Improving HIV Outcomes: Using Ryan White HIV/AIDS Program Client-level Data to Target Interventions and Address Health Inequities in the U.S.

Stacy Cohen, MPH, Branch Chief
Pamela Klein, MSPH, PhD, Health Scientist

Evaluation, Analysis, and Dissemination Branch
Division of Policy and Data, HIV/AIDS Bureau
Health Resources and Services Administration

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Ryan White & Global HIV/AIDS Programs

Session Overview

- About the Ryan White HIV/AIDS Program (RWHAP)
- Who we serve
- Measuring outcomes
- Using data to address gaps and disparities
- Using data at the local level
  - State perspective: Washington State
  - Group discussion
  - Data exercise
- Resources

About the Ryan White HIV/AIDS Program

HAB Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care and treatment services for vulnerable people living with HIV/AIDS and their families

RWHAP Moving Forward

Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV

Who we serve

Ryan White HIV/AIDS Program Clients

- **RWHAP serves over half a million people each year**

- **2015:**
  - 533,036 clients
  - 97% living with HIV

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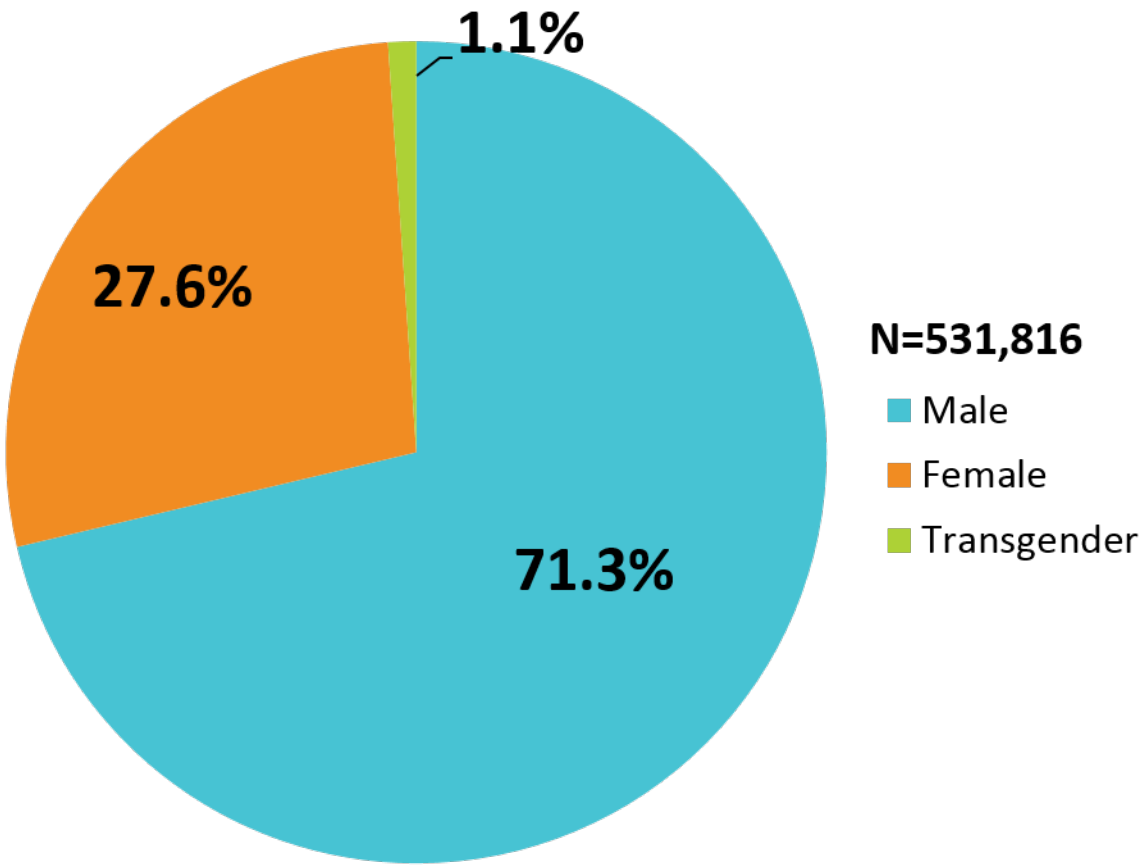
Clients Served by the Ryan White HIV/AIDS Program by Gender, 2015—United States and 3 Territories[a]



[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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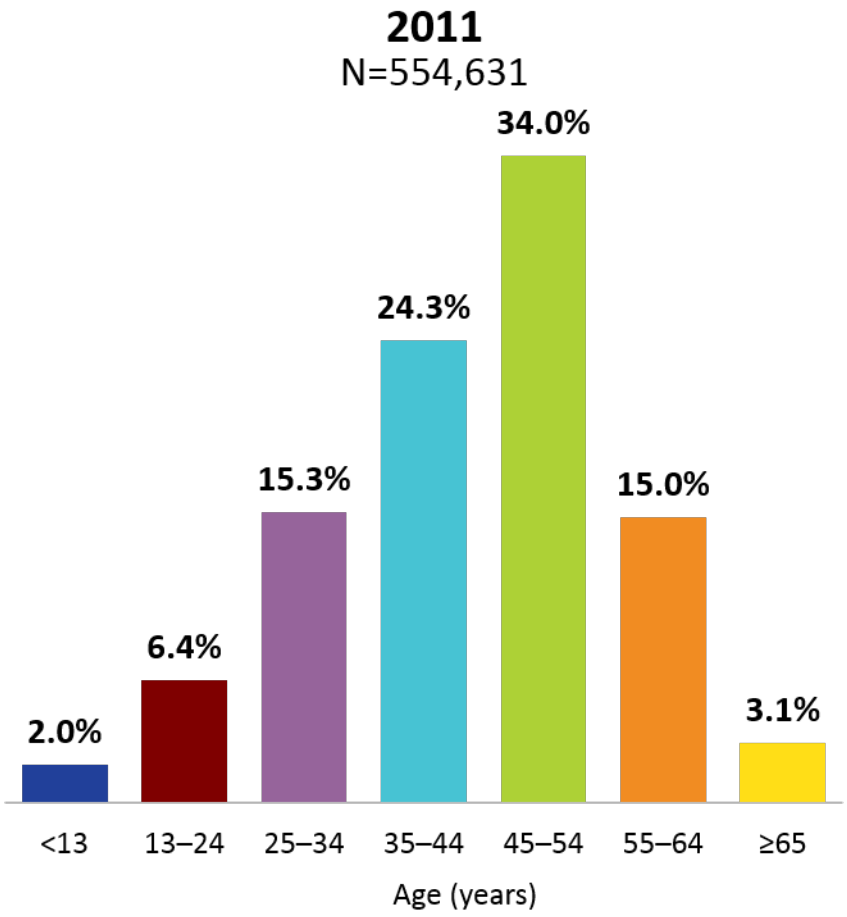
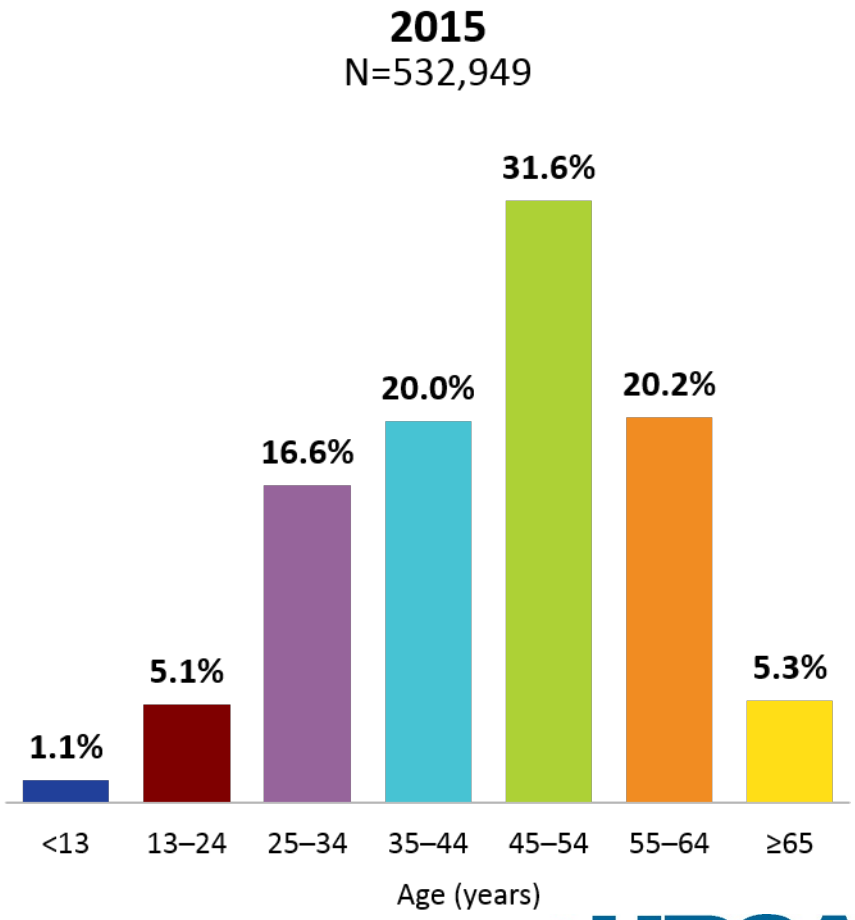
Clients Served by the Ryan White HIV/AIDS Program by Age Group, 2011 to 2015—United States and 3 Territories[a]





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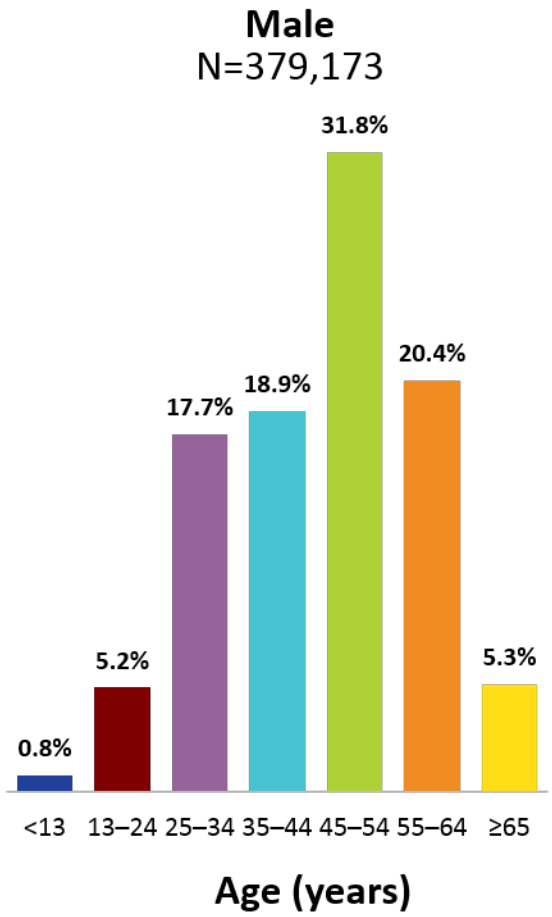
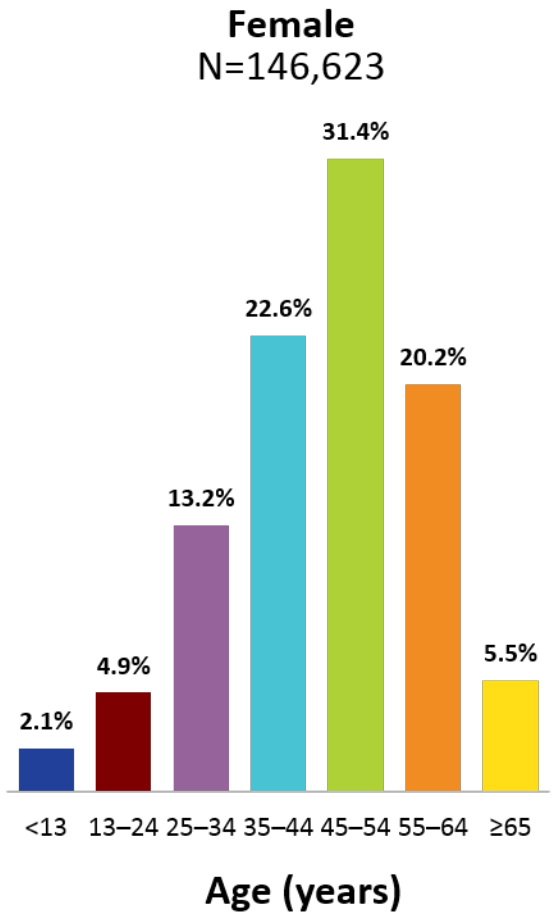
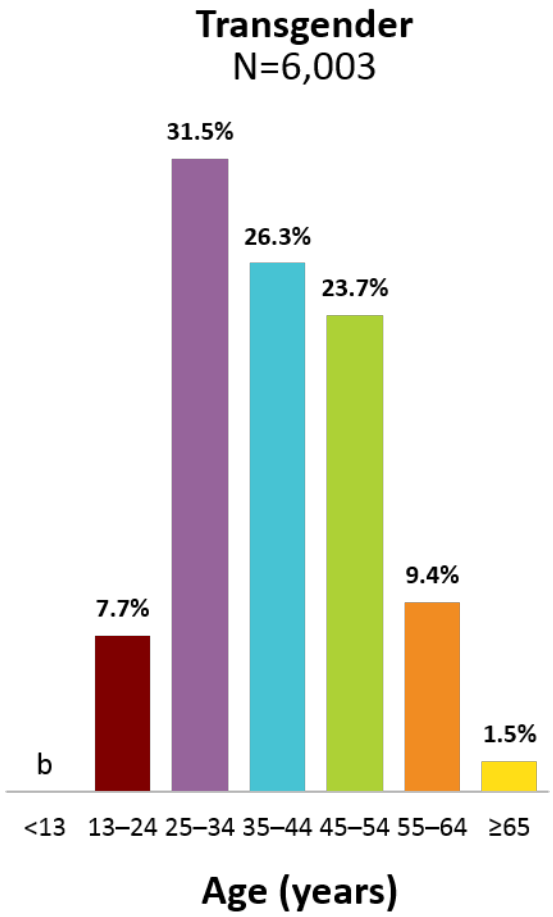
Clients Served by the Ryan White HIV/AIDS Program by Gender and Age Group, 2015—United States and 3 Territories[a]







[a] Guam, Puerto Rico, and the U.S. Virgin Islands.
[b] To ensure confidentiality, data have been suppressed.

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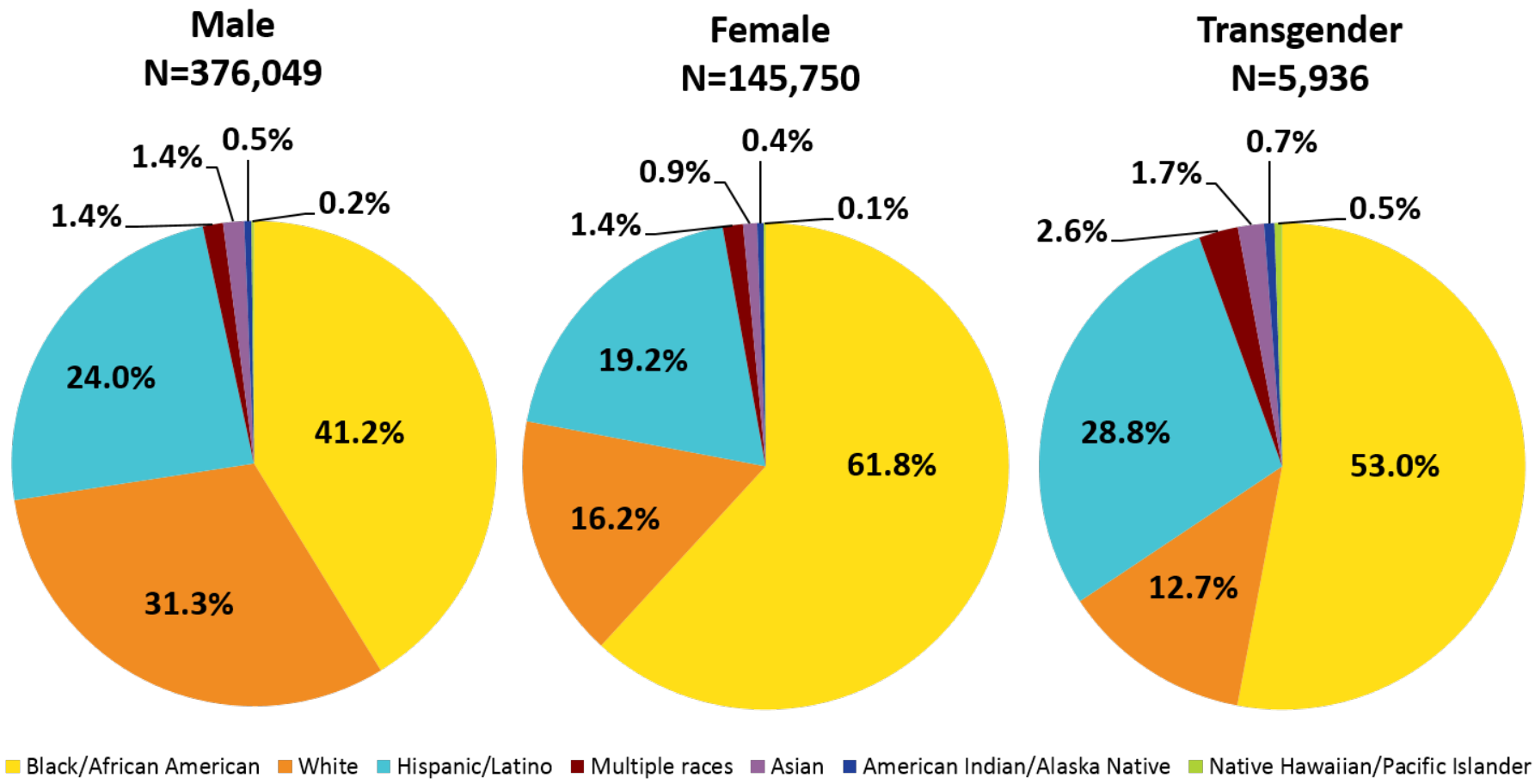
Clients Served by the Ryan White HIV/AIDS Program by Gender and Race/Ethnicity, 2015—United States and 3 Territories[a]



Hispanics/Latinos can be of any race.

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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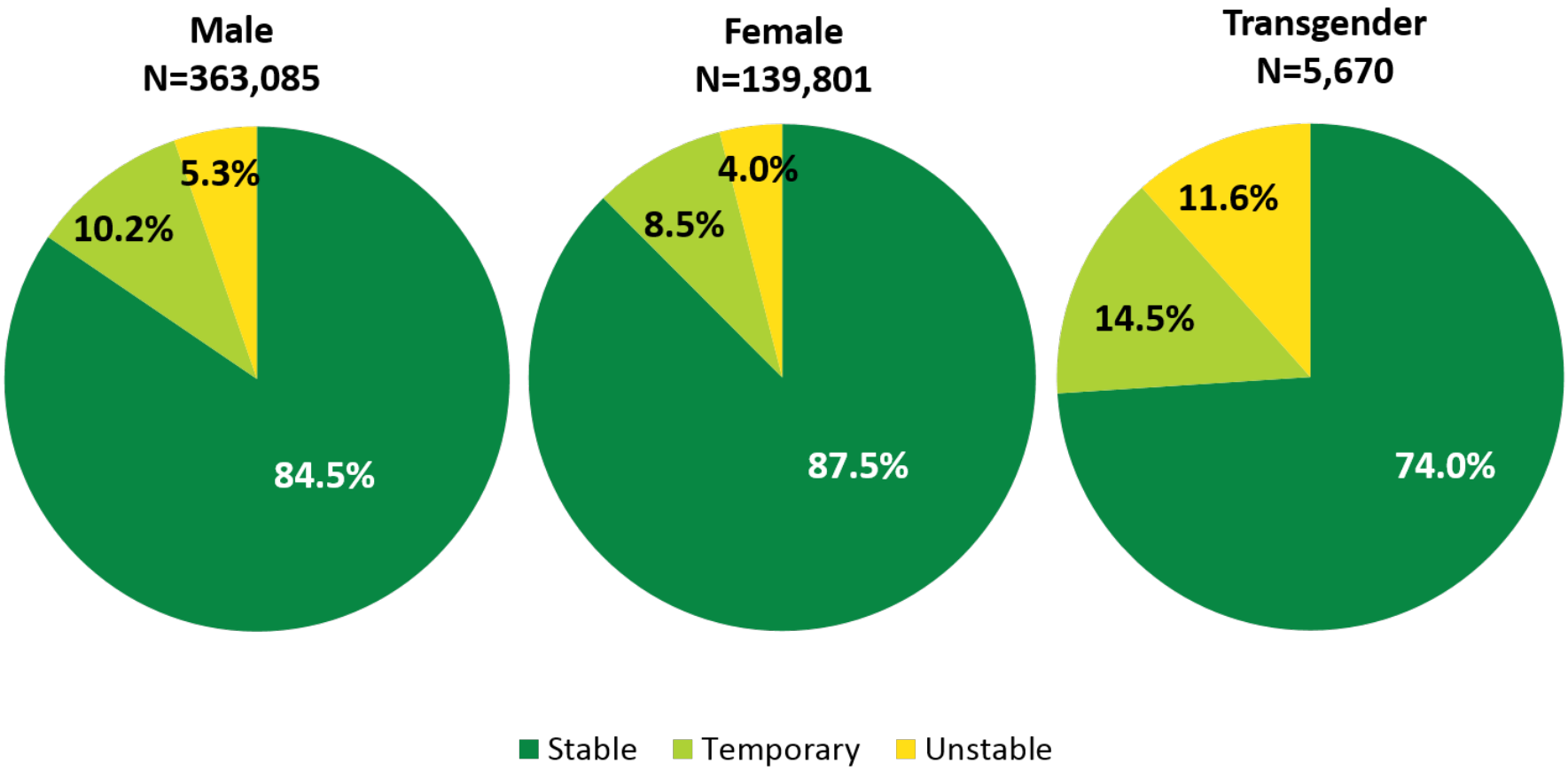
Clients Served by the Ryan White HIV/AIDS Program by Gender and Housing Status, 2015—United States and 3 Territories[a]



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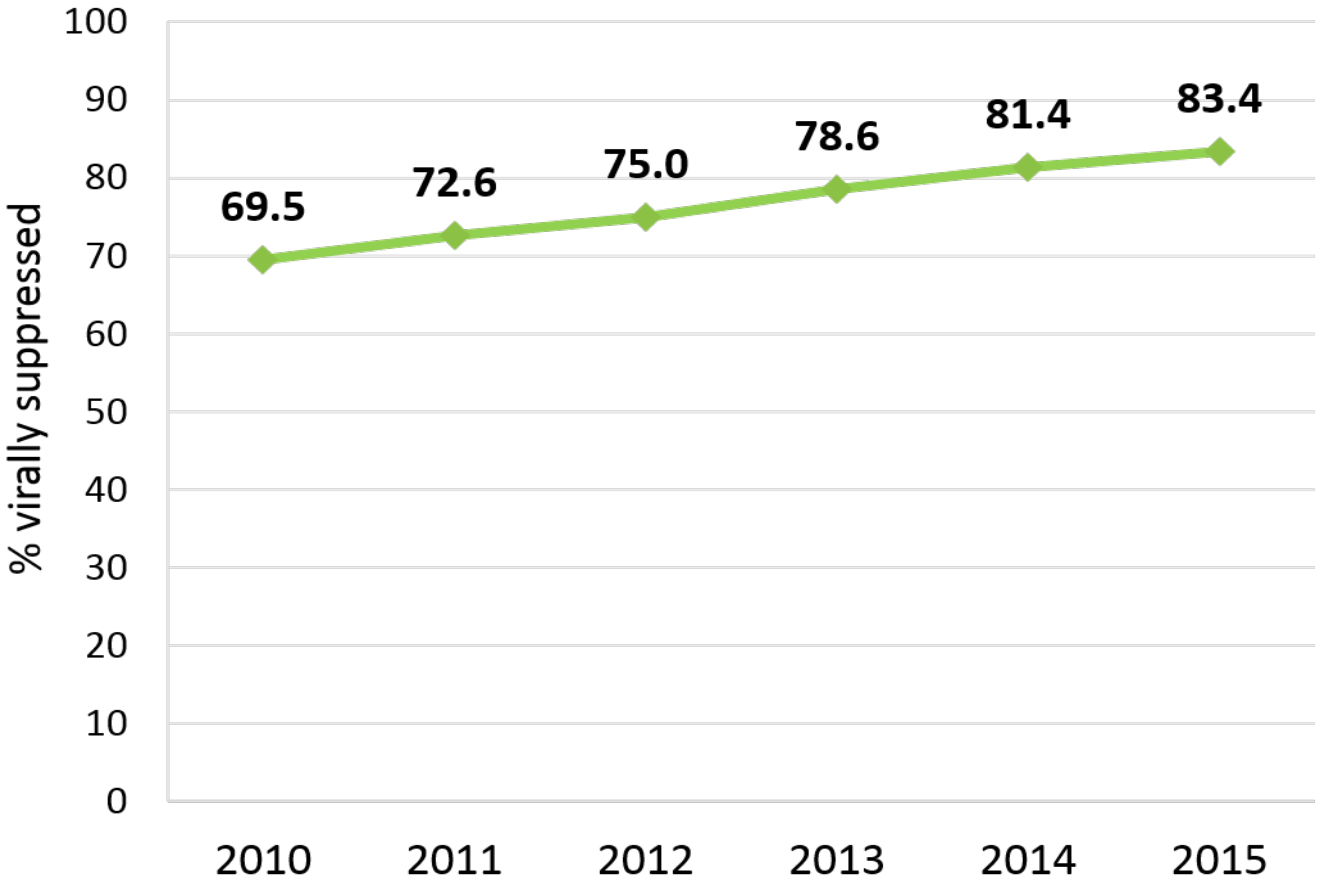
Measuring outcomes

Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, 2010–2015—United States and 3 Territories[a]



Viral suppression: ≥1 outpatient/ambulatory medical care visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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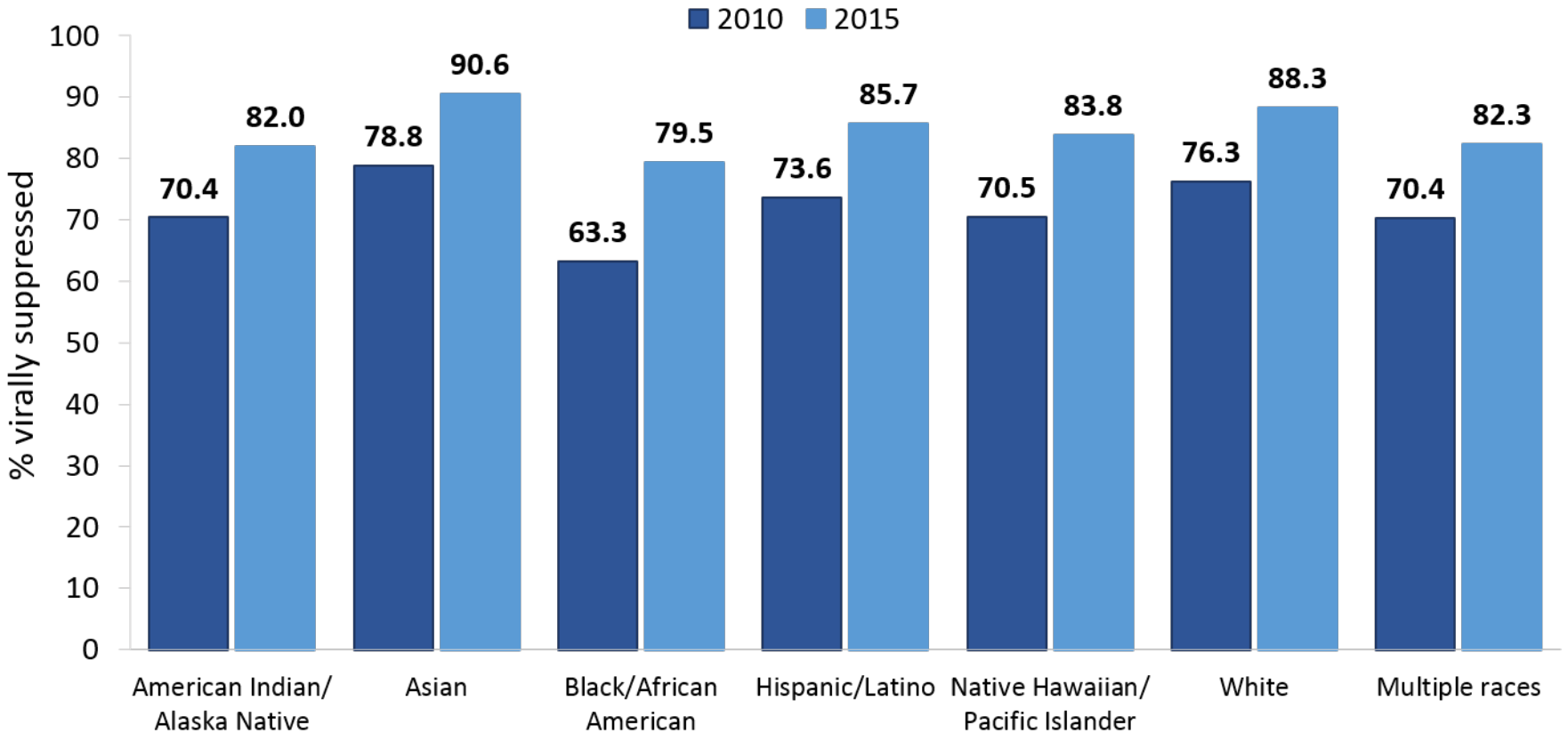
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by Race/Ethnicity, 2010–2015—United States and 3 Territories[a]



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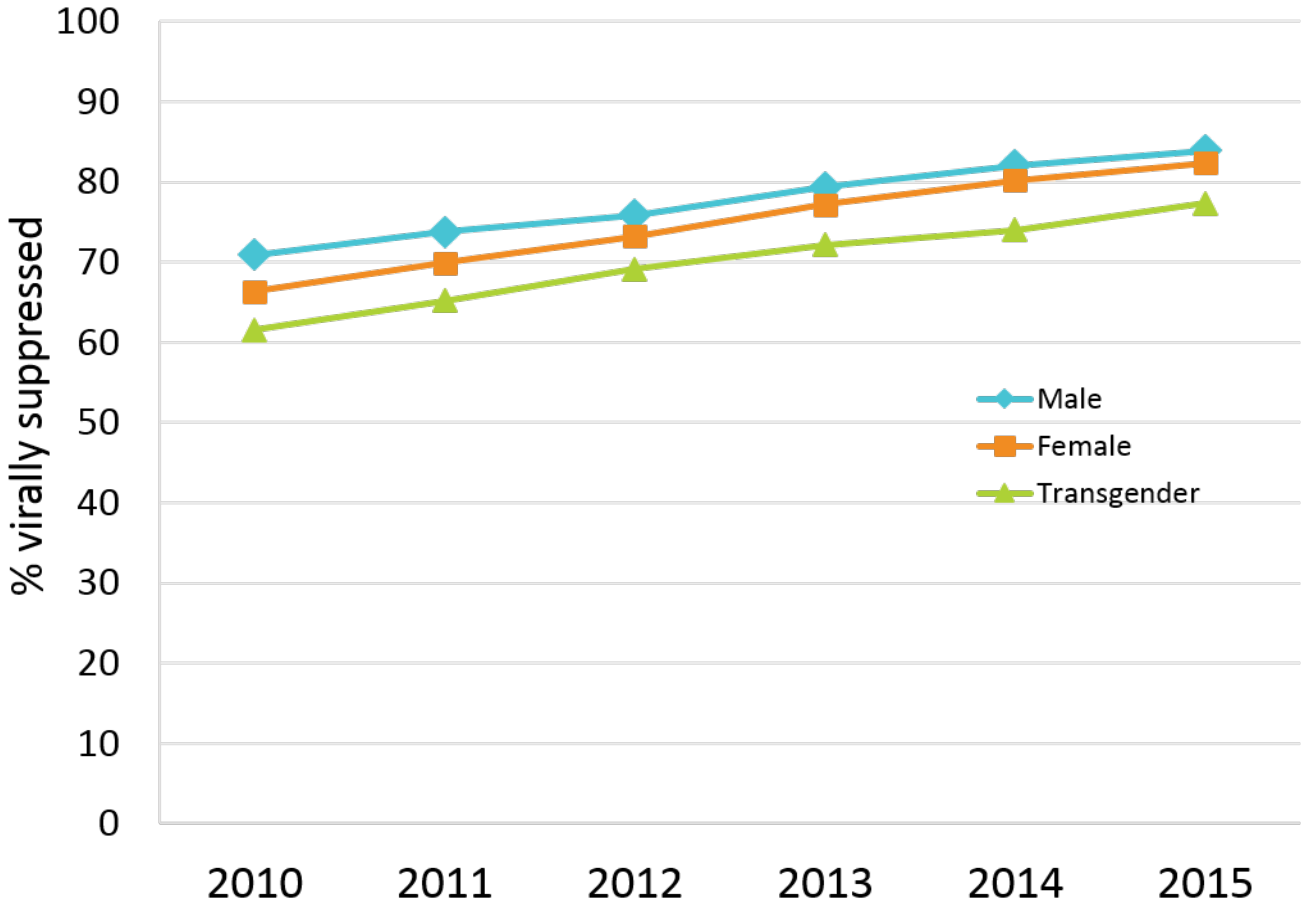

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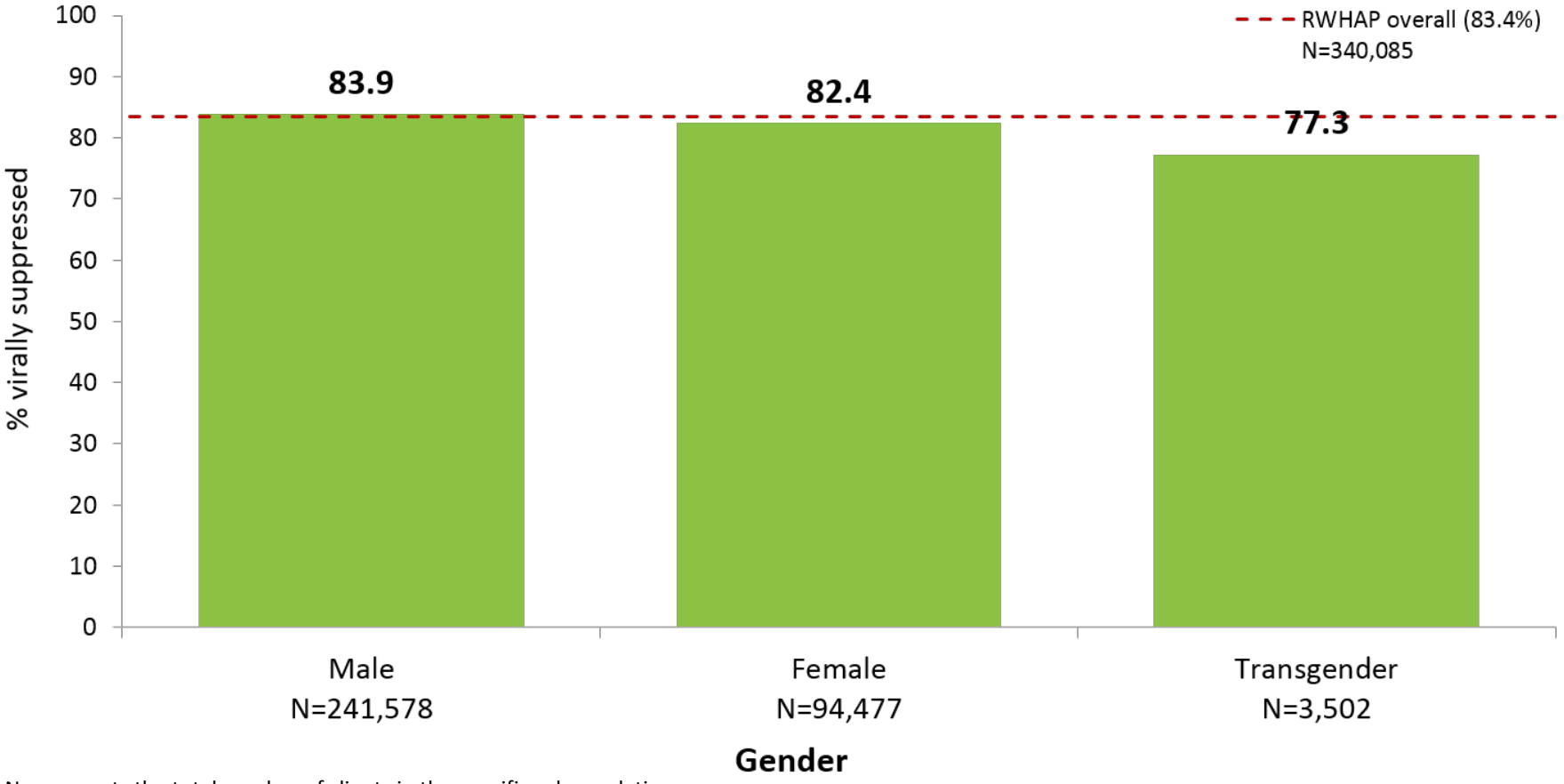

N represents the total number of clients in the specific subpopulation.

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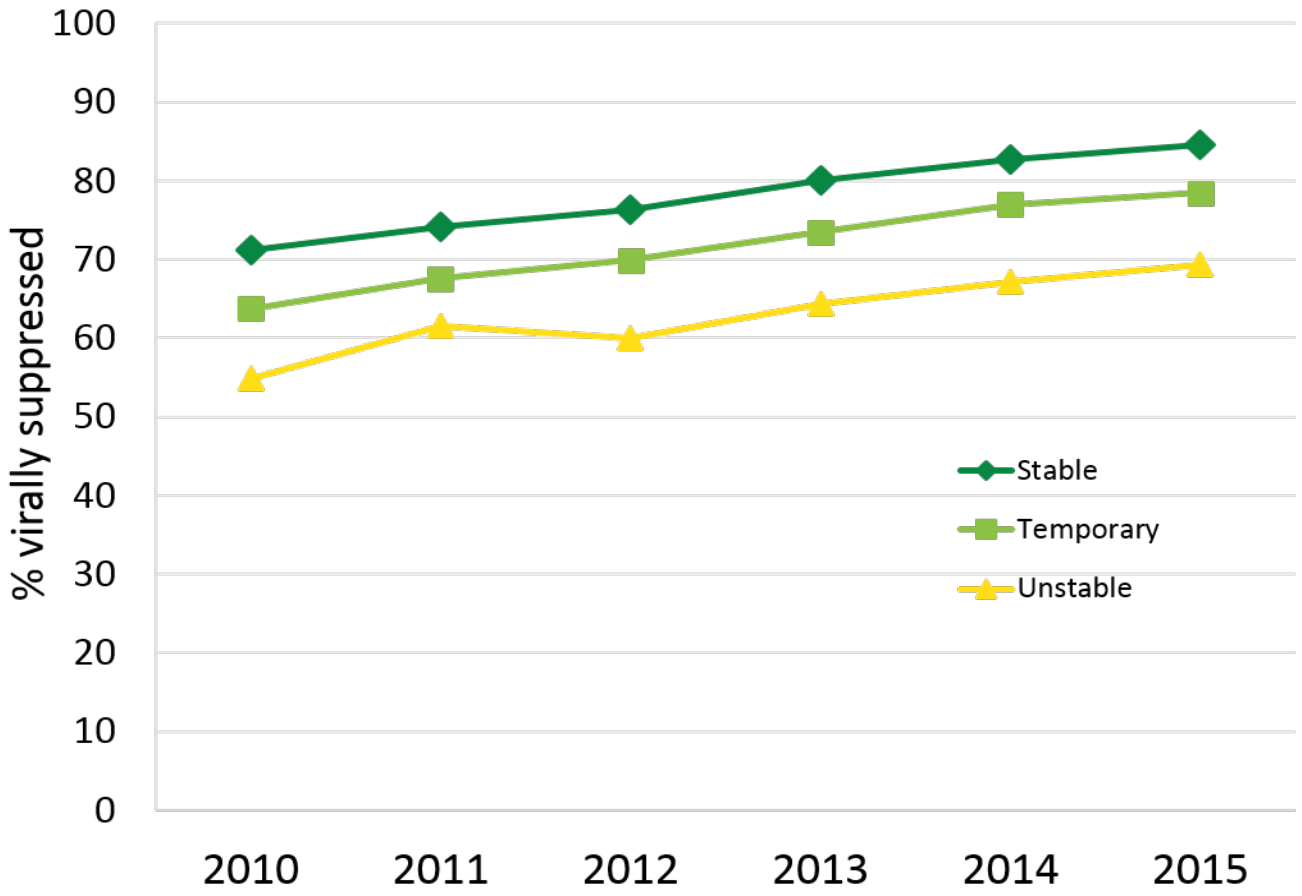
Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by Housing Status, 2010–2015—United States and 3 Territories[a]



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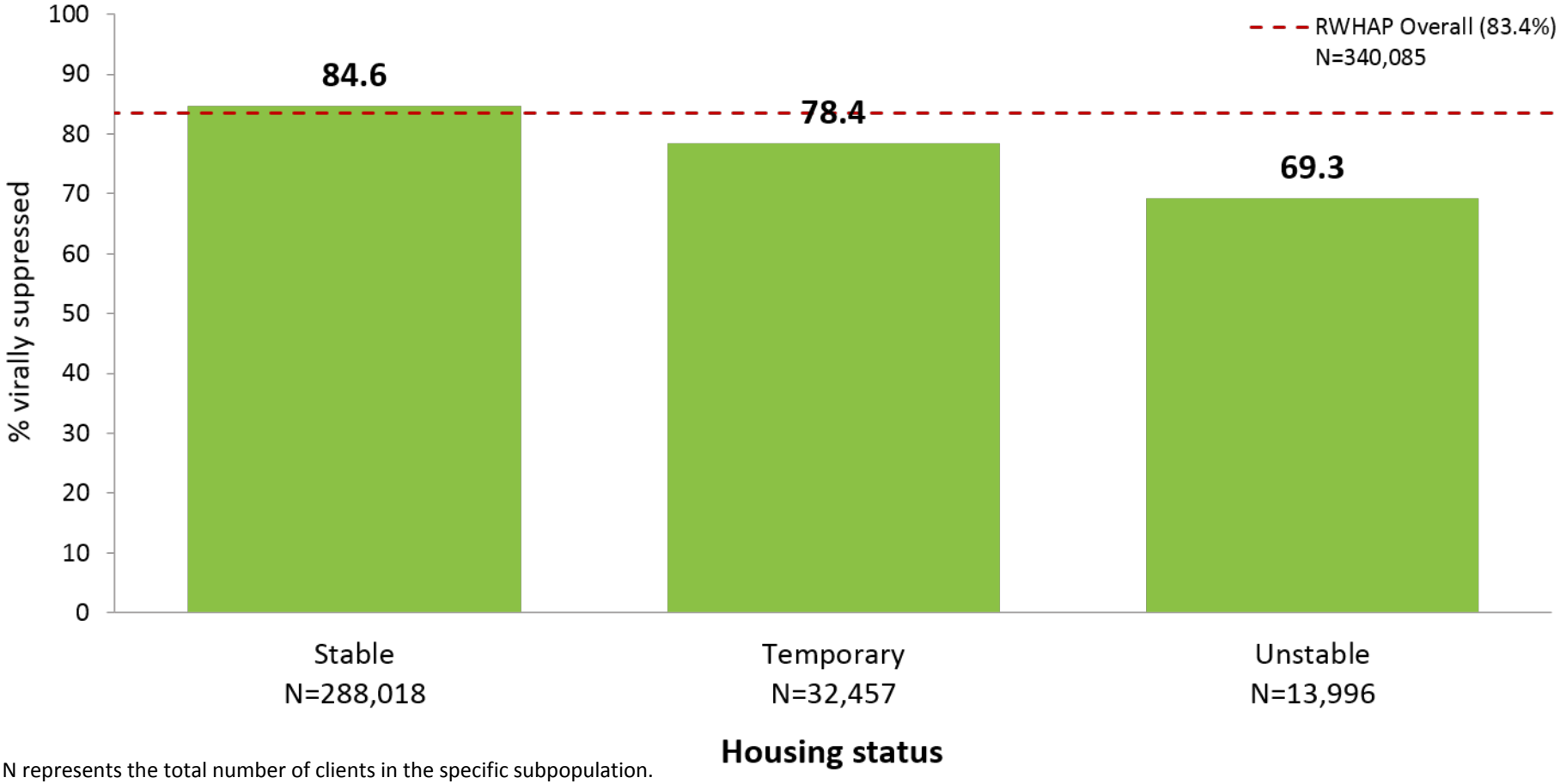

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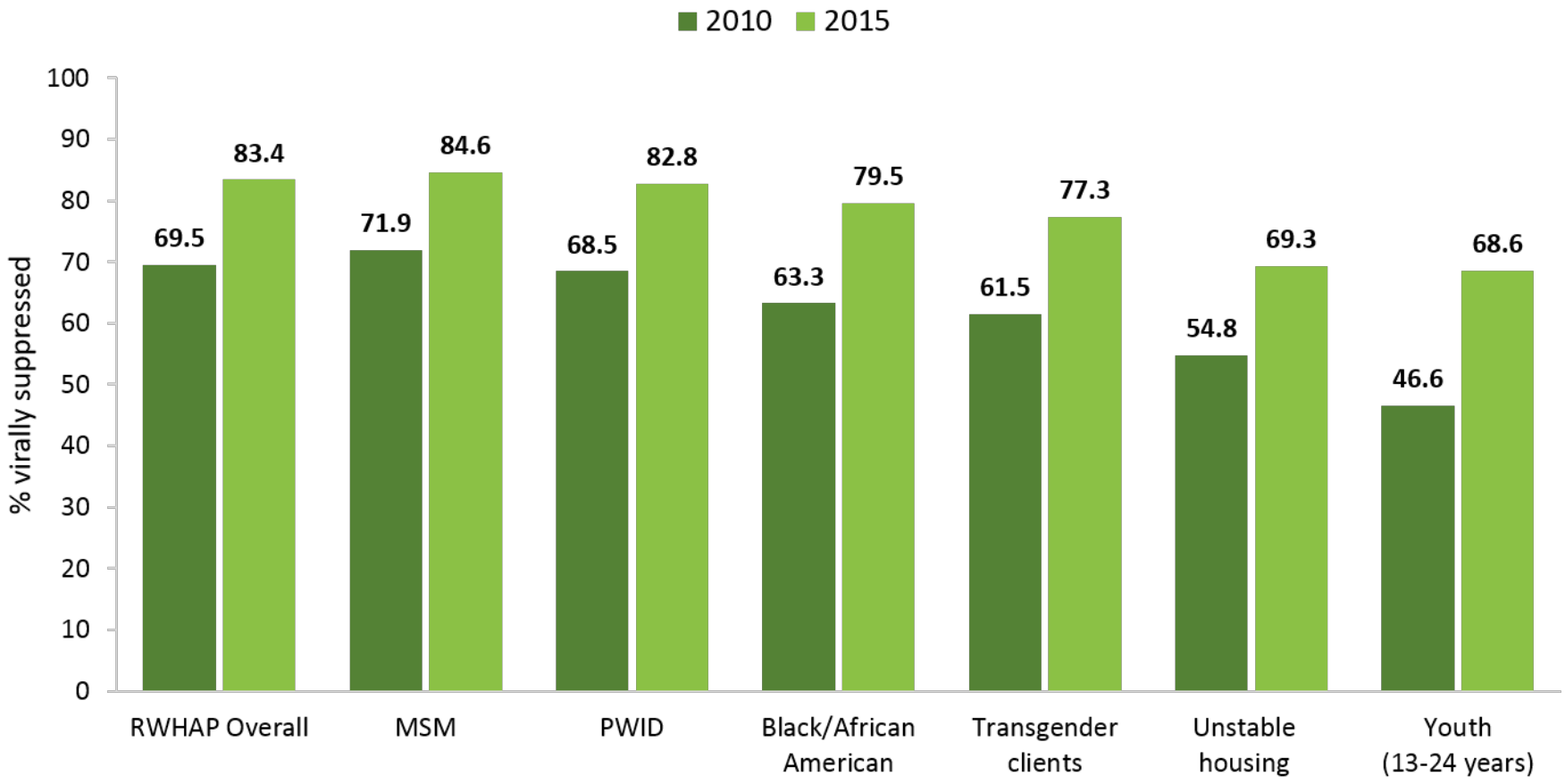
Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010–2015—United States and 3 Territories[a]



Viral suppression: ≥1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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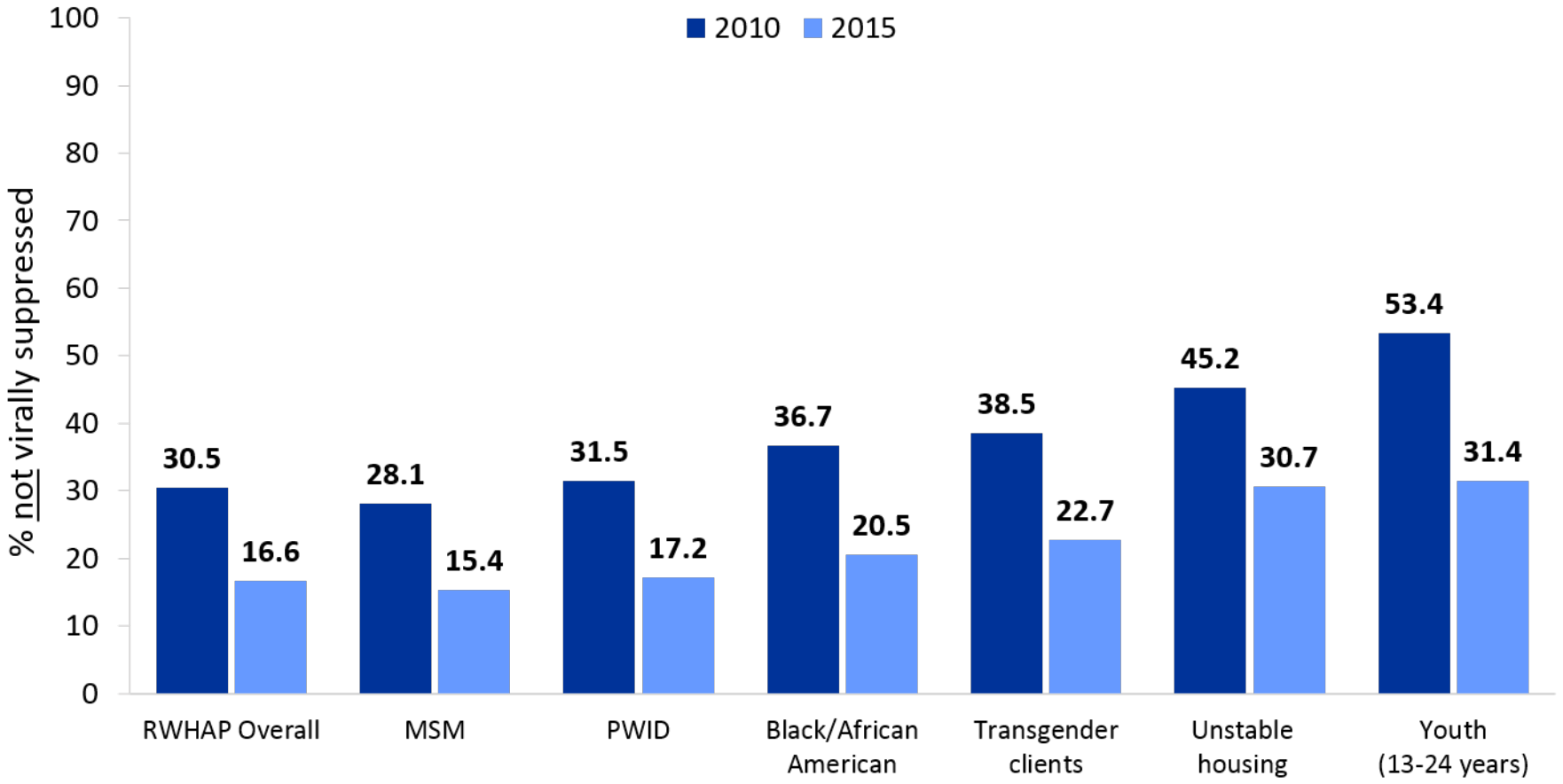
Detectable Viral Load among Key Populations Served by the Ryan White HIV/AIDS Program, 2010–2015—United States and 3 Territories[a]



Viral suppression: ≥1 OAMC visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

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Using data to address gaps and disparities

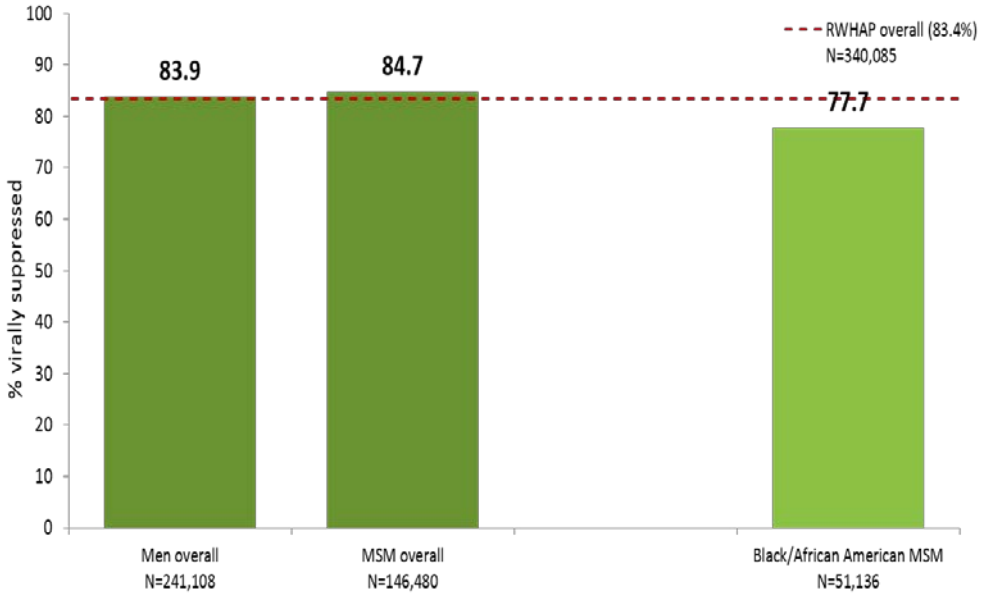
Implementing Solutions
Identifying New Approaches to Improve Health Outcomes

Implementing Solutions: Improving Health Outcomes Among Black MSM

Center for Engaging Black MSM Across the Care Continuum

His Health (www.HisHealth.org) and Well Versed www.WellVersed.org) websites launched Fall 2016

Viral Suppression among Men who have Sex with Men (MSM) Served by the Ryan White HIV/AIDS Program, 2015—United States and 3 Territories[a]



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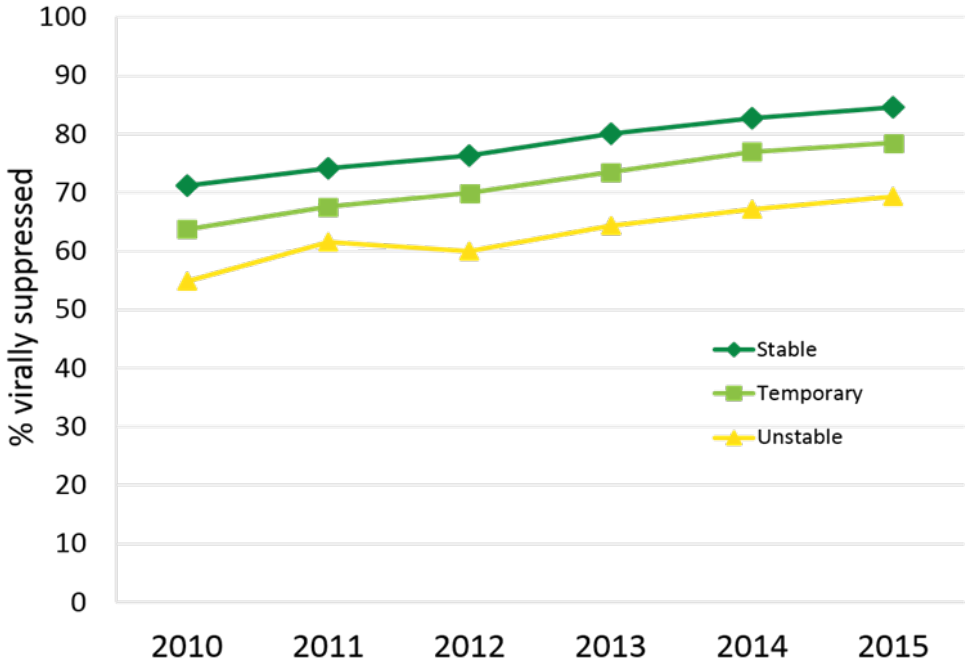
Source: HRSA. Ryan White HIV/AIDS Program Services Report (RSR) 2015. Does not include AIDS Drug Assistance Program data.

Implementing Solutions: Focusing on Housing and Employment

- **HIV Care & Housing – Using Data Integration to improve Health Outcomes along HIV Care Continuum**
- **Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services**

Viral Suppression among Clients Served by the Ryan White HIV/AIDS Program, by Housing Status, 2010–2015—United States and 3 Territories[a]



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Identifying New Approaches to Improve Health Outcomes

- **Building Futures for Youth Living with HIV (evaluation study)**
  - Use data to assess the current state of youth living with HIV aged 13-24 receiving RWHAP-funded care.
  - Identify best practices to improve care and treatment for youth living with HIV
    - Overcome barriers to care, fill gaps in care, optimize health outcomes
  - Develop and provide technical assistance for youth-serving RWHAP providers

Identifying New Approaches to Improve Health Outcomes (continued)

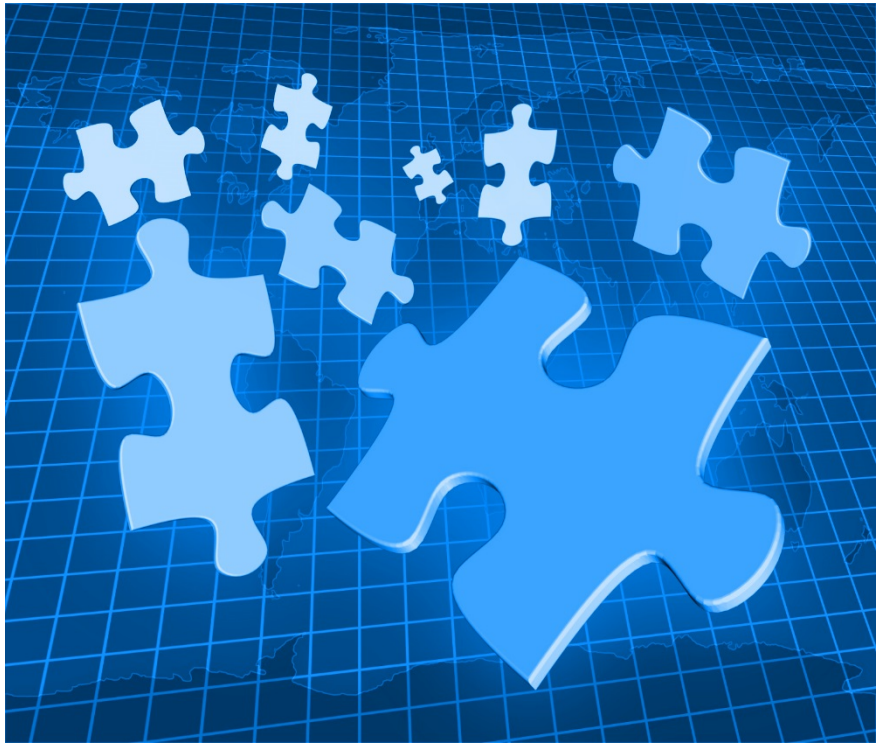
- **Implementation Center for HIV Clinical Quality Improvement**
  - Provide training and technical assistance to recipients aimed at improving patient health outcomes

- **Assessing client factors with detectable viral load (evaluation study)**
  - Identify differences between PLWH who are virally suppressed and those who are not
  - Identify new strategies to achieve improved viral suppression

Identifying New Approaches to Improve Health Outcomes (continued)

- **Dissemination of Evidence-Informed Interventions to Improve Health Outcomes Along the HIV Care Continuum**
  - Four evidence-informed care and treatment interventions for linkage and retention
  - Based on evidence informed interventions: Jail, Outreach, Buprenorphine, and Re-Engagement and Retention initiatives

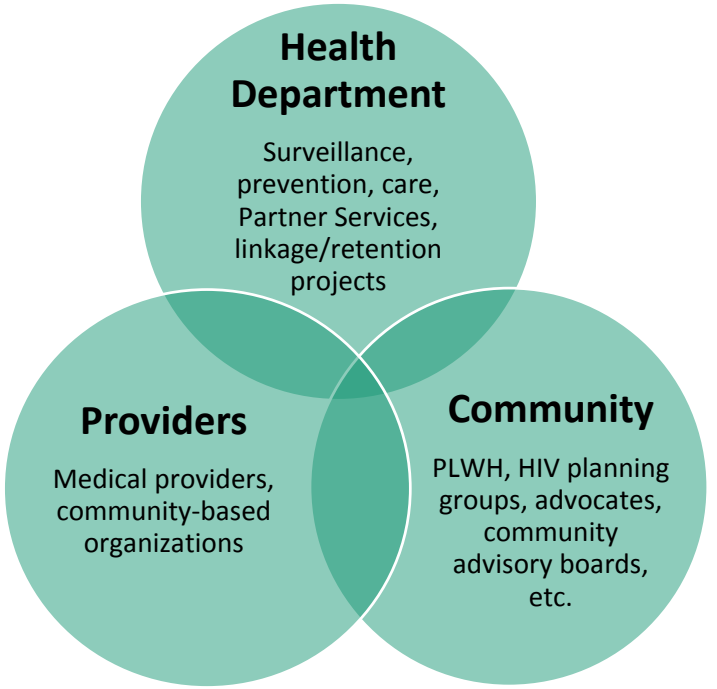
- **Using Evidence Informed Interventions to Improve Health Outcomes among People Living with HIV**
  - Improving HIV health outcomes for transgender women and black men who have sex with men
  - Integrating behavioral health with primary medical care for people living with HIV
  - Identifying and addressing trauma among people living with HIV



Using data at the local level

Important Pieces of Data to Care

- **Collaboration!**
  - HIV surveillance and prevention
  - STD surveillance and prevention
  - Disease intervention specialists (DIS)
  - Other agencies/providers
  - State Medicaid
  - Prison and jail system
  - Shelters
- **Leverage various data systems to ensure most comprehensive information**
  - May require data sharing agreements and ethical review
- **Improved data quality**



CDC. Data to care technical assistance tools, Engaging providers in data to care.

State perspective

Washington State

Data to Care: Utilizing Data in Washington State

Richard Aleshire and Ariel VanZandt
Washington State Department of Health
2017 RWHAP Part B Administrative Reverse Site Visit
August 30, 2017

Washington State Department of Health

The Office of Infectious Disease

- 4 Programs
  - Assessment Unit (HIV, STD, Viral Hepatitis, TB)
  - Infectious Disease Prevention Section (HIV, STD, Viral Hepatitis)
  - HIV Care (Ryan White HIV/AIDS Program Part B)
  - TB
- 72 staff (including 6 field staff)
- 1 Floor

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Acronyms

- ADAP – AIDS Drug Assistance Program
- CMS - Centers for Medicare and Medicaid Services
- D2C – Data to Care
- DOH – Washington State Department of Health
- eHARS – enhanced HIV/AIDS Reporting System
- EiC – Engagement in Care
- EIP – Early Intervention Program (Washington's ADAP)
- HCA – Washington State Health Care Authority (Washington's Medicaid program)
- LOOC – Locating Out of Care
- MAI – Minority AIDS Initiative
- MMP – Medical Monitoring Project
- MTM – Medication Therapy Management
- WDRS – Washington Disease Reporting System

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Systems

1. eHARS
2. Accurint
3. Lab Tracker
4. PHIMS
5. Out of State Surveillance
6. EIP - ADAP
7. Provide
8. CAREWare
9. LOOC
10. Ramsell
11. Local Electronic Medical Records (EMR)
12. Evaluation Web
13. Local Systems
14. WDRS*

*Coming soon

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WA Data to Care

- The first official D2C project began in 2012 when WA received Category C funding.
- The Locating Out of Care (LOOC) project found:
  - Most (47%) were actually in care
  - Many (36%) had moved out of WA
  - 10% Not located
  - <5% were actually out of care

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Next Steps

- Integration of Care and Prevention teams
  - Strengthen connection between Disease Intervention Specialists (DIS) and Case Managers (CM)
- Development of joint Prevention and Care contracts
  - Provide services to People at High Risk (PAHR) & People Living with HIV (PLWH)
- Establish Engagement in Care (EiC) Group
- CAREWare for PAHR
- Find new data sources
  - Medicaid

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EiC Workgroup

- Includes staff from Assessment, Care, and Prevention
- Meets 2-3 times per month
- Mapping out all projects that focus on engagement in care
  - MMP, MAI, VL Project, MTM, LOOC, EvalWeb, CMS
- Establish office-wide standards
- Define terms

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What We Found

- 7 D2C projects currently happening
  - Medical Monitoring Project (MMP)
  - Minority AIDS Initiative (MAI)
  - Viral Load (VL) Project
  - Medication Therapy Management (MTM)
  - Locating Out of Care (LOOC)
  - Evaluation Web
  - Centers for Medicare and Medicaid Services (CMS)
- Mapped out projects to find overlaps

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Current Projects - Populations

- MMP
  - All HIV positive patients who have been reported to WA
- MAI
  - Black/African Americans and Hispanic/Latinos
  - New HIV or Old HIV with new STD
- VL Project
  - Clients in CAREWare who are virally unsuppressed
  - No successful contact in previous 4 months
- MTM
  - EIP clients who: have not filled an rx and/or are unsuppressed or no VL reported
- LOOC
  - No HIV-related lab in eHARS within a 15 month timeframe
- EvalWeb
  - Patients with a preliminary positive HIV test reported to EW
- CMS
  - EIP clients who are also on Medicare/Medicaid

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Current Projects - Goals

- MMP
  - Learn more about the experiences and needs of PLWH including barriers to care and met and unmet needs
- MAI
  - Increase HIV dx and linkage to medical care and support services for target minority populations
- VL Project
  - Via case note review, identify clients who are at risk for being out of care
- MTM
  - Find out why clients aren't filling their rx and refer to CMs if help needed to remove barriers
- LOOC
  - Find and relink patients who are out of care
- EvalWeb
  - Get newly HIV positive patients linked to medical care
- CMS
  - Get up-to-date address data

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Commonalities

- Determination of care status
  - Initial Linkage
  - Retention
  - Re-linkage
  - Viral Suppression
- Improve data quality
- Roadblocks

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Affinity Workgroup

- DOH will use Health Care Authority (HCA – WA's Medicaid agency) data to identify Medicaid clients with HIV and additionally learn those who are not virally suppressed
- DOH case managers (or HCA's Care Coordinators) work with clients to remove barriers to accessing HIV care so that they can reach viral suppression

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HCA – DOH Workflow

- HCA provides list of names of all PLWH on Medicaid (3,400)
- DOH matches names to eHARS and analyzes data
- DOH creates CARE Cascade of Medicaid clients and sends this to Medicaid
- DOH can also identify which Managed Care Organization (MCO) has a better CARE Cascade than others
- DOH MCMs and HCA Care Coordinators work with PLWH who are unsuppressed

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Washington State Next Steps

- EiC Group – Grand Rounds?
- Addressing “marginal care”
- Finding new resources
- Discovering trends
- Figure out definitions
  - Retention
  - Marginal Care
  - Out of Care
  - Engagement
  - Re-investigation
- WDRS

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Of Note…

- Team effort
- Integration of Assessment, Care and Prevention teams
  - Strengthens connection between DIS and CM
- Partner with outside agencies
- Results take time – Be patient
- Remember: The point of data collection is to use it!

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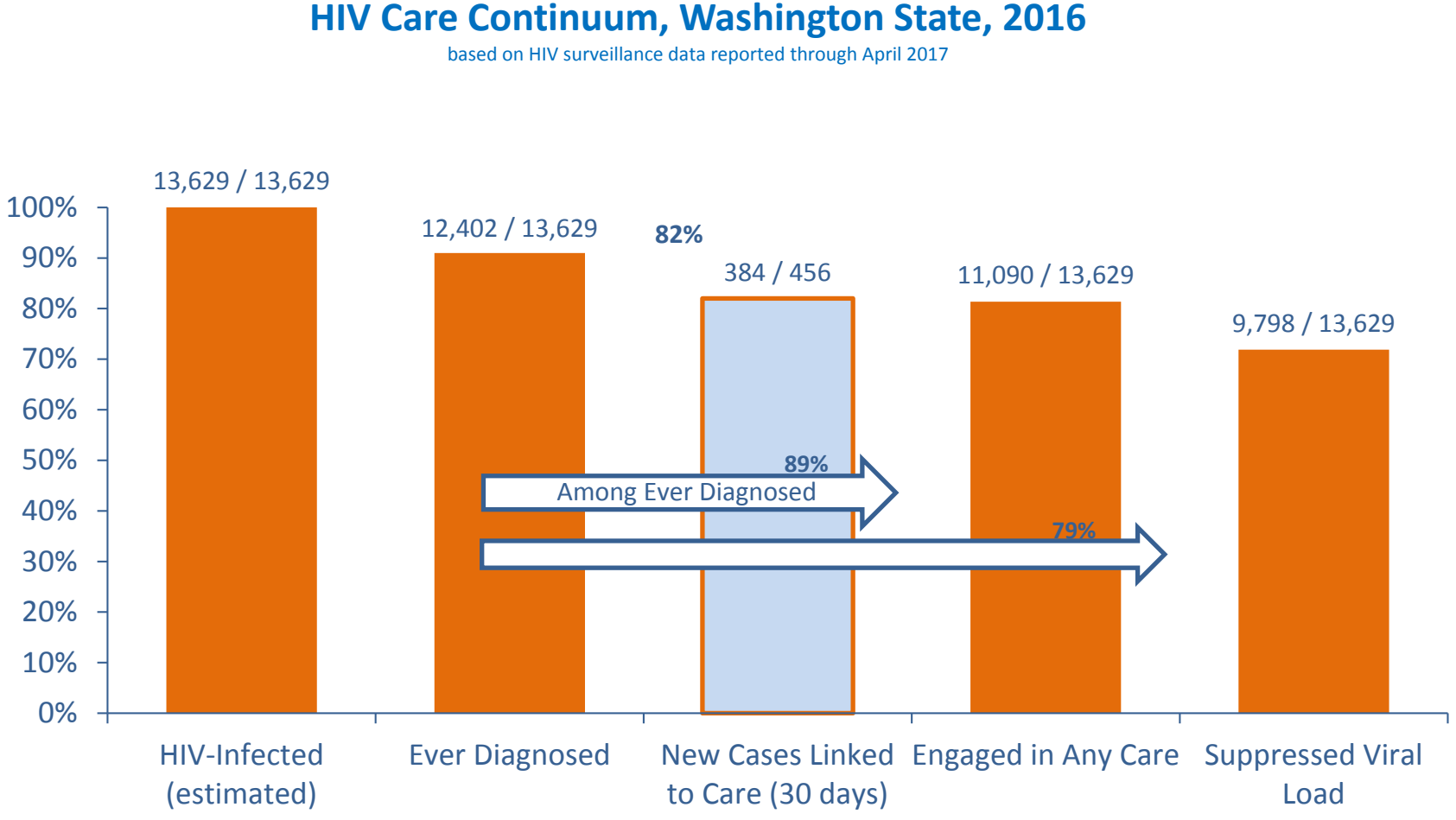
Washington State HIV Care Continuum



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Thank you

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Interactive session

Group Discussion

Share successes, challenges, tips, and lessons learned about:

- Data sharing agreements
- Innovative data resources
- Partnerships

Using Data at the Local Level

- Reviewing and interpreting data to best target resources
- Ensuring goals, strategies, activities are responsive to data
- Data Exercise

Reviewing and Interpreting Data to Best Target Resources

- **Most affected communities**
  - Geographic areas or populations with
    - Highest numbers or rates of diagnoses
    - Highest prevalence numbers or rates
    - Increasing numbers or rates of diagnoses over time
    - Lowest percentages of people at various steps along the care continuum (e.g., linkage, retention, ART, viral suppression)
    - High levels of comorbidity
  - Geographic “hot spots” for recent diagnoses and/or unusual trends
  - Populations with the highest levels of risk behaviors

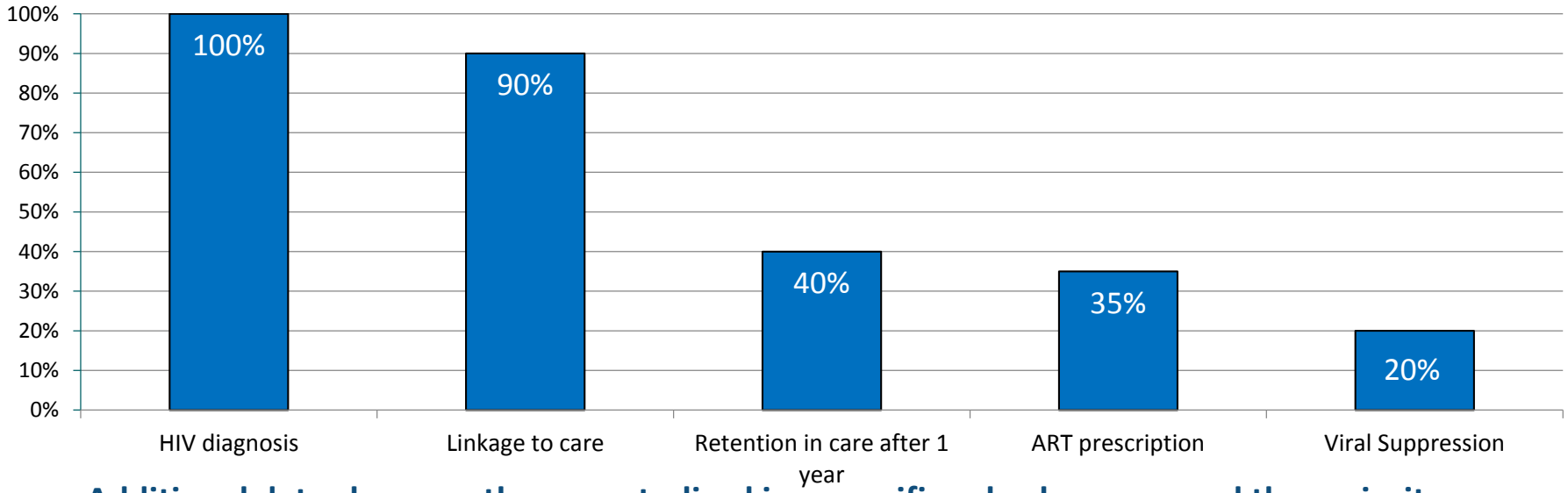
Ensuring Goals, Strategies, Activities are Responsive to the Data

1. **Assess trends**
   - More data may be needed to explain unexpected trends
2. **Focus on most affected communities**
3. **Ensure strategies and activities culturally appropriate**
4. **Engage most affected communities to inform decisions and assist with implementation**
5. **Engage care providers**

Example: Jurisdiction 123
Analyzing Data

Finding: Unusually high rates of new diagnoses among Latinos

- Further analysis reveals majority of new diagnoses in this population are among males aged 16-21
- Care continuum for male Latino youth in Jurisdiction 123:



- Additional data show youth are centralized in a specific suburban area and the majority received testing and linkage services by the same entity

How can these data be used to target resources?

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Example: Jurisdiction 123
Reviewing & Interpreting Data to Target Resources

1. Specific population affected
2. Specific cultural considerations
3. Specific geographic area
4. Same entity conducted testing and linkage
5. Same provider conducting care (?)

Example: Jurisdiction 123
Ensure Data-Responsive Goals, Strategies, Activities

- **Newly HIV-diagnosed youth**

Example: Jurisdiction 123
Ensure Data-Responsive Goals, Strategies, Activities

- **Newly HIV-diagnosed youth**
  - Culturally appropriate interventions
  - Care re-engagement activities/Peer navigation
  - Linkage to core medical and supportive services (e.g., case management, mental health services, substance use treatment, transportation)
  - Partner services to identify transmission networks
  - Additional testing for comorbidities (e.g., HCV, STDs)
  - Education about care and treatment
  - HIV "prevention with positives" activities
  - Activities to identify and address barriers to care
    - Gather qualitative data directly from youth regarding falling out of care, ART non-adherence, etc.
    - Access to care: density of care providers within a reasonable distance; expertise of care providers; types of services available; etc.

Example: Jurisdiction 123
Ensure Data-Responsive Goals, Strategies, Activities

- **Community**

Example: Jurisdiction 123
Ensure Data-Responsive Goals, Strategies, Activities

- **Community**
  - Culturally appropriate interventions
  - HIV prevention and education activities
  - PrEP
  - Using peers for outreach and testing activities
  - Partner services
  - Routine HIV/HCV/STD testing, as indicated
  - Linkage to essential services, if needed (e.g., mental health, substance use treatment)
  - Activities to identify and address barriers
    - Community-level indicators, including the social and political landscapes, poverty, stigma, and other factors that might be pertinent

Example: Jurisdiction 123
Identify Technical Assistance Needs

- Testing/Linkage Entity

Example: Jurisdiction 123
Identify Technical Assistance Needs

- **Testing/Linkage Entity**

  Assess and address:

  - Gaps in knowledge, skills, abilities of testing and linkage specialists
  - "Care landscape"
    - Reaching people where they are (linkage specialists, peer navigators)
    - Ability to link clients to culturally appropriate care
    - Density of care providers within a reasonable distance
    - Expertise of community care providers
    - Types of medical and support services available

Example: Jurisdiction 123
Identify Technical Assistance Needs

- Care Providers

Example: Jurisdiction 123
Identify Technical Assistance Needs

- **Care Providers**

  Assess and address:

  - Gaps in knowledge, skills, abilities
  - Ability to provide culturally appropriate care
  - Attitudes toward clients

Resources

Resource List

- **Ryan White HIV/AIDS Program Annual Client-Level Data Report:** National- and state-level data on all clients served by RWHAP, including select indicators of the care continuum https://hab.hrsa.gov/data/data-reports
- **Ryan White HIV/AIDS Program Resources for Delivery of HIV Care** https://hab.hrsa.gov/clinical-quality-management
- **AIDS Education and Training Centers (AETC): Multidisciplinary** education and training programs for health care providers treating PLWH https://aidsetc.org/
- **TARGET Center** Technical Assistance resources for programs to better serve people living with HIV https://careacttarget.org/

HRSA
Ryan White & Global HIV/AIDS Programs

Resource List, *continued*

- ***Integrated Guidance for Developing Epidemiologic Profiles: HIV Prevention and Ryan White HIV/AIDS Programs Planning, July 2014***

  http://www.cdc.gov/hiv/pdf/guidelines_developing_epidemiologic_profiles.pdf

  - SAS programs for developing the Epi Profiles (contact CDC's HIV Incidence and Case Surveillance Branch)

- **Epidemiologic Overview and HIV Care Continuum components of Section One of the Integrated HIV Prevention and Care Plan, including the SCSN Guidance, June 2015**

  http://hab.hrsa.gov/manageyourgrant/hivpreventionplan062015.pdf

- **Guidance for developing an HIV care continuum (contact CDC's HIV Incidence and Case Surveillance Branch)**
- **Capacity building assistance (CDC)/Technical assistance (HRSA)**
- **CDC HIV reports, slide sets, fact sheets**

  http://www.cdc.gov/hiv/library/index.html

Thank you

Stacy Cohen
HIV/AIDS Bureau
sgagne@hrsa.gov

Pamela Klein
HIV/AIDS Bureau
pklein@hrsa.gov