ▶ Staff roles and responsibilities
 - ▶ Guidance on program processes
- ▶ Standardized forms
 - ▶ Intake
 - ▶ Care Plan
 - ▶ Case Conference
 - ▶ Adherence Assessments
 - ▶ And more...



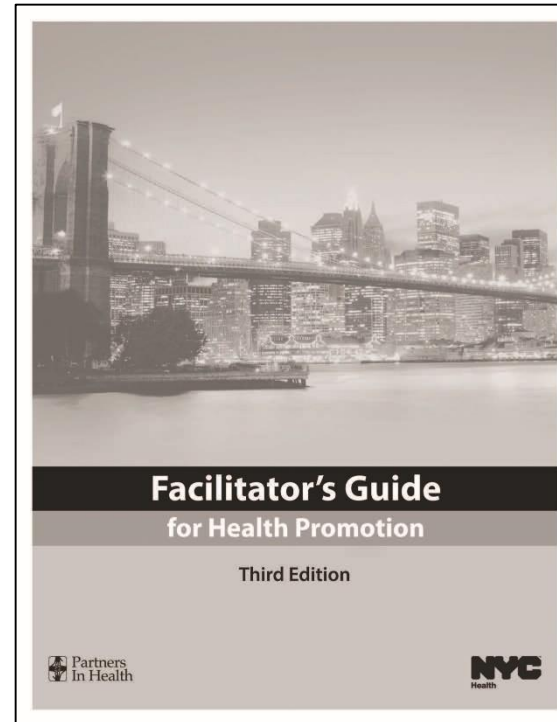
Navigation Tools

- ▶ Helpful tools:
 - ▶ Logistics for Navigator Form
 - ▶ Contact Information Form
 - ▶ Field Safety Guidelines

LOGISTICS FOR NAVIGATOR																			
Patient Name: _____	Patient Record #: _____																		
Complete this form with the patient at the time of introducing the program and conducting informed consent in your office or at the first scheduled visit. Update as needed, with any major changes affecting the logistics for Navigator encounters. INTRO: Before you begin your work with the staff for this home-based support program, we have a few questions that will help us meet your needs for privacy and comfort as a patient.																			
1. Patient will be enrolled in: ☐ Quarterly HP (No ART) ☐ Quarterly HP ☐ Monthly HP ☐ Weekly HP ☐ DOT																			
2. What days and times are best for you to meet with someone from this program? Check as many days as patient says he/she could meet, and fill in available times for each checked day. For patients enrolled in DOT at intake, identify time(s) for every day of the week. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Day(s) of Week:</th> <th style="width: 40%;">Time(s) of Day:</th> </tr> </thead> <tbody> <tr><td>☐ Monday</td><td></td></tr> <tr><td>☐ Tuesday</td><td></td></tr> <tr><td>☐ Wednesday</td><td></td></tr> <tr><td>☐ Thursday</td><td></td></tr> <tr><td>☐ Friday</td><td></td></tr> <tr><td>☐ Saturday</td><td></td></tr> <tr><td>☐ Sunday</td><td></td></tr> <tr><td>☐ Other answer (Specify: _____)</td><td></td></tr> </tbody> </table>		Day(s) of Week:	Time(s) of Day:	☐ Monday		☐ Tuesday		☐ Wednesday		☐ Thursday		☐ Friday		☐ Saturday		☐ Sunday		☐ Other answer (Specify: _____)	
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If the patient is not enrolled in Weekly or Daily: 2a. Which week of the month is best for your Navigator visit? ☐ Any ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Last																			
3. Are there any days or times when you will <i>not</i> be available for a meeting with someone from this program? _____ _____																			
4. Where would you most like to meet for adherence support? <i>Read choices:</i> ☐ At home ☐ At another person's home (Specify the home and relationship: _____)* ☐ Patient's PCP clinic within the Care Coordination Program ☐ Other location (Specify: _____)* *Please specify location on the Contact Information Form																			
5. Where do you store your medications? _____																			
6. Is anyone routinely involved in your care who could support your participation in this program? ☐ YES ☐ NO																			
6a. If YES, who is that person? First Name: _____ Relationship to Patient: _____ **If named, please refer back to person when completing contact information form																			

Helpful Health Promotion Tools

- ▶ Care Coordination Workbook
- ▶ Care Coordination Facilitator Guide
- ▶ Curriculum Coverage Log



Topic 5: What is Adherence?

Learning objectives

After completing this topic, the patient will be able to:

- Explain the importance of adherence
- Identify barriers to adherence
- Establish a routine for taking ART that works with patient's schedule

Preparation

- Bring the Care Coordination Workbook.
- Review patient's chart for documented problems in adherence.
- Review your notes on this patient from the last topic you completed together, and identify areas that need review or reinforcement.
- Review your notes from the Me and HIV conversation in Topic 2.
- Review the conversations and PN instructions for this topic.

Conversation	Materials & tools
Review from last session	
A: Your patient's perceptions of treatment	
B: What is adherence?	Elements of Adherence Resource (FG page xxx)
C: Why is adherence to ART important?	
D: Taking medications on time	Tool F: Chart (Workbook page xx) A Day in the Life of a PH (Workbook page xx) Surrounding HIV (FG page xxx)
E: Resistance	Conversation E1 guide (FG page xx) Conversation E2 guide (FG page xx) Conversation E3 guide (FG page xx) Conversation E4 guide (FG page xx) Conversation E5 guide (FG page xx)
F: Daily routine chart	Daily Routine Chart (Workbook page 21)
Wrap Up	

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Case Conferencing Tools

- ▶ Review several aspects
 - ▶ Lab values
 - ▶ Adherence (medications and appointments)
 - ▶ Home conditions
- ▶ Develop/update Care Plan
- ▶ Helpful tool:
 - ▶ Case conference form

CARE COORDINATION CASE CONFERENCE

Client Name: _____ Client Record #: _____ Enroll Date: ____/____/____
 Navigator: _____ Last PCP Visit Date: ____/____/____

Note: For clients in non-ART track (A), skip ART Regimen Review (bottom of P. 1) and Adherence Review (top of P. 2). Care Coordinator or Navigator: Please discuss the client with the PCP and use this form to guide discussion at least once quarterly, throughout the client's program enrollment.

Is this a formal/scheduled ongoing case review? ☐ Yes ☐ No If No, only field required for eSHARE is Date of Case Conference.
 Date of Case Conference: ____/____/____

Current Track (Check One): ☐ A: Quarterly (No ART) ☐ B: Quarterly (ART) ☐ C1: Monthly ☐ C2: Weekly ☐ D: DOT

Previous Conference (Date: ____/____/____)	Current Conference From EMR and CC records
#	Date(s)
Previous CD4: _____	Most Recent CD4: _____
Previous VL: _____	Most Recent VL: _____
	Hospitalizations since last Case Conference: _____
	ED visits since last Case Conference: _____
Missed PCP appointments reported at last Conference: _____ ☐ N/A (no prior Conference)	PCP appointments missed since last completed appointment: _____
	Topics covered since last Conference: _____
	Total # of topics covered to this point: _____

*Refer to intake, if this is first Conference.

Progress Notes (include progress with enrollment in services, topics covered, adherence barriers, risk behaviors, disclosure issues, social issues or services, and any other developments relevant to care plan):

ART Regimen Review Currently prescribed ART: ☐ Yes ☐ No If No, skip to Notes on Page 2

Check the appropriate option
☐ Regimen unchanged since last conference If checked, skip to Page 2
☐ Regimen changed since last conference If checked, indicate reason for regimen change below
 Reason for regimen change:
☐ Treatment failure/Viral resistance
☐ Intolerance/Side effects (Specify: _____)
☐ Change in guidance/regimen simplification
☐ Other (Specify: _____)

Current ART Medications:	Pills/dose	Dose Frequency	Continued or New?	If New, Start Date:
			☐ Continuing ☐ New	____/____/____
			☐ Continuing ☐ New	____/____/____
			☐ Continuing ☐ New	____/____/____
			☐ Continuing ☐ New	____/____/____

NYC
Health

NYC Ryan White Part A Care Coordination Forms – Page 1 of 2 – Revision Date: 2/11/11



Adherence Monitoring Tools

- ▶ Depending on your organization's resources and staffing, you can implement a range of adherence tools.

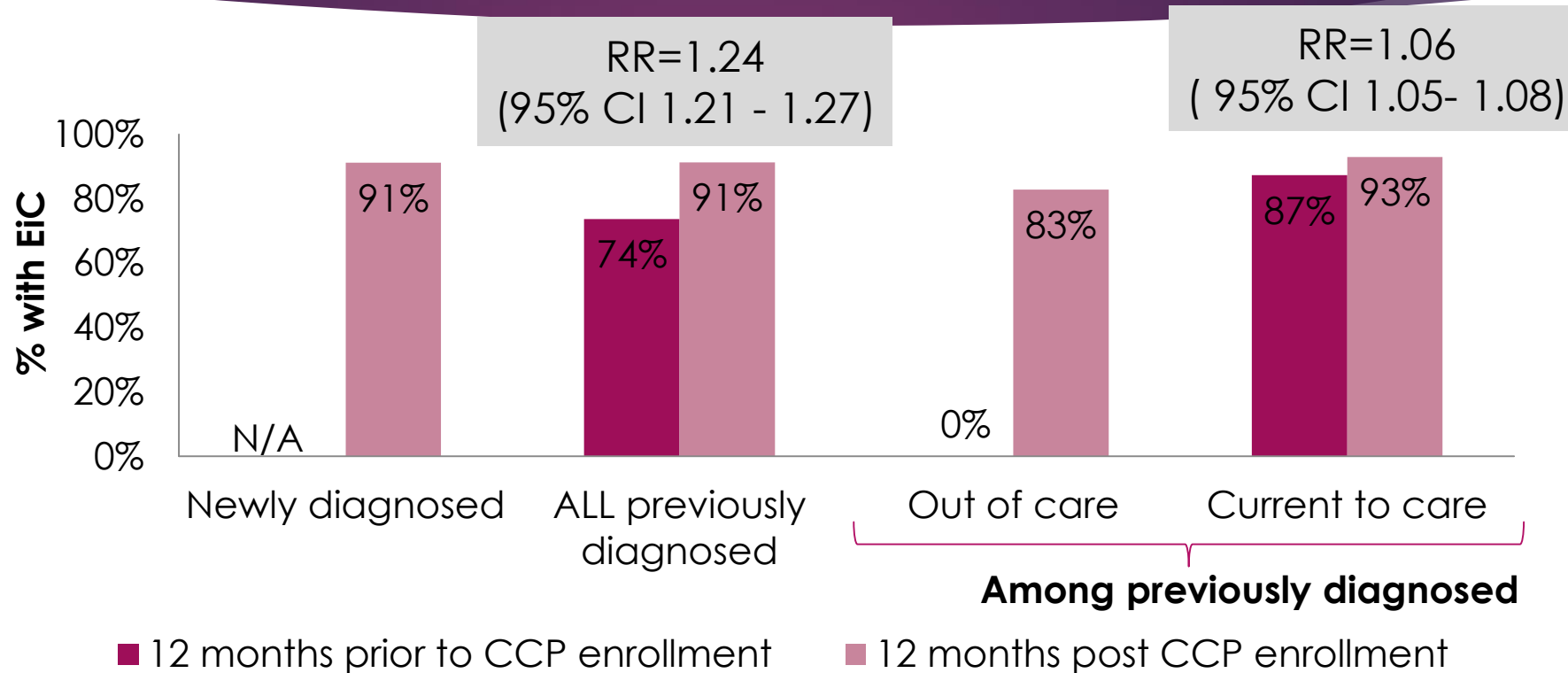


Care Coordination Outcomes

- ▶ Does this intervention work?
- ▶ Initial outcomes evaluation in
 - ▶ Assess the effectiveness of this large-scale, multi-site HIV care coordination program in NYC
 - ▶ Compare engagement in care (EiC) and viral load suppression (VLS) in 12 months before and after CCP enrollment

Results:

Engagement in Care, Pre & Post

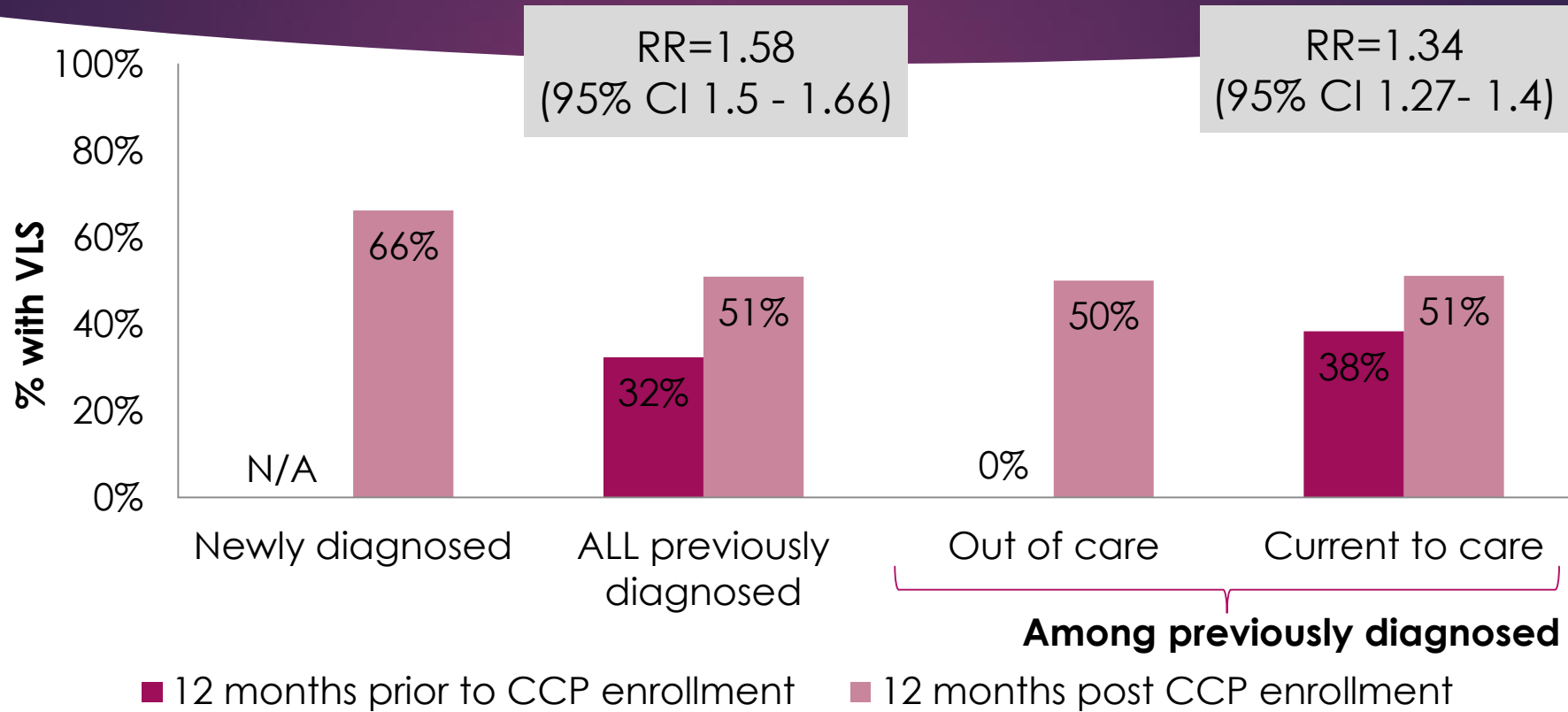


- Improvements were observed for EiC at 25 (89%) of the 28 agencies

Results:

VL Suppression Pre & Post

38



- Improvements were observed for VLS at 21 (75%) of the 28 agencies

Results by 'Resolution' of Barriers

→ Hard Drug Use:

- ▶ Clients with resolution showed >EiC improvement than those without

→ Unstable Housing:

- ▶ Clients with resolution showed >VLS improvement, same *trend* for EiC

→ Poor Mental Health Functioning:

- ▶ Differences based on increased mental health functioning (SF-12 MCS) (≤ 37.0 to >37.0) were non-significant for VLS, but significant in odd direction for EiC (greater improvement among those without 'resolution')

Conclusions

- ▶ Short-term EiC and VLS improvements were robust across **all** subgroups examined
 - ▶ Especially among those previously diagnosed and out of care
 - ▶ Among those with hard drug use, unstable housing, and poor mental health functioning
 - ▶ Includes clients with issues associated with poorer outcomes even after HIV care interventions
- ▶ Newly diagnosed also show promising outcomes
- ▶ CCP may substantially improve short-term adherence to care and treatment among persons at risk for sub-optimal outcomes

Prerequisites for Success With this Model

- ▶ Aligned mission and goals
- ▶ Appropriately targeted population
- ▶ Experienced with team-based care
- ▶ Organizational buy-in
- ▶ Culture of change and ongoing improvement
- ▶ Understanding of monitoring and evaluation
- ▶ Sound financial environment



**“I walk through life differently now.
I put myself first.”**

- PACT Patient

Want More?

The NYC DOHMH's Capacity Building Assistance (CBA) program works to empower organizations and increase health equity through:

- ▶ Training
- ▶ Technical assistance
- ▶ Culturally and linguistically appropriate information

For more information contact us at: NYCCBA@health.nyc.gov

Submit a request by visiting getcbanow.org

Resources

- ▶ Compendium Of Evidence-based Interventions And Best Practices For HIV Prevention:
http://www.cdc.gov/hiv/pdf/prevention/research/compendium/cdc-hiv-HIVCCP_EI_Retention.pdf
- ▶ HIV Care Coordination Tools: <http://www.nyc.gov/html/doh/html/living/hiv-care-coord-tools.shtml>
- ▶ Irvine, 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.
 - ▶ <http://cid.oxfordjournals.org/content/early/2014/11/10/cid.ciu783.full>
- ▶ Irvine, Mary K., et al. "Update: Improved Care Engagement and Viral Load Suppression among HIV Care Coordination Clients with Psychosocial Barriers at Baseline " IAPAC, June 2015
http://www.iapac.org/AdherenceConference/presentations/ADH10_OA109.pdf

Your Questions?

Acknowledgments

We look forward to hearing from you!

Julie L. Barnes, LMHC

Michele Dorsainvil, MA, CHES

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Jill Williams

NYC RYAN WHITE PART A CARE COORDINATION & THE CHORDS STUDY*

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**New York City
Department of
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&

**CUNY School of
Public Health,
New York, NY**

BACKGROUND

HIV CARE COORDINATION IN NYC

- In late 2009, the NYC Department of Health and Mental Hygiene (DOHMH) began implementing a comprehensive Care Coordination Program (CCP)
 - At 28 Ryan White-funded agencies across NYC
 - Targets patients at high risk for suboptimal care outcomes
 - Targets several outcomes along the care continuum
- The CCP intervention combines various evidence-based programmatic elements into a package
- The CCP is above all a service delivery program – i.e., there is no randomization (as in an RCT)



STUDY AIMS



- **Aim 1:** *To assess short and long-term CCP effectiveness by comparing care engagement and VL suppression among CCP participants with that of similar PLWH in HIV care who do not receive the CCP intervention.*
- **Aim 2:** *Among those who enroll in the CCP, identify individual and CCP site-level determinants of care engagement and VL suppression up to 36 months following CCP enrollment.*
- **Aim 3:** *To assess the cost-effectiveness (cost per quality-adjusted life year [QALY]) of the CCP relative to usual care outside the CCP, considering downstream cost-savings and individual and public health benefits due to improved VL suppression and HIV infections averted.*

PREDICTORS OF SUBOPTIMAL CARE OUTCOMES

- Black or Latino race/ethnicity
 - Birth outside U.S.
 - Lower income
 - Younger age
 - Non-AIDS status
 - Substance use issues
 - Mental health issues
 - Unstable housing
 - Low levels of social support
- *Interventions with positive effects on HIV outcomes may not be effective among those with key psychosocial barriers.**

Torian & Wiewel, *AIDS Patient Care STDS* 2011.
Hsu, Chen, Kali, et al., *AIDS Care* 2011.
Wohl, Galvan, Myers, et al., *AIDS Behav* 2011.
Aidala, Lee, Abramson, et al., *AIDS Behav* 2007.
Israelski, Gore-Felton, Power, et al., *Prev Med* 2001.

Higa, Marks, Crepaz, et al., *Curr HIV Rep* 2012
Thompson, Mugavero, Amico, et al., *Annals of Internal Med* 2012

*Gardner, Giordano, Marks, et al., *CID* 2014

RYAN WHITE HIV/AIDS PROGRAM

- **Legislation:** the Ryan White CARE Act, passed in 1990
 - Reauthorized as Ryan White HIV/AIDS Treatment Extension Act, 2009
- **Purpose:** Care and support services for low-income PLWHA who have no other payer for services
 - A key 'safety net' program for reducing HIV-related health disparities
- **Clients:** >500,000 individuals served annually
- **Funding:** \$2.2 billion, with \$624.7 million to Part A (FY2015)
- **Part A:** emergency assistance to Eligible Metropolitan Areas & Transitional Grant Areas most severely affected by epidemic.

CARE COORDINATION PROGRAM (CCP) POPULATION

- Eligibility based on indicators of need:
 - newly diagnosed
 - previously lost to care/never in care
 - irregularly in care
 - initiating a new regimen
 - with incomplete medication adherence or response to treatment

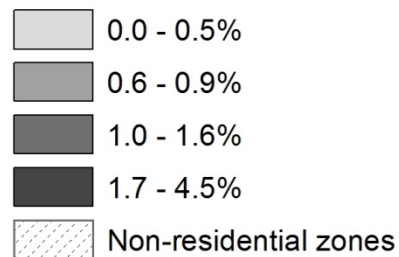
CCP INTERVENTION DESCRIPTION

- **CCP model provides:**
 - case management
 - patient navigation, including accompaniment
 - adherence support, including directly observed therapy (DOT)
 - health promotion in home visits
 - assistance with medical/social services
- **See CDC Compendium of Evidence-based Interventions:**
http://www.cdc.gov/hiv/pdf/prevention/research/compendium/cdc-hiv-HIVCCP_EI_Retention.pdf

CCP Lead and Partner Service Sites, 2015^a

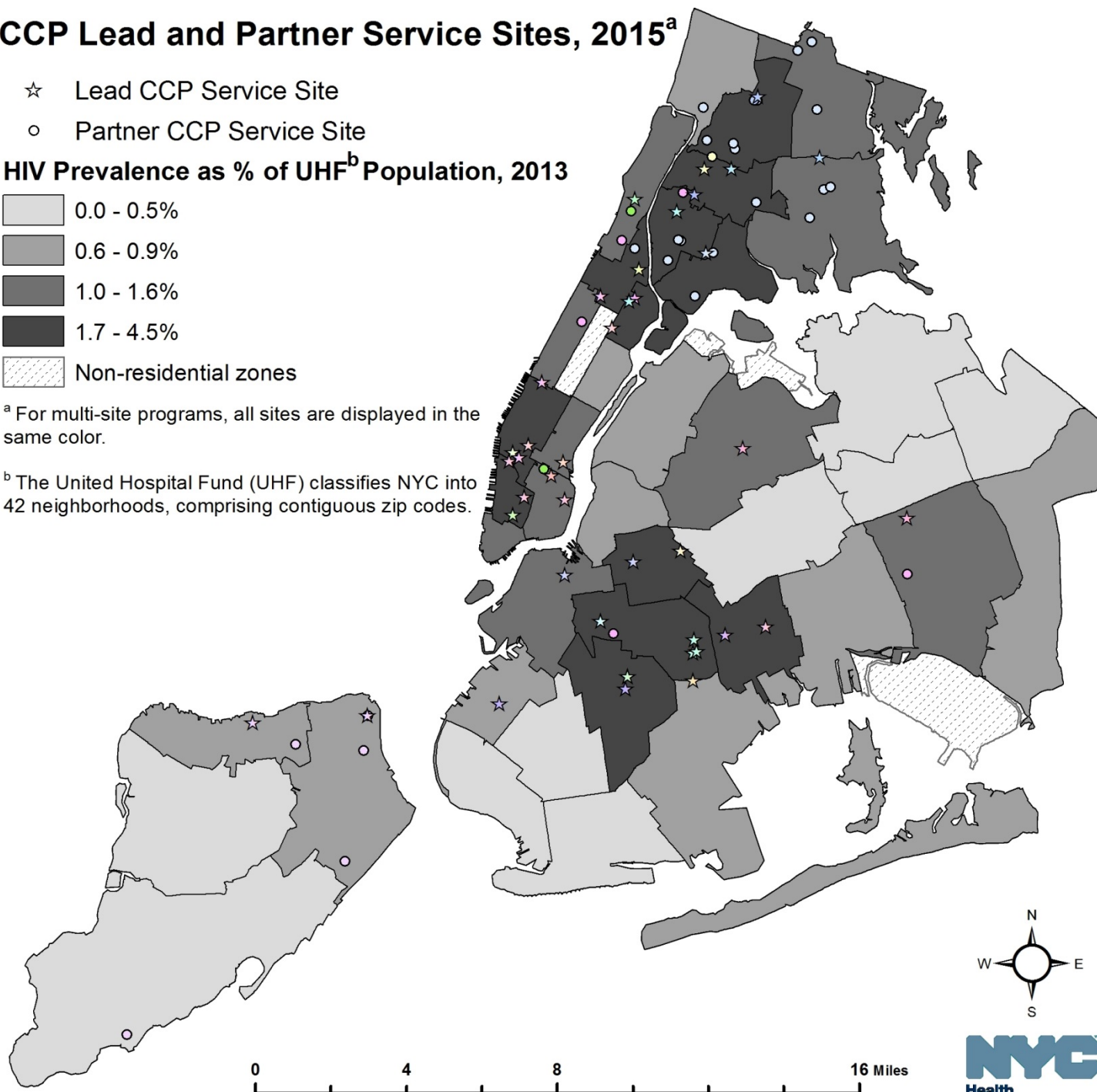
- ☆ Lead CCP Service Site
- Partner CCP Service Site

HIV Prevalence as % of UHF^b Population, 2013



^a For multi-site programs, all sites are displayed in the same color.

^b The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprising contiguous zip codes.



28 CCP
AGENCIES IN
NYC

AIM 1, PRE-POST STUDY: OBJECTIVES

- Compare engagement in care (EiC) and viral load suppression (VLS) in 12 months before/after CCP enrollment
 - Examine subgroup* differences in EiC, VLS
 - Further examine EiC and VLS among those with barrier resolution over time

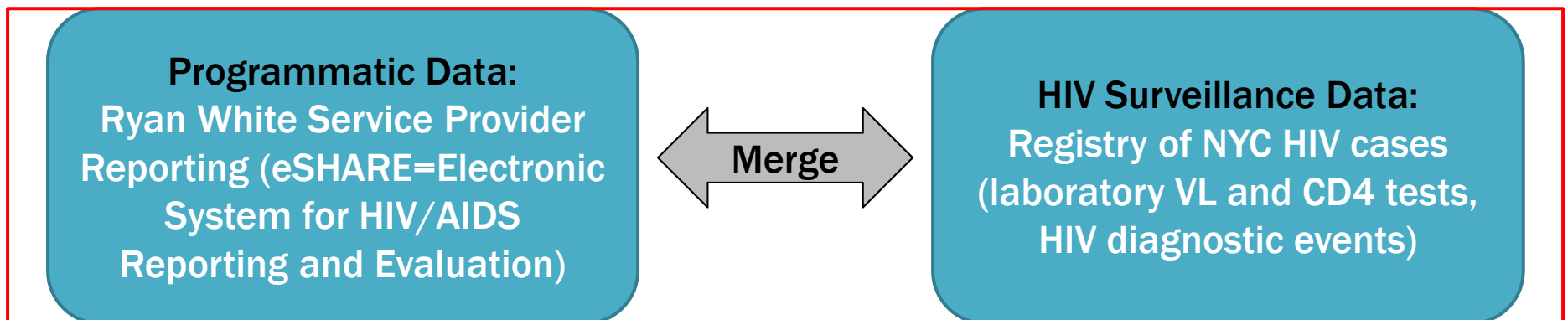
* Subgroups defined based on characteristics at time of enrollment

METHODS

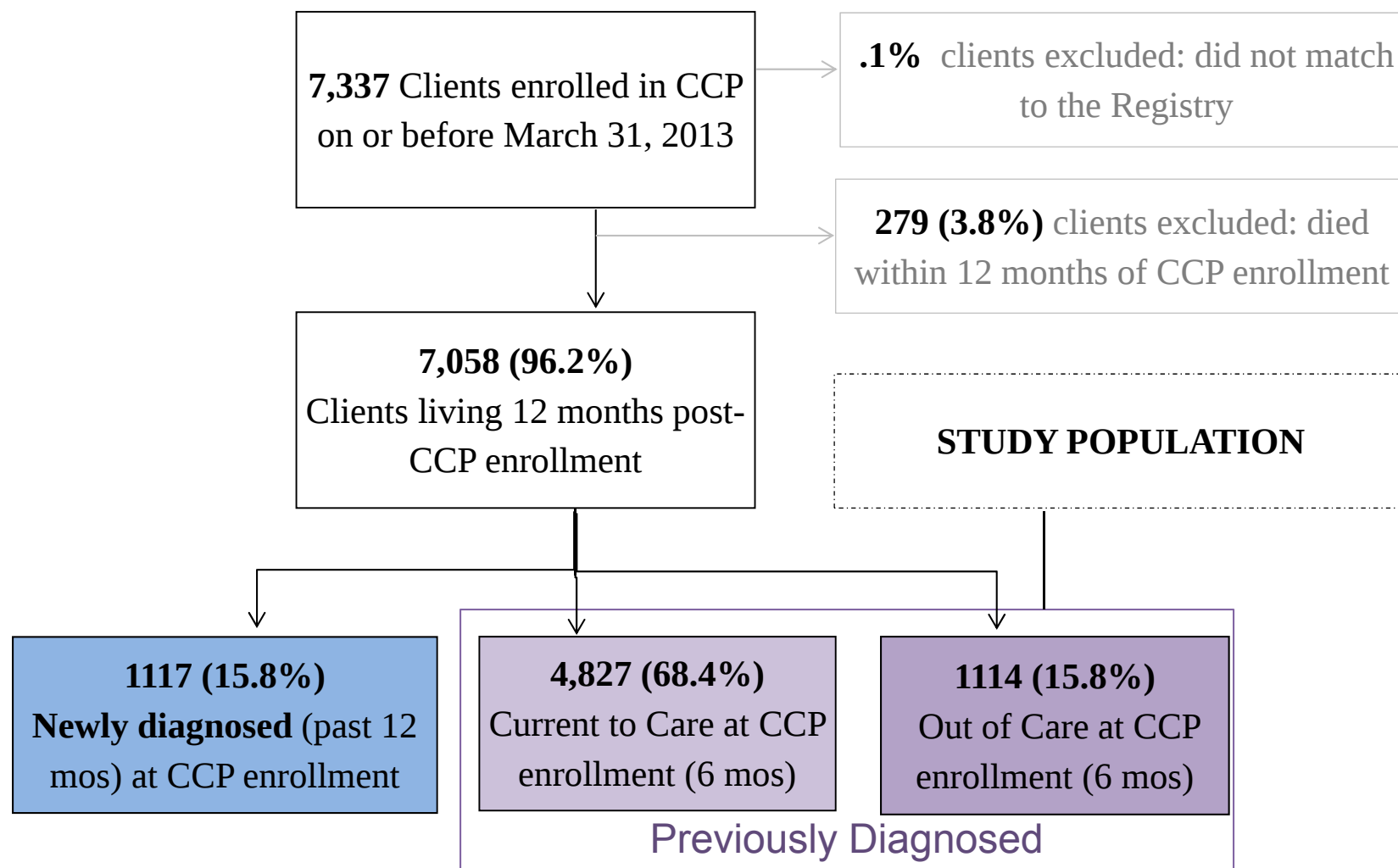
**Aim 1: Pre-
Post Study**

DATA SOURCES

- Matched CCP programmatic data with NYC HIV Registry data



STUDY ELIGIBILITY (FOR LATEST COHORT)



STATISTICAL MEASURES

■ Outcome Measures:

- 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): $VL \leq 200$ copies/mL on most recent test in second half of 12-month period*

■ Estimated post- vs. pre- CCP enrollment relative risks (RRs) for EiC and VLS using GEE

*Missing VL in 2nd half of 12-month period considered equivalent to unsuppressed VL.

PSYCHOSOCIAL BARRIERS

Psychosocial Barriers Definitions*

- **Unstable housing:** Homelessness or residence in temporary/transitional housing
- **Lower mental health functioning:** Mental component summary (MCS) score ≤ 37.0 on the SF-12(v2) functional health assessment
- **Recent hard drug use:** Self-report of using heroin, cocaine, methamphetamines, or Rx drugs to get high (past 3 months)

* Based on CCP Assessment: Baseline= Intake Assessment;
Post-baseline=Reassessment

PSYCHOSOCIAL BARRIER RESOLUTION

Resolution of Psychosocial Barriers Definitions*

- **Housing resolution:** If unstable housing present at baseline, evidence of stable housing post-baseline
- **Mental health resolution:** If MCS ≤ 37.0 at baseline, a post-baseline MCS score increase ≥ 3.5 points
- **Hard drug use resolution:** If recent hard drug use present at baseline, no use of these drugs post-baseline

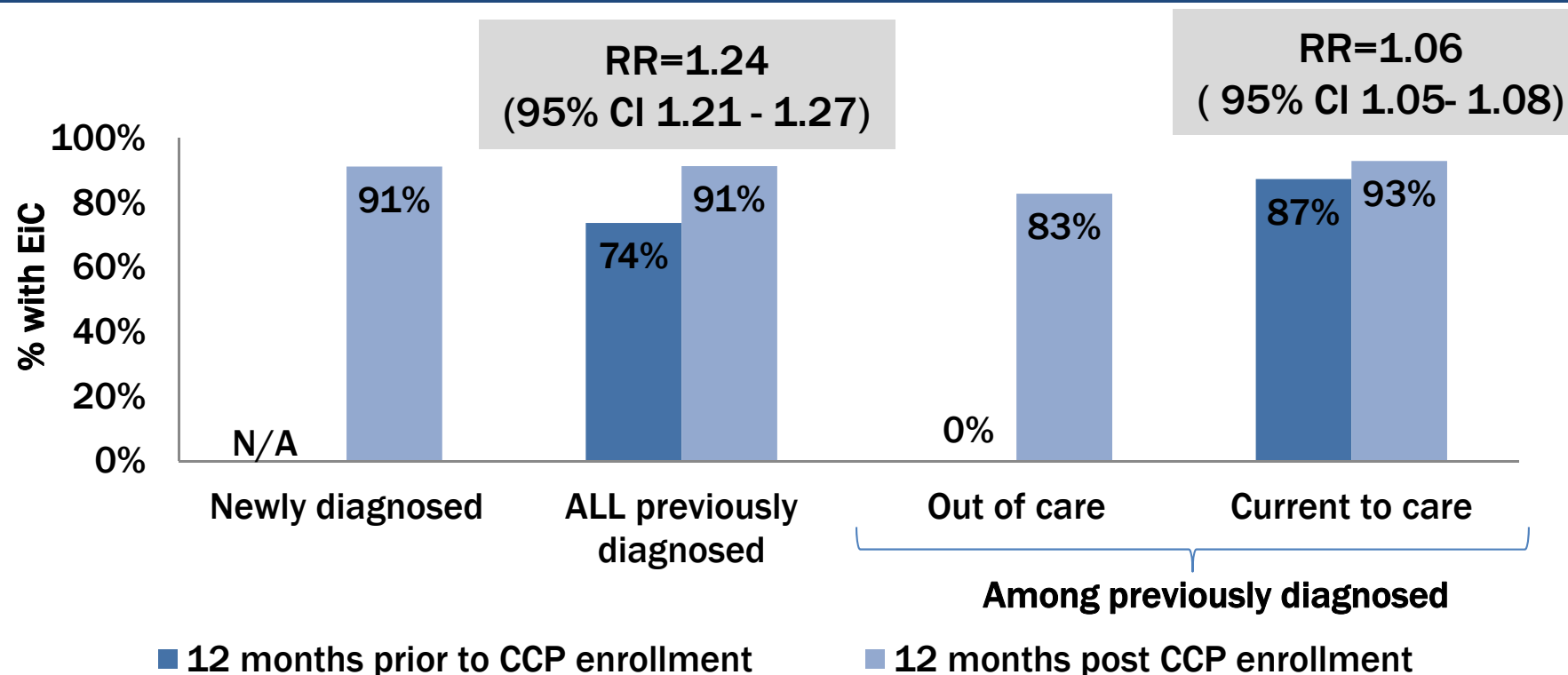
* Based on latest CCP Assessment during the year of follow-up

RESULTS

PUBLISHED FINDINGS (CID) & UPDATE WITH LARGER COHORT (7,058 ENROLLED BY 3/31/13)

Aim 1: Pre-
Post Study

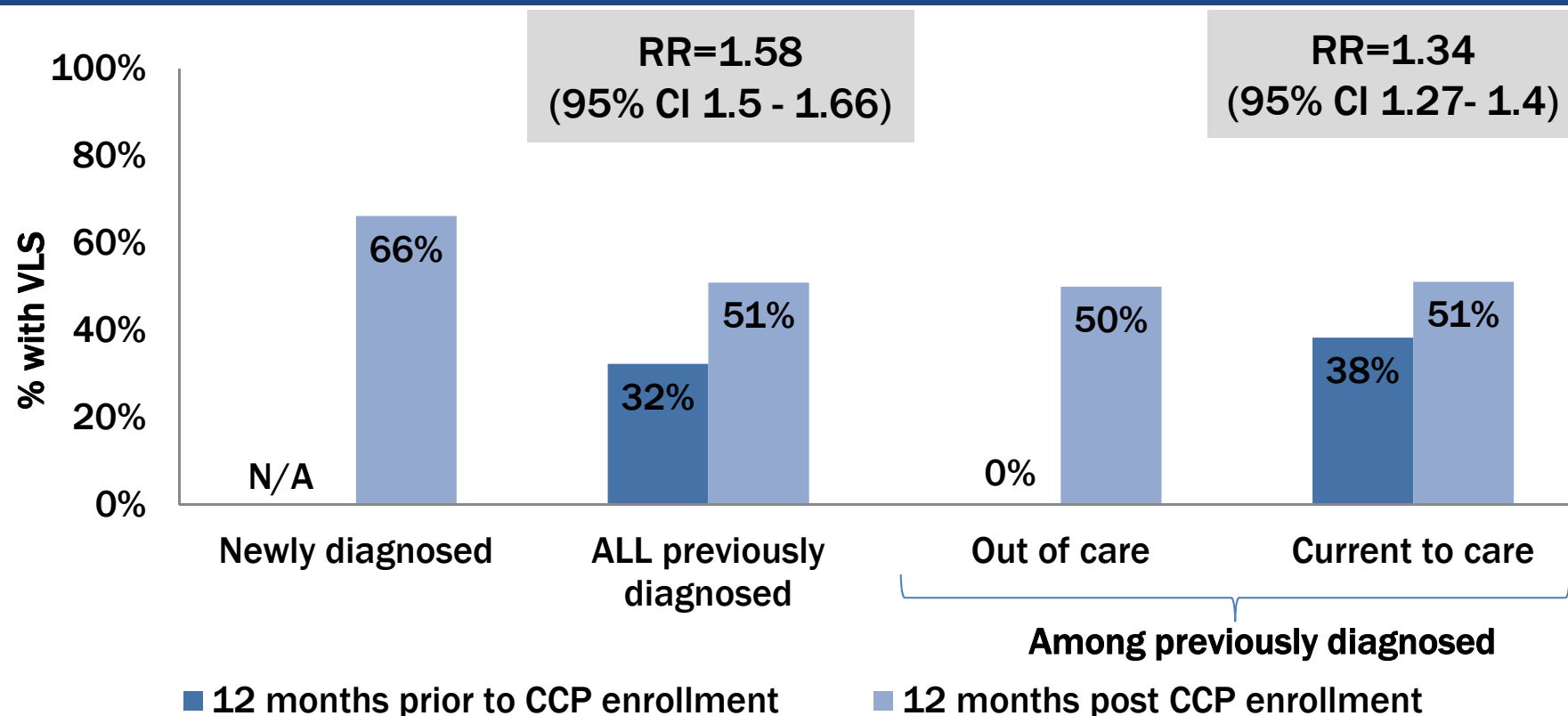
CID*: ENGAGEMENT IN CARE, PRE & POST



- Improvements were observed for EiC at 25 (89%) of the 28 agencies

* Irvine MK, Chamberlin SA, Robbins RS, et al. Improvements in HIV care engagement and viral load suppression following enrollment in a comprehensive HIV care coordination program. *Clin Infect Dis* 2015;60:298-310.

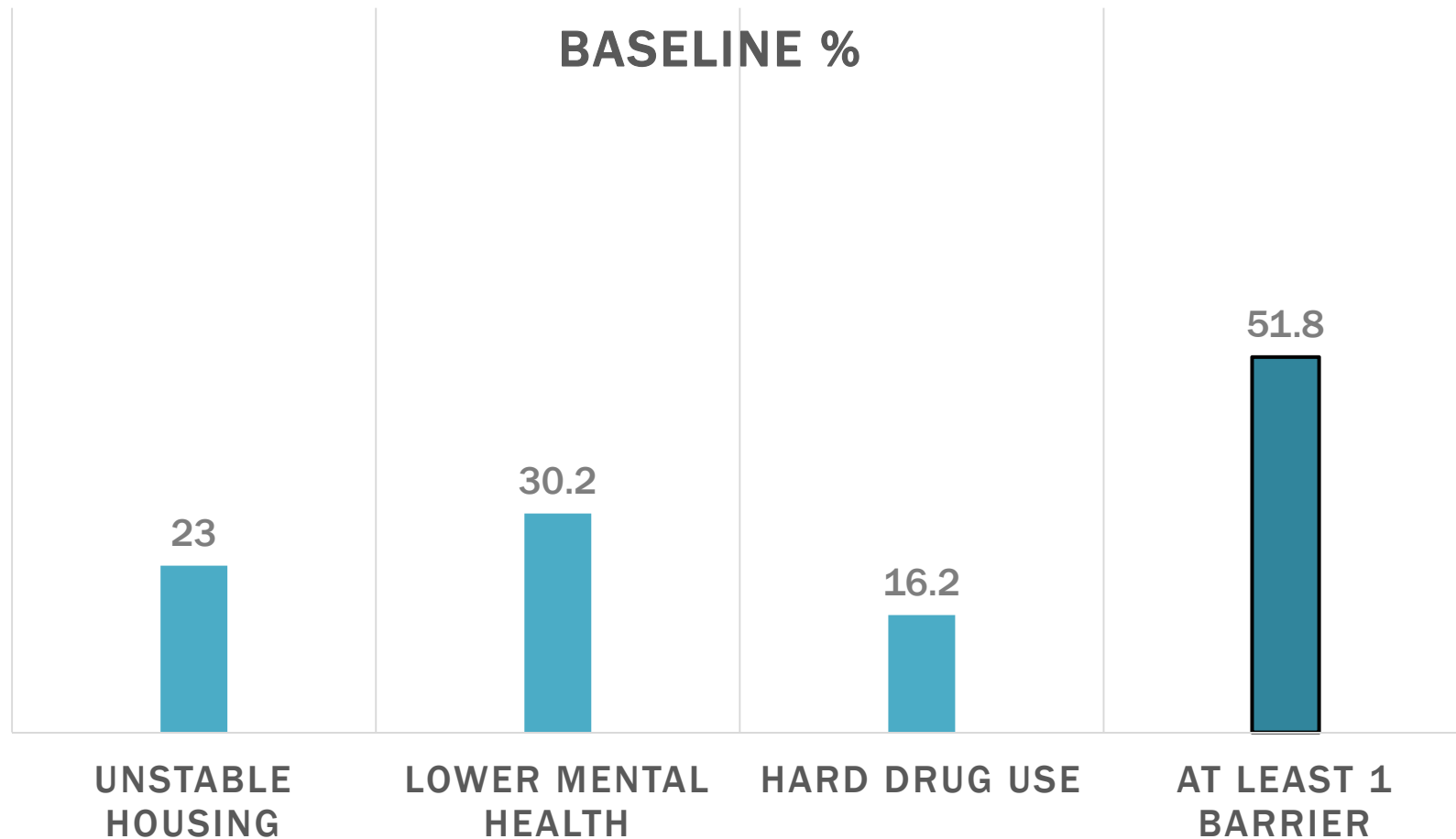
CID*: VL SUPPRESSION, PRE & POST



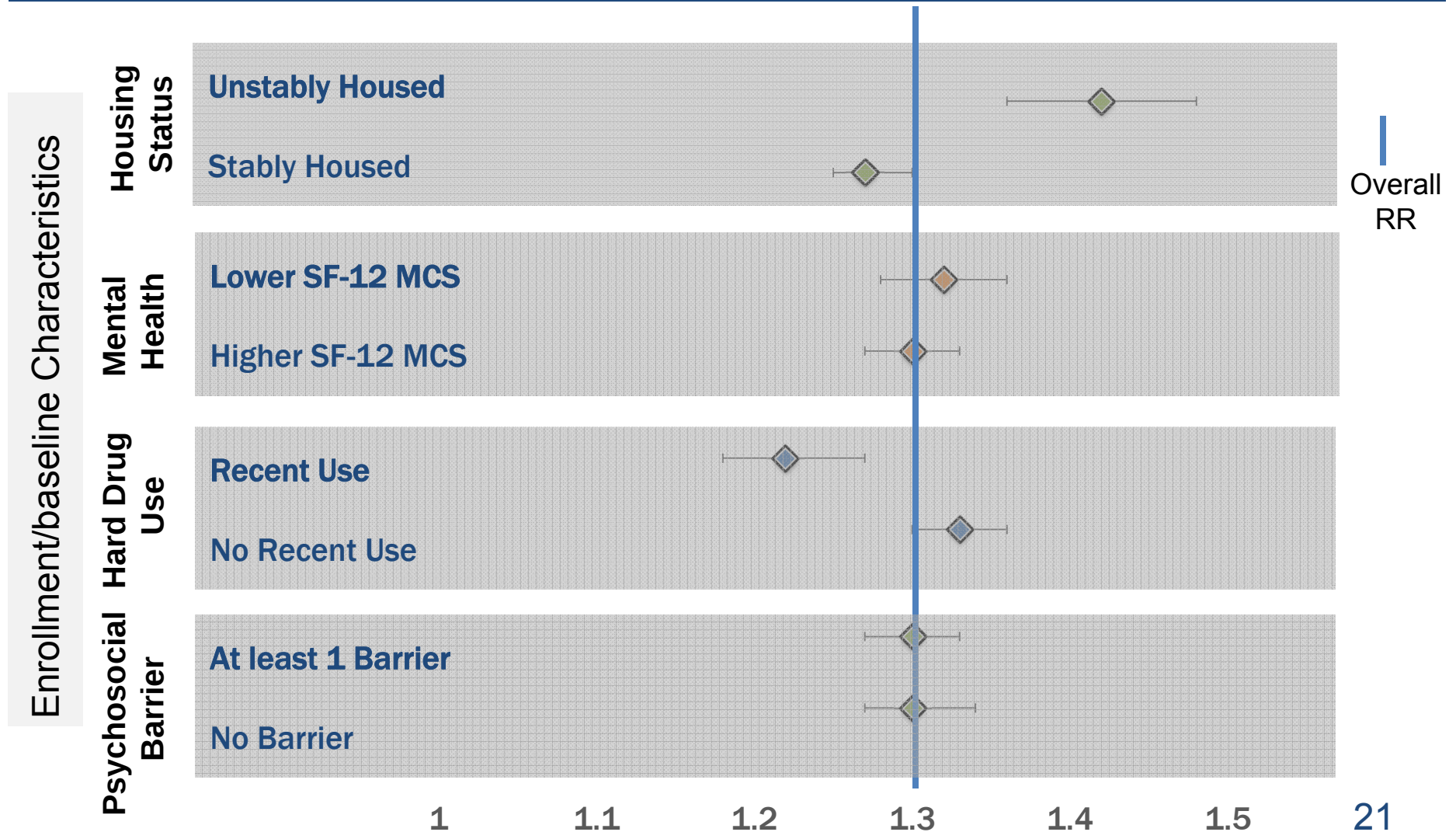
- Improvements were observed for VLS at 21 (75%) of the 28 agencies

* Irvine MK, Chamberlin SA, Robbins RS, et al. Improvements in HIV care engagement and viral load suppression following enrollment in a comprehensive HIV care coordination program. *Clin Infect Dis* 2015;60:298-310.

UPDATE: PSYCHOSOCIAL BARRIER PREVALENCE: PREVIOUSLY DX'D

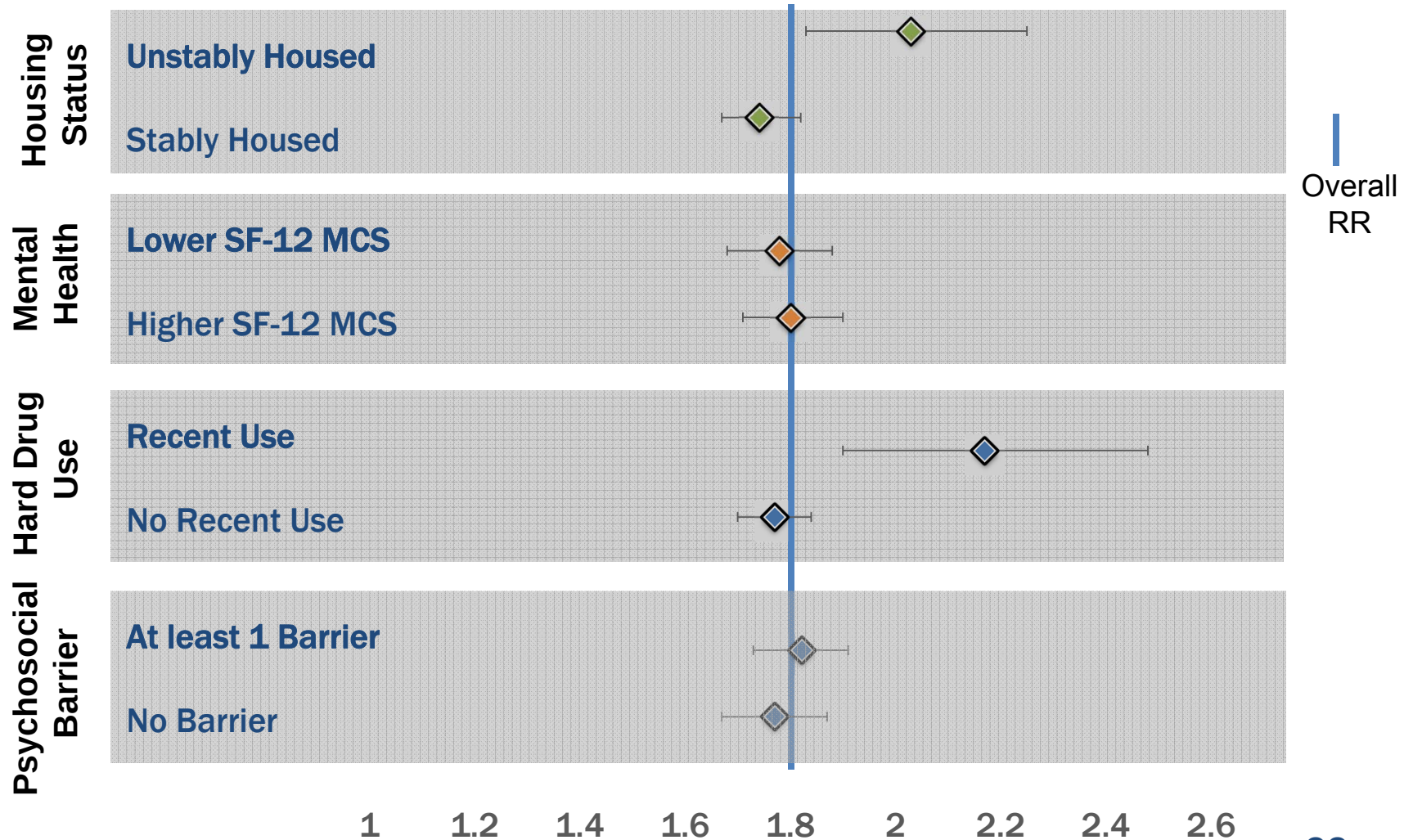


UPDATE: POST- VS. PRE-ENROLLMENT EIC (RR, 95% CI)



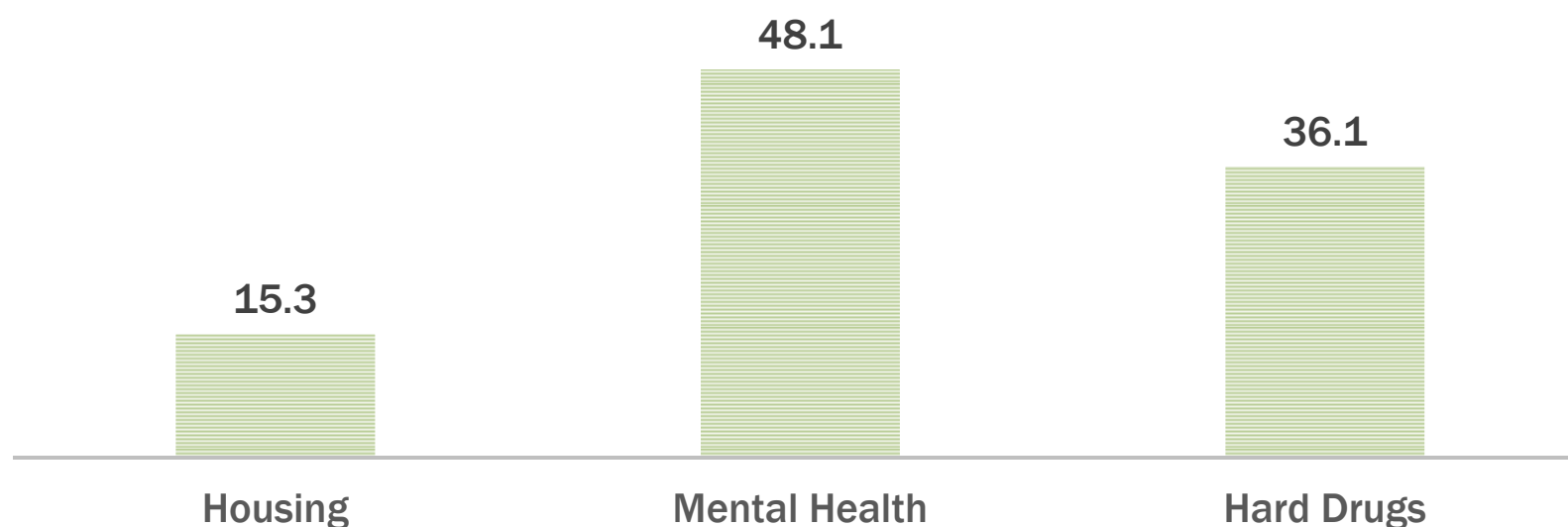
UPDATE: POST- VS. PRE-ENROLLMENT VLS (RR, 95% CI)

Enrollment/baseline Characteristics

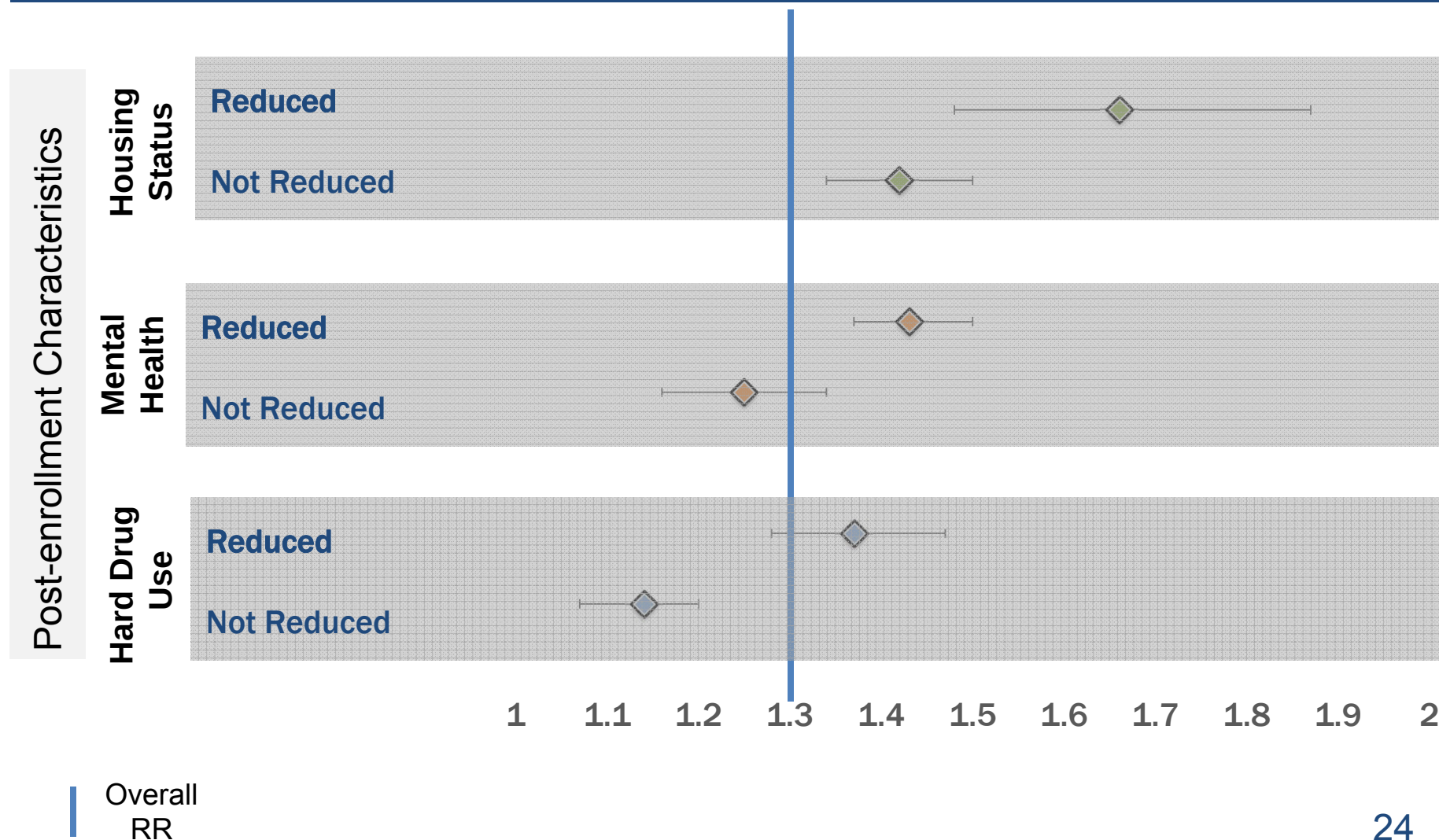


UPDATE: PROPORTION OF THOSE WITH BARRIER AT BASELINE WHO SUBSEQUENTLY EXPERIENCED RESOLUTION

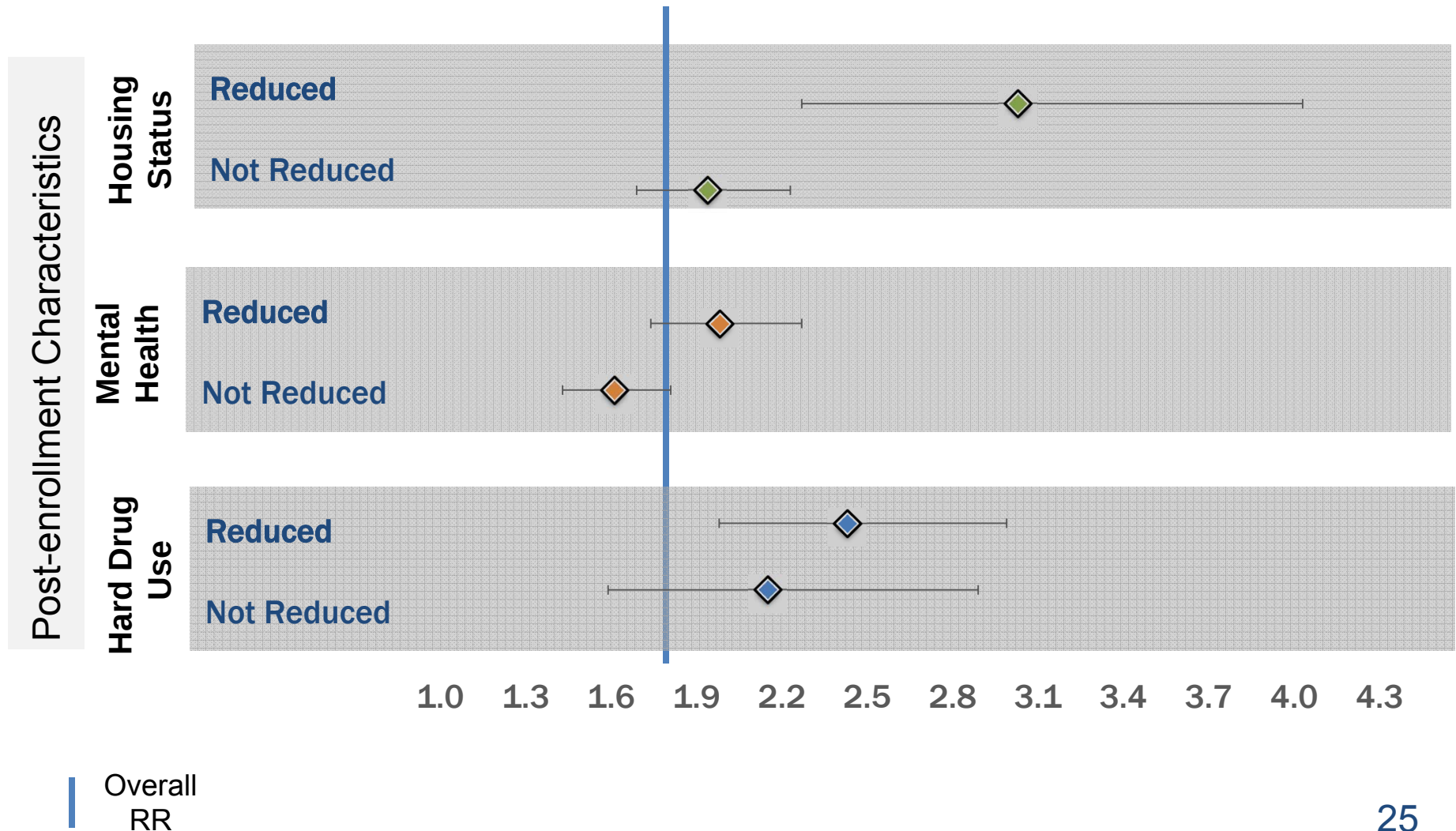
POST-BASELINE RESOLUTION %



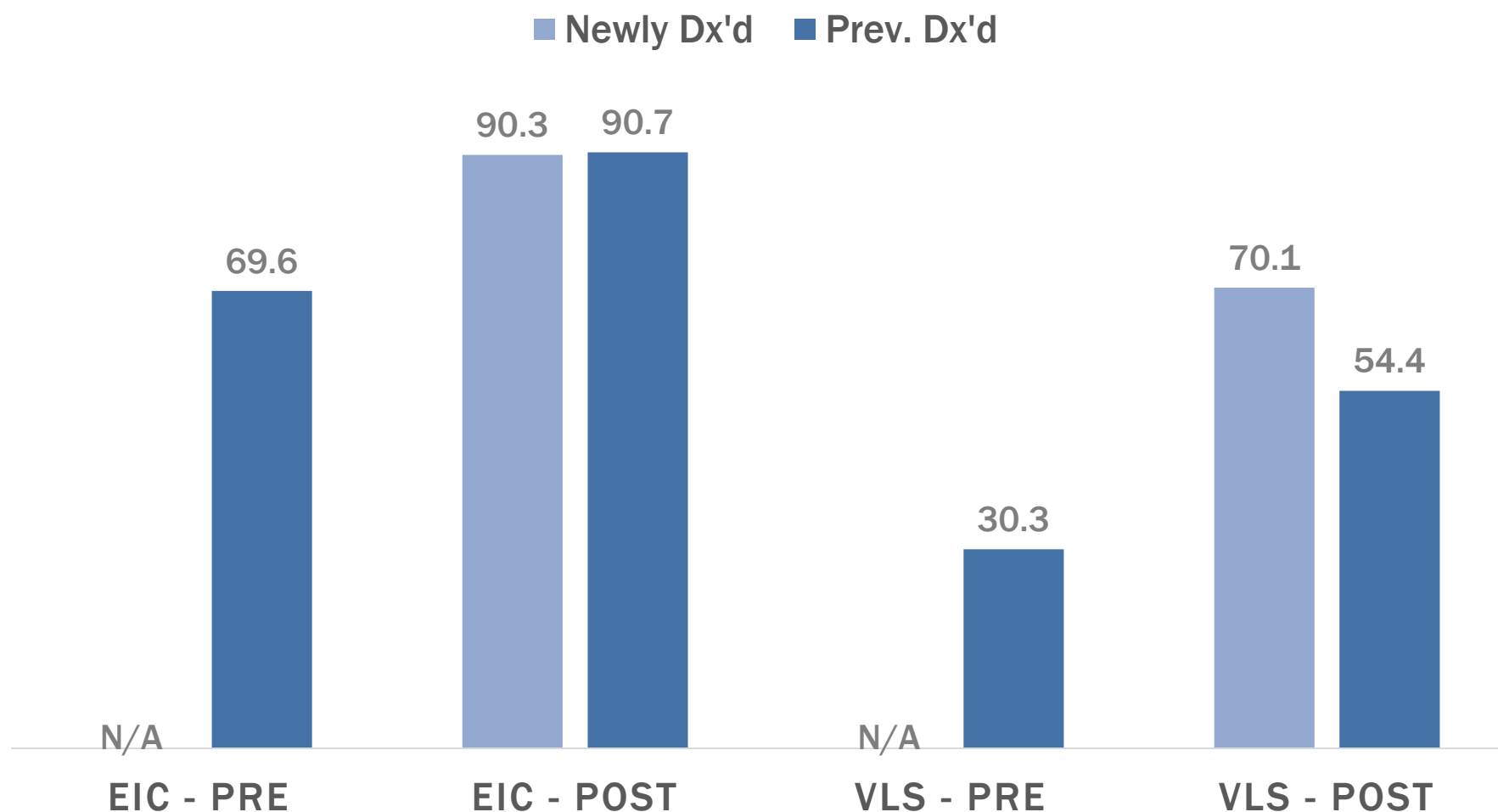
UPDATE-EIC BY BARRIER RESOLUTION: POST- VS. PRE-ENROLLMENT (RR, 95% CI)



UPDATE-VLS BY BARRIER RESOLUTION: POST- VS. PRE-ENROLLMENT (RR, 95% CI)



UPDATE: NEWLY VS. PREVIOUSLY DIAGNOSED OUTCOMES



DISCUSSION

**Aim 1: Pre-
Post Study**

CONSIDERATIONS (PRE-POST ANALYSES)

- Lab test dates used as proxy for primary care visits
 - Provide comparability across sites, pre-post enrollment
 - Could lead to over- or under-estimation of EiC
- More information needed on mechanisms for barrier reduction, longer-term trajectories, and how the CCP may be supporting improvements even among those whose barriers persist
- Observational study without comparison groups
 - Subjects as own controls in pre-post comparison
 - Observed improvements in CCP are occurring against backdrop of citywide improvements in EiC and VLS

CONCLUSIONS (PRE-POST ANALYSES)

- Significant EiC and VLS increases occurred in all subgroups, including those with key barriers to HIV care and treatment adherence
 - Higher RRs among certain groups reflect lower baseline levels of EiC & VLS (room to improve)
- Findings suggest a link between services addressing psychosocial barriers and greater improvement on care/treatment outcomes
- Newly diagnosed achieved high levels of EiC, VLS*
- CCP shows promise for increasing health/ survival opportunities among those at highest risk for suboptimal HIV health outcomes

*Compare our **90%** EiC and **70%** VLS with Wiewel, Braunstein, Xia, et al., *JAIDS* 2015 report of **72%** EiC (≥ 2 visits ≥ 3 mos apart) and **61%** VLS (*any* VL ≤ 200 copies/mL) within 18 mos of diagnosis (for those diagnosed with HIV in 2011). 29