Strengthening and Improving the HIV Care Continuum within Ryan White HIV/AIDS Program Part A Jurisdictions

2016 National Ryan White Conference on HIV Care and Treatment

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August, 2016

HRSA
Ryan White & Global HIV/AIDS Programs

Disclosures

- **Presenter(s) has no financial interest to disclose.**

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Workshop Learning Objectives

- Be able to apply the HIV care continuum framework to HIV prevention and care activities based on learning about various jurisdictional approaches.
- Give examples of specific HIV Care Continuum improvement domains that can be pursued within or across jurisdictions.
- Identify the approaches/techniques involved in a national learning collaborative model.

Obtaining CME/CE Credit

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HIV/AIDS Bureau 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.

HIV/AIDS Bureau Priorities

- **National HIV/AIDS Strategy (NHAS) 2020/ The US President's Emergency Plan for AIDS Relief 3.0 (PEPFAR) -** Maximize HRSA HAB expertise and resources to operationalize NHAS 2020 and PEPFAR 3.0
- **Leadership -** Enhance and lead national and international HIV care and treatment through evidence-informed innovations, policy development, health workforce development, and program implementation
- **Partnerships -** Enhance and develop strategic domestic and international partnerships internally and externally
- **Integration -** Integrate HIV prevention, care, and treatment in an evolving healthcare environment
- **Data Utilization -** Use data from program reporting systems, surveillance, modeling, and other programs, as well as results from evaluation and special projects efforts to target, prioritize, and improve policies, programs, and service delivery
- **Operations -** Strengthen HAB administrative and programmatic processes through Bureau-wide knowledge management, innovation, and collaboration

Purpose of the Cooperative Agreement

- In response to the 2015 NHAS, Goal 2: Increasing access to high quality HIV care and treatment and improving health outcomes.
- HRSA/HAB funded a national project engaging RWHAP Part A recipients in an interactive process to address the HIV epidemic in their respective jurisdictions using the HIV Care Continuum framework.
- 80% of RWHAP Part A recipients participated in the first phase to identify domains of interest:
  - Data Access and Coordination;
  - Using Data to Inform Evidenced-based/informed Approaches;
  - Identifying and Implementing Targeted Evidenced-based/informed Interventions;
  - Linkage to Care; and,
  - Affordable Care Act (ACA)-Related Changes to HIV Care Systems.

Goals of the Cooperative Agreement

- Affect positive outcomes along the HIV care continuum by providing guidance and technical assistance using a collaborative learning approach and rapid improvement principles and practices

- Apply data driven evidence based strategies for improving population level health outcomes

- Scale-up interventions to improve HIV outcomes by stimulating action across jurisdictions and among many partners

HHS HIV Common Indicators

Measure	Numerator	Denominator
HIV positivity	Number of HIV positive tests in the 12-month measurement period	Number of HIV tests conducted in the 12-month measurement period
Late HIV diagnosis	Number of persons with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12-month measurement period	Number of persons with an HIV diagnosis in the 12-month measurement period
Linkage to HIV Medical Care	Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis	Number of persons with an HIV diagnosis in 12-month measurement period
Retention in HIV Medical Care	Number of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequent 6 month period	Number of persons with an HIV diagnosis with at least one HIV medical care visit in the first 6 months of the 24-month measurement period
Antiretroviral Therapy (ART) Among Persons in HIV Medical Care	Number of persons with an HIV diagnosis who are prescribed ART in the 12-month measurement period	Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period
Viral Load Suppression Among Persons in HIV Medical Care	Number of persons with an HIV diagnosis with a viral load <200 copies/mL at last test in the 12–month measurement period	Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period

Unique and Critical Role of RWHAP Part A Jurisdictions

- Roughly 72% of People Living With HIV/AIDS (PLWH) in the 52 Part A jurisdictions
- Ever-changing epidemic, clinical & financial paradigm
- Not just a set of discrete services but a community-based system of care
- Public health focus, data-driven, responsive procurement
- HIV care continuum and evidence based/informed interventions
- NHAS has cited metropolitan areas and the Southern region as the key focal points for reducing new infections.

Why a Learning Collaborative?

- Recipients learn from each other and from experts
- Reliance on distance technology to grow and sustain "cyber teams" of self-selected individuals
- Innovation fueled by frequent, non-hierarchical communication patterns
- Work patterns characterized by transparency and openness to contributions from all participants
- The majority of the work of the Care Continuum Learning Collaborative (CCLC) occurs through the highly-interactive Accelerating Change Through Interactive Online Networks (ACTION) Portal created for this initiative

Implementation Overview and Process

- **First step in domain identification**
  - Abt and Associates reviewed all RWHAP Part A FY 2016 applications and summarized systematic approaches to address gaps in the HIV Continuum of Care (Section 1) as well as the abstracted HIV Care Continuum narratives (Section 2).

- **National Executive Steering Committee – initial and ongoing input**

CCLC Domain Selection Progress

- Identification of Possible Domains
- Refine Domains
- LC Selection

- Virtual Introductory Meetings
- Online Commentary and Response
- Recipients' Selection of LC Domains
- Initiate Virtual LC

Progress Leading to Domain Identification

- 8 regional conference calls held
- 42/52 RWHAP Part A jurisdictions participated
- Synthesized and distilled with National Expert Steering Committee and on-line input
- 32 Part A jurisdictions have selected a critical domain to work on collaboratively with others
- Domain-specific readiness survey sent to each jurisdiction
- What are the domains……??????

Identified Domains

- Data Access and Coordination
- Using Data to Inform the Need for, and Selection of Evidenced-based/informed Approaches
- Identifying and Implementing Targeted Evidenced-based/informed Interventions
- Linkage to Care
- ACA Implementation Changes to HIV Care Systems

Pilot

- **Launch Pilot Learning Collaborative**
  - Regular, interactive meetings
  - Learning collaborative-based organized training and technical assistance sessions
  - Training and Technical Assistance outreach
  - Virtual platform
- **Determine Measures**

Data Access and Coordination

Focus

- Creating opportunities, approaches and methods for sharing and coordinating data across stakeholders. This might include state systems (e.g., surveillance, Medicaid), RWHAP Part recipients, insurers, or others.

Sample Goals

- Improving data collection and collaboration among state partners.
- Developing data use agreements with the state health department to access surveillance data.
- Combining eHARS and CAREWare data.
- Developing data use agreements with other key HIV services stakeholders.
- Accessing and tracking antiretroviral (ARV) use and viral load data from clients recently enrolled in the ACA insurer care.
- Developing the necessary data security approaches/methods to allow the sharing of data across prevention and care service providers.
- Improving data accuracy and reporting.
- Migrating multiple data sources into one shared data system.
- Using various data sources to conduct quality improvement activities.

Using Data to Inform the Need for, and Selection of Evidenced-based/informed Approaches

Focus

- Use of data systems (e.g., surveillance, RSR) to obtain a detailed understanding of jurisdictions' HIV Care Continuum epidemic profiles and to identify subpopulation-level disparities.

Sample Goals

- Identifying disparities in outcomes across subpopulations (e.g. youth, minority, men having sex with men, transgender, undocumented immigrants, injection drug users, recently-released prisoners).
- Use of data-driven population health approaches to identify support services likely to improve outcomes for clients not achieving viral suppression.
- Implementation of core measures throughout the Part A jurisdiction.
- Using state surveillance data to support linking individuals into care.
- Examining the role of supportive services data in linkage to care and retention.
- Merging city/state data with CAREWare to improve care coordination.
- Matching RSR to Medicaid data to create a more complete picture of system of care.

Identifying and Implementing Targeted Evidenced-based/informed Interventions

Focus

- Identifying specific subpopulation disparities at each point of the HIV Care Continuum and matching those with targeted population-appropriate evidence-based/informed interventions.

Sample Goals

- Identifying evidence-based/informed interventions for subpopulations experiencing disparities in Hepatocellular (HCC) outcomes. (Black men and women, minority men having sex with men, transgender individuals, Latinos, Youth, Homeless, Recently-released prisoners, Aging HIV Population)
- Using Pre-Exposure Prophylaxis (PrEP) for care and prevention efforts.
- Identifying evidence-based/informed case management (and other) interventions to improve retention in care.
- Identifying gaps and service needs in populations who may be getting medical care through other payers.
- Working with planning councils to develop their capacity to assess population-based needs and evidence-based interventions.

Linkage to Care

Focus	• Identifying and implementing interventions specifically focusing upon individuals not linking to care after diagnosis.
Sample Goals	• Better coordinating activities and communication across state and Part A jurisdictional-level prevention, testing and entry into care services. • Using of Part A funds to conduct outreach using a navigator approach for linking people to care. • Exploring social media as an approach to attract youth and young men having sex with men (MSM) of color (and other populations not entering into provider networks) into testing. • Determining how to handle the "surge" of successful linkage and engagement programs, e.g. sufficient medical visits capacity and resources. • Working with major healthcare systems to implement HIV testing.

ACA Implementation Changes to HIV Care Systems

Focus	• Opportunities or challenges regarding ACA implementation and the role of Ryan White clinics.
Sample Goals	• Meeting clients' health care coverage education and decision support materials needs regarding ACA and marketplace insurance. • Improving Part A recipients transitioning clients into health care plans. • Realigning Ryan White services for providers with large percentages of newly-insured clients. • Adjusting to ongoing ACA-related changes including clients switching insurance coverage and changes in benefits offered by existing plans. • Coordination of clients' insurance benefits across state lines. • Obtaining client data from insurance providers.

Cross-Learning Collaborative Symposia Topics

- **Centralized service eligibility screening**
- **Standardizing definitions in the HIV care continuum**
- **“Getting to Zero” Initiative.**
- **Provider and workforce development / training:**
  - Medical and non-medical case management
  - Providers new to treatment and care of the RWHAP population.
  - Increasing providers understanding the HIV care continuum frame
  - Cultural competency for providers to better engage stigmatized, underrepresented and hard to access populations
- **Increasing bilingual staff to reach the Latino communities**

Evaluating Success

- **Learning Collaborative Process**
  - Rates of attendance and participation of Learning Collaborative teams
  - Learning team assessment of Learning Collaborative support (e.g. liaisons/facilitators, virtual platform function, training/TA, perceived value of LC participation in meeting goals)

- **Learning Collaborative Teams' Goals**
  - SMART Objectives tailored to each Learning Collaborative domain
  - Mixed methods:
    - Key Informant Discussions/ Interviews
    - Data Analysis (e.g. RSR, intervention-specific data collection)
    - Post Collaborative Activities (Sustainability)

Questions?

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