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HIV Care Continuum

2017-2021 District of Columbia Eligible Metropolitan Area Integrated HIV/AIDS Prevention and Care Plan

REGION	South
PLAN TYPE	Integrated state/city/county prevention and care plan
JURISDICTIONS	District of Columbia (includes Washington D.C. and counties in Virginia, Maryland, and West Virginia)
HIV PREVALENCE	High

Washington D.C.'s HIV Care Continuum includes a thorough and detailed description of how the HIV Care Continuum is being used to inform use of resources to meet the needs of people living with HIV in the jurisdiction. In addition, the section describes an excellent continuous quality improvement process that includes a plan to regularly review, identify, update, and expand the measures and data sources to include more data points; as well as the identification of opportunities for improvement for local and jurisdiction-level HIV Care Continuum development. Further, this section demonstrates the challenges and successes in HIV Care Continuum development for an EMA that includes three states and describes HIV prevention and care services at each stage of the HIV Care Continuum, as well as how the jurisdiction uses HIV Care Continuum data for priority setting and resource allocation (PSRA).

SELECTION CRITERIA: HIV CARE CONTINUUM

Exemplary HIV Care Continuum sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Description of diagnosed- or prevalence-based HIV Care Continuum, including the numbers with clear definitions of numerators and denominators, for each step in the HIV Care Continuum
- ☑ Clear visuals of the HIV Care Continuum
- ☑ Description of HIV Care Continuum disparities among key populations
- ☑ Description of how the HIV Care Continuum informs Integrated Plan activities and use of available resources in response to needs of people living with HIV (PLWH) in the jurisdiction
- ☑ Description of how the HIV Care Continuum is used to improve engagement and outcomes of PLWH

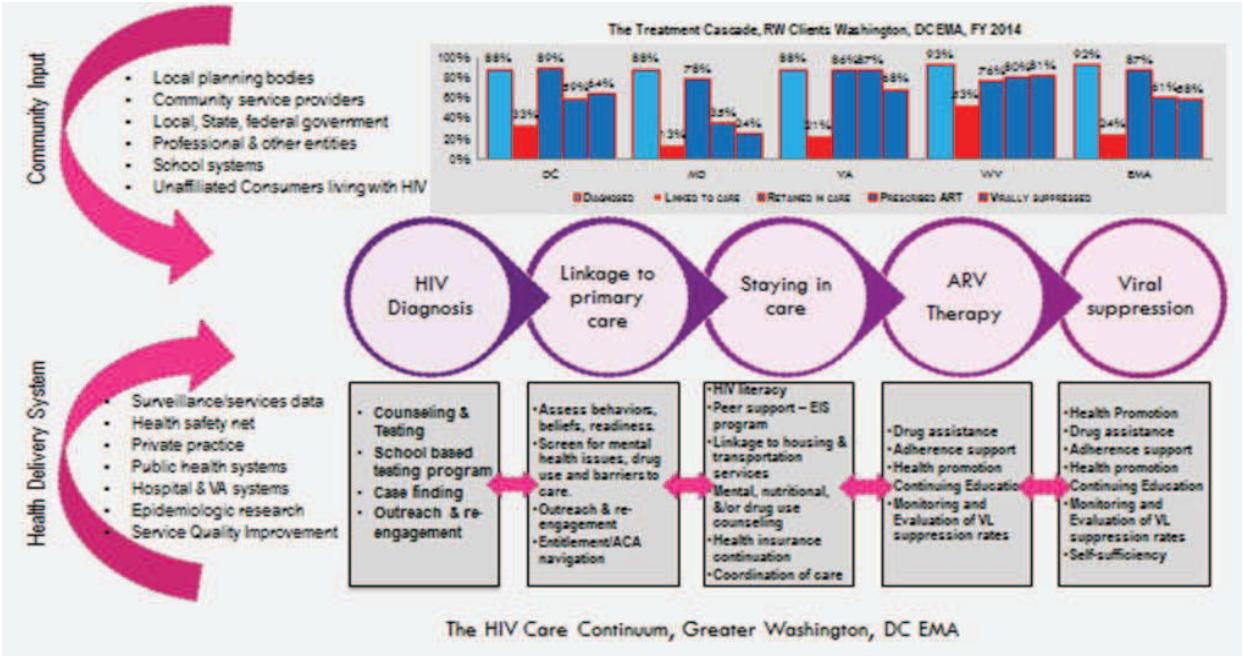
Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

I-B: HIV Care Continuum

HIV Care Continuum Graph with Five Main Stages of Diagnosis.

The figure below illustrates the distinct components of the continuum of HIV care for the DC EMA. Success in the care continuum relies on the synergy of the community system of planning, support, and accountability with the health care system of direct care, quality management, and data systems. The interdependence of these systems and the entities represented in them are essential to maintain persons through a dynamic career of HIV care to achieve consistent viral load suppression and health outcomes. The following two inputs are fundamental to support an ongoing process of system improvement:

- **Community input –** Involving a wide array of entities, including local, state, and federal entities, professional groups, the school system, and unaffiliated HIV consumers that together provide guidance and influence how the continuum will be used to track progress of people living with HIV in the different stages of the treatment cascade.
- **Health Delivery System –** A set of health care institutions, professional practitioners, and public health systems, epidemiologic research bodies, disease surveillance units, and others that directly impact the continuum of care. These entities provide the components of HIV care and ensure that standards of care are executed to achieve viral suppression among clients.



Using the 2014 RW Service Report (RSR), an EMA-wide continuum was generated by using consolidated data sets from each of the jurisdictional regions. The total number of diagnosed cases in the EMA is 36,369. The caseload for each jurisdiction reflects the burden of HIV disease, with DC having almost 45 percent of total EMA cases. Maryland is second and has similar population characteristics to DC. Virginia, the largest in land area and demographically diverse, had about 21 percent of the cases in the EMA. Berkeley and

Jefferson counties, West Virginia, have about 1 percent of the caseload. Regarding the continuum in all four jurisdictions, it is important to note the following:

- **Diagnosed:** The EMA has an estimated 41,303 cases living with HIV disease; of these 36,393 or 92 percent are reported and diagnosed. Approximately 12 percent are unaware that they are HIV- positive. In each of the jurisdictions, about 88 percent (total number of reported and diagnosed HIV, including Stage 3) of cases are reported and diagnosed with HIV disease.
- **Linked to Care:** Using the requisite definition of linked to care, 24 percent of the EMA's diagnosed cases are in RW care; DC has 33 percent of its cases linked to care, Maryland is 13 percent, Virginia is 21 percent, and West Virginia is 53 percent.
- **Retained in Care:** Following the requisite definition of retained in care, 87 percent of the EMA's RW clients are retained in care. DC, Maryland, Virginia, and West Virginia jurisdictions indicate that 89 percent, 78 percent, 86 percent, 76 percent are retained in care, respectively.
- **Prescribed ART:** As required, the proportion of EMA clients prescribed Anti-Retroviral Therapy is 61 percent, above the national average of 37 percent. The continuum indicates that Virginia has the highest proportion (87 percent) of its HIV medical care clients prescribed ART; West Virginia is at 80 percent, DC is at 59 percent, and Maryland is at 35 percent.
- **Viral Suppression:** The National Continuum indicates that of those people living with HIV in medical care, about 30 percent are virally suppressed. The EMA's Continuum indicates 58 percent are virally suppressed; West Virginia has the highest proportion (81 percent) of PLWHA who are virally suppressed; DC and Virginia have 64 and 68 percent respectively. Maryland reports 24 percent.

The continuum shows the focus and direction of planning HIV prevention and care services. In each stage of the continuum, a set of prevention and care services, including counseling and testing and early intervention programs, are implemented to ensure that outcomes along each stage are realized. These services/programs are best described as the integration of HIV prevention and care of people living with HIV. In the first stage, the expected result of the increase in the number of newly diagnosed cases is conservatively projected at about 3.5 percent. Increased access and referral to medical care and other services are strategies that enable clients to progress from diagnosis to viral suppression.

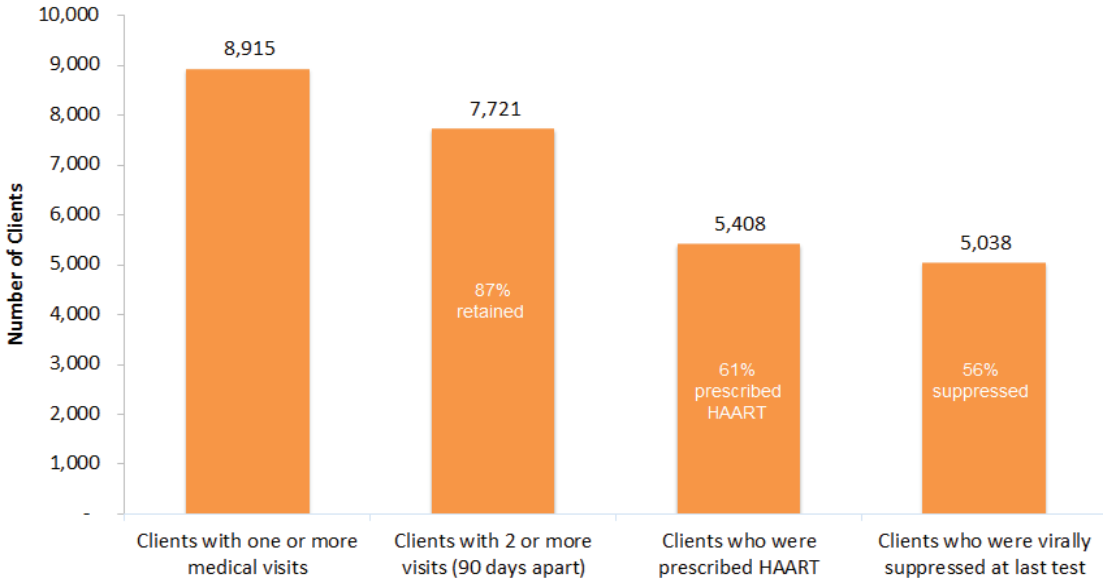
In the next stage, HIV primary medical care and medical case management possess key intervention roles. Using Public Health Service guidelines for primary care, a person living with HIV will complete all required medical assessments and diagnostic screens for comorbid conditions like sexually transmitted infections, substance use, mental health, oral health, and other health conditions. A treatment plan is devised with components such as prescription of

antiretroviral medications, risk-reduction counseling and education, and appropriate referrals to other services like oral health and nutrition therapy. Follow-up visits are also incorporated.

HIV Care Continuum: EMA and by Jurisdiction

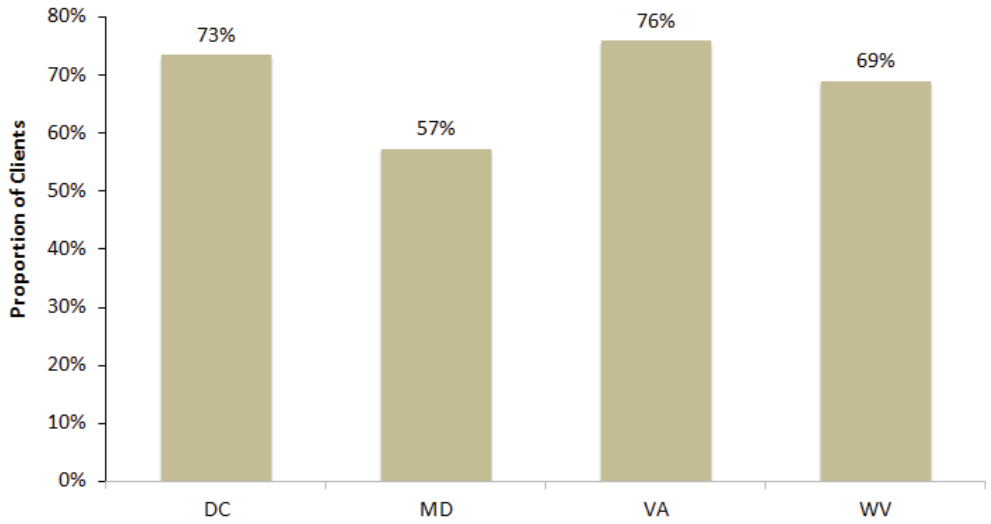
Of the 8,915 RW clients with at least one medical visit in 2014, 87% of were considered retained in care, 61% were prescribed ART, and 56% were virally suppressed. Though the traditional continuum looks at all clients as the denominator, data from CAREWare for RW consumers uses clients who had at least one primary care visit as a denominator because not all clients used RW primary care services.

HIV Continuum of Care among Ryan White Clients in the EMA, 2014



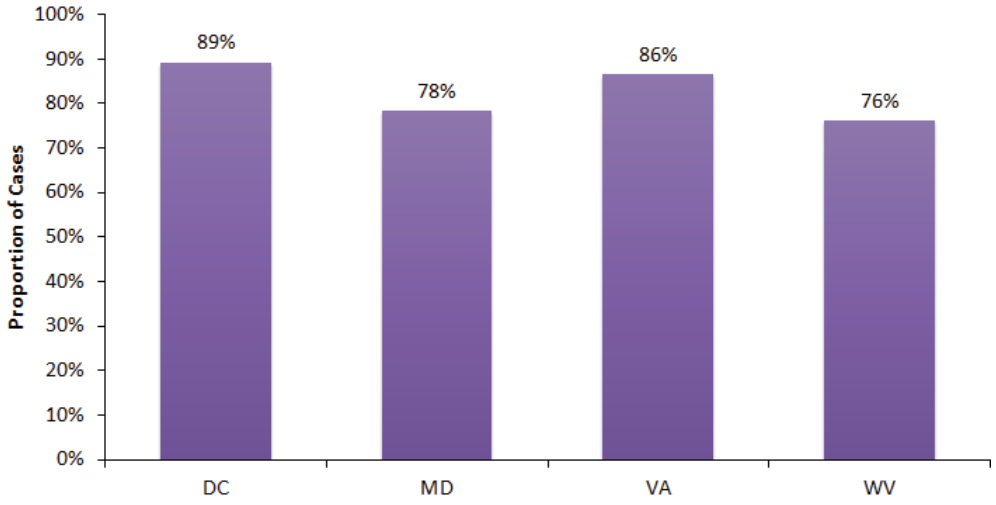
Proportion of RW Clients Receiving Services Who had 1 or More Primary Care Visits by Jurisdiction, 2014

A majority of Ryan White clients who were receiving any type of services had at least one primary care visit in 2014. The highest proportion of RW consumers receiving primary HIV care was in Virginia (76%) and the lowest proportion RW consumers receiving primary HIV care was in Maryland (57%).



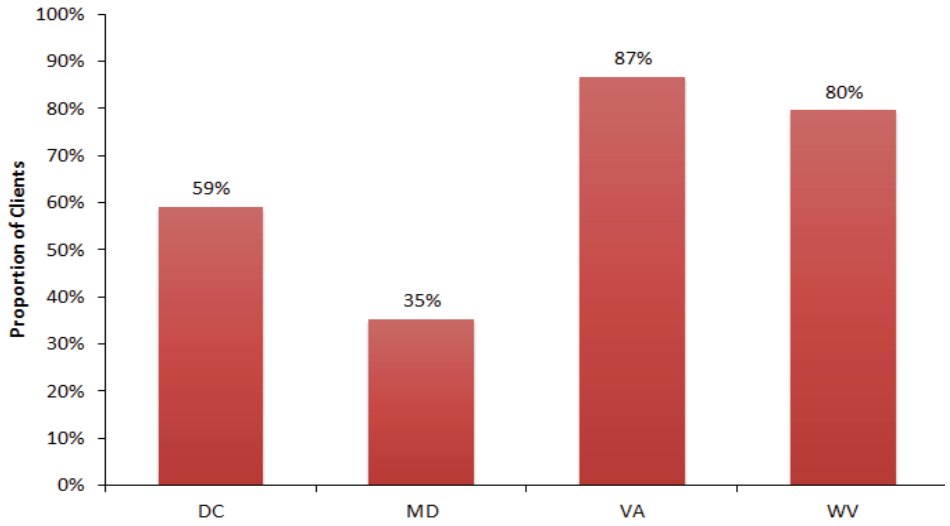
Proportion of RW Clients Receiving Services who had 2 or More Primary Care Visits at Least 90 Days Apart by Jurisdiction, 2014

Rates of retention in care among RW consumers were similar across jurisdictions. The rate of retention in care ranged from 76% in West Virginia to 89% in DC.

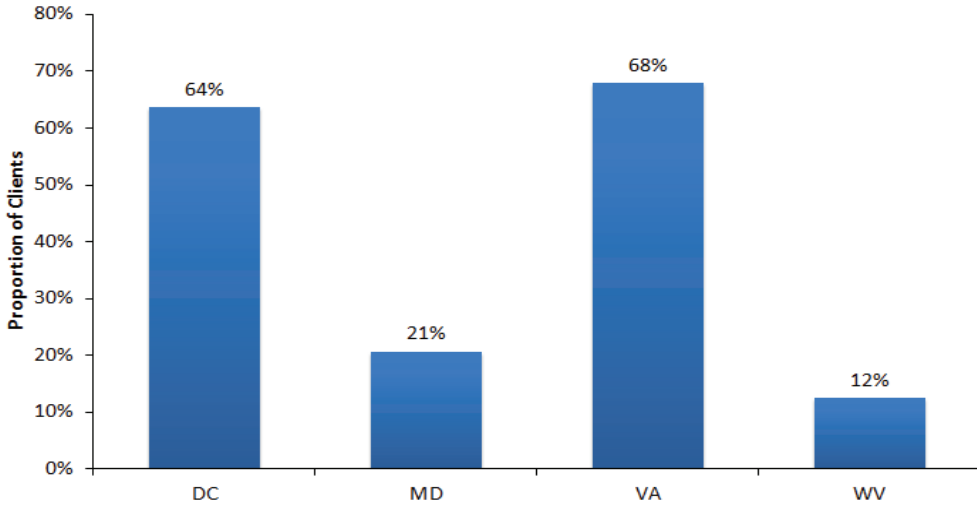


Proportion of RW Clients Receiving Services Who were Prescribed ART by Jurisdiction, 2014

RW consumers who were prescribed ART varied by jurisdiction. The rate of being prescribed ART ranged from 35% in Maryland to 78% in Virginia.



Proportion of RW Clients Receiving Services Who were Virally Suppressed by Jurisdiction, 2014
Viral suppression varied considerably among RW consumers throughout the EMA. Over two-thirds of RW consumers in Virginia were virally suppressed compared to 12% in West Virginia.



HIV Care Continuum: Planning. The HIV Care continuum for the EMA is utilized in planning and prioritization through a process known as priority setting and resource allocation (PSRA). Led by the Ryan White Planning Council, this process is a participative and cooperative and aims to identify needs at all levels; namely, providers, people living with HIV, stakeholders in the community, jurisdictional agencies, and nonaffiliated consumers. In the 2015 PSRA process, for instance, presentation of the HIV Care Continuum led to additional resource set-asides to targeted early intervention services to three specific populations—Latinos, African-American, and young MSM—to reach, identify, and link them to care and treatment.

No single set of services can effectively address the needs of a wide range of races, ethnicities, social identities, risk behaviors, clinical statuses, and service expectations throughout the

EMA. The aim is for a service delivery system that establishes and maintains a continuum to ensure access, retention, and coordination of all required care and support services. This is characterized by:

- A full complement of client-focused, culturally competent, and multidirectional interventions.
- Coordination, collaboration, comprehensiveness, co-location, and competency-based care.
- Multiple points of entry and "reentry."
- Recognition that clients utilize services in very different proportions, sequences, and frequencies.
- A focus on the whole person.
- An extensive provider network that incorporates early intervention, prevention, counseling and testing, and care services.

The continuum is purposely not hierarchical to model the many varied and iterative ways in which clients experience the service delivery systems. This increases the likelihood that all eligible persons with HIV disease—newly diagnosed, historically underserved, disproportionately impacted, and requiring non-standard settings—will be covered in care. A special focus is placed on the persons who are aware of their HIV status but are not in care and clients who are out of care for six months or more.

The HIV Care Continuum as illustrated is a guide to its focus and direction. Each stage has an accompanying set of services that may increase or augment the number of PLWHA moving along the continuum. Planning for services can be easily identified. It also aims to identify subpopulations that are underserved at the jurisdictional level. This information is used to effectively monitor service delivery in each local jurisdiction and redirect efforts in service planning and allocation of resources when appropriate.

HIV Care Continuum: Approaches to Address Health Disparities. The DC EMA contends with significant health disparities as a result of race, gender identity/expression, and sexual orientation. These difficulties are largely driven by unique service delivery gaps, including cultural, language, and stigmas that bar access to primary medical care. These focus populations experience social determinant factors (poverty, lack of employment opportunities, housing instability, behavioral health conditions, and transportation access, among others) that need specific, additional resources to access the care continuum. The table below presents the care continuum data by demographics and allows an analysis of which populations may need extra resources and at what point in their care experience. As part of the Integrated Plan, monitoring this data will reveal where to target efforts.

HIV Care Continuum among Ryan White Clients in the EMA, by Demographics, 2014
Below is a chart of the demographic breakdown at the different stages of the continuum of care for all RW clients in 2014. The continuums of care rates by gender are similar across all stages of the continuum. RW clients age 13-34 had the lowest rates across the continuum and

clients aged 55 and older had significantly higher rates of being engaged in care and virally suppressed. However, part of this may be just an outcome of more years living with HIV. By race, Asian, Pacific Islander, Native Hawaiian, American Indian, and Native Alaskan had the lowest rates of engagement across the continuum, with viral suppression as low as 34%. However, the total number of persons is very low, which affects the rate calculation. Whites and African Americans living with HIV have similar rates of retention in care, but Whites were prescribed ART at a higher rate and have higher viral suppression rates than Black RW consumers. Hispanic RW Consumers had higher rates of being prescribed ART and virally suppressed compared to non-Hispanics.

	In Medical Care	Retained in care		Prescribed ART		Virally suppressed	
	N	N	%	N	%	N	%
Gender Identity							
Male	5,368	4,840	90.2	3,437	64.0	3,203	59.7
Female	3,090	2,716	87.9	1,860	60.2	1,722	55.7
Transgender	187	165	88.2	111	59.4	113	60.4
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
Current Age							
0-12	13	3	23.1	0	0	0	0
13-24	413	325	78.7	177	42.9	141	34.1
25-34	1,640	1,379	84.1	919	56.0	820	50.0
35 - 44	2,035	1,742	85.6	1,279	62.9	1,140	56.0
45 - 54	2,781	2,449	88.1	1,755	63.1	1,640	59.0
55 - 64	1,686	1,518	90.0	1,053	62.5	1,050	62.3
65+	344	305	88.7	225	65.4	247	71.8
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
Race**							
White	1,572	1,357	86.3	1,210	77.0	981	62.4
Black	6,505	5,641	86.7	3,809	58.6	3,340	51.3
Asian	159	103	64.8	94	59.1	80	50.3
NH/PI/NA/AI	38	22	57.9	17	44.7	13	34.2
Missing	694	598	86.2	278	40.1	624	89.9
Total	**8,968**	**7,721**	**86.1**	**5,408**	**60.3**	**5,038**	**56.2**
Ethnicity							
Hispanic	1,035	860	83.1	714	69.0	674	65.1
Non-Hispanic	7,880	6,861	87.1	4,694	59.6	4,364	55.4
Total	**8,915**	**7,721**	**86.6**	**5,408**	**60.7**	**5,038**	**56.5**
HIV Risk Exposure**							
MSM	2,653	2,482	93.6	1,755	66.2	1,476	55.6
IDU	336	311	92.6	221	65.8	174	51.8
Heterosexual contact	4,038	3,700	91.6	2,862	70.9	2,203	54.6
Other*	219	168	76.7	127	58.0	72	32.9
RNI/Missing**	1,758	1,060	60.3	476	27.1	1,113	63.3
Total	**9,004**	**7,721**	**85.8**	**5,441**	**60.4**	**5,038**	**56.0**

*Other HIV risk exposures includes hemophilia, blood transfusion, occupational exposure (healthcare workers), and perinatal exposure
**Discrepancy in data due to the exclusion of data from four providers

HIV Care Continuum: Approaches to Address Other Barriers or Unique Challenges. The unique challenges identified at the jurisdictional level are addressed locally:

- Data transfer and collection for the EMA is at various stages of maturity; two of the four jurisdictions have implemented CAREWare. Virginia and West Virginia implemented CAREWare three years ago. DC and Maryland implemented CAREWare in 2014. In DC and Maryland, where there are significantly lower proportions of documented ART prescription and viral suppression rates, several measures were adopted to improve data inputs for the Care Continuum.
- A Data Improvement Project is needed EMA wide to address quality measures and establish a feedback process for providers to utilize viral load, medical visits, ART prescriptions, and patient outcomes data to improve the care continuum.
- To address various medical insurance and ADAP policies that may pose as a barrier to accessing ART, Virginia was designated by the PC to implement an EMA-wide local pharmaceutical assistance.
- With the expansion of Medicaid in three of the four EMA jurisdictions, obtaining Medicaid utilization data will better illustrate care dynamics to improve the care continuum. DC implemented a data-sharing agreement between DC Medicaid and HAHSTA.
- Provider education is critical to the success of the continuum of care; there is a need for ongoing cultural competency training.
- To increase access to care, enhance continuity and sustainability of care provision, and improve accountability, the current reimbursement method of funding for RW providers was assessed in 2015. The planning for an alternative method of service delivery payments that is equitable and accessible to people living with HIV is underway. The plan will adopt a phase-in approach to ensure it is beneficial for PLWHA and their providers.

The care continuum is a vital tool that reveals the state of HIV care in a region using data from the first appointment with a primary medical service provider to, ideally, viral suppression. Though there are limitations in the data, the care continuum assists in the evaluation of cases through the course of care for effective planning purposes. Overall, RW consumers who had at least one medical visit in 2014 had high rates of retention in care, 87% of clients who had at least medical visit being retained in care at the end of 2014. However, prescription of ART and viral suppression varied considerably and reveal that particularly racial minorities and young people living with HIV could benefit from focused strategic service efforts to improve engagement and retention in care leading to increased viral suppression among people living with HIV who are RW consumers.

For 2017 planning, there have been improvements in Continuum of Care measures in 2016, including increased testing, reduced late testing, increased entry into care within 90 days, and improved viral outcomes, as well as data improvement projects.