NEW YORK EMA 2009-2012 COMPREHENSIVE STRATEGIC PLAN ANNUAL UPDATE

Progress to Date: 2008-2010

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PRESENTATION OVERVIEW

- Background on the Comprehensive Strategic Plan
- Overview of data sources used to measure progress against targets
- Summary of demographics
- Goals 1-4
  - Objectives and Indicators for Ryan White and the EMA
  - Progress towards targets: 2008-2010
- Goal 5 – A brief update
- Highlights of findings
- Discussion

BACKGROUND

- Ryan White legislation mandates that planning councils develop a comprehensive plan for the delivery of HIV-related services.
- For 2009-2012, the New York EMA used HRSA guidance, as well as the 2005-2008 Plan and available indicator data, to develop a plan that would comply with legislation and meet local needs.
- This presentation focuses on data for 2008-2010 (calendar years or grant years, depending on the specific data source used).
- Baseline data (2008) and Year 1 data (2009) were updated for all data sources to reflect refined methodology in measuring the indicators, and to ensure comparability between all three years.

DATA SOURCES FOR INDICATORS

1. **Required client-level Ryan White data reported by contractors**
   a. AIDS Institute Reporting System (AIRS) data for 2008-2010, supplemented by EMR extracts for two agencies
   b. eSHARE (new) data combined with AIRS for 2010
   c. Allows analysis by Ryan White service category or combination
   d. Limited by providers' completeness of reporting
   e. Limited to NYC programs (no Tri-County data) for these analyses

DATA SOURCES FOR INDICATORS (CTD.)

2. **HIV/AIDS Surveillance Registry (HSR) data from DOHMH HEFSP***
   a. Includes data from provider reporting forms (PRF) and electronic laboratory reporting
   b. Offers more complete laboratory test data (CD4 counts and viral loads, also used as proxies for care) than other available sources
   c. Cannot address actual services or treatment received
   d. Entails greater reporting lag than other data sources used
   e. Represents NYC PLWHA only

* *HIV Epidemiology and Field Services Program, Surveillance Unit*

DATA SOURCES FOR INDICATORS (CTD.)

3. **Rapid testing data from DOHMH HIV Prevention Program**
   a. Submitted by all agencies with NYC DOHMH funding for testing
   b. Generally represents tests conducted (test-level vs. client-level), although Ryan White Part A providers report client-level data
   c. Limited to NYC
      - Tri-County data are available from Ryan White programs only, and are not included in results utilizing the match with the NYC HIV surveillance registry (HSR)

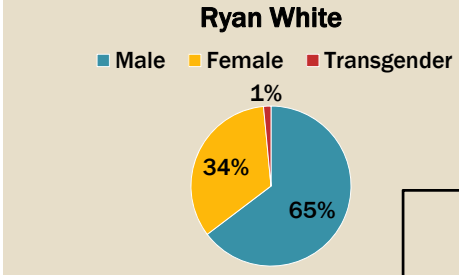
DATA SOURCES FOR INDICATORS (CTD.)

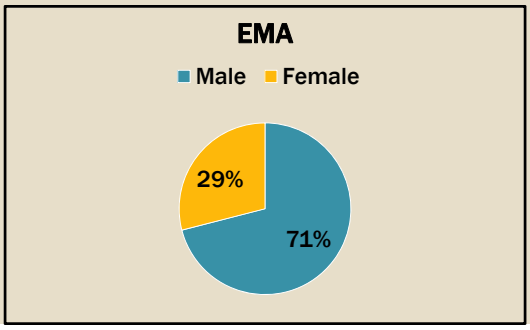
4. **The Community Health Advisory and Information Network (CHAIN) Study**
   a. Is a longitudinal study (conducted by Columbia University with DOHMH and WCDOH) of PLWHA in NYC and Tri-County
   b. Draws on interviews with persons recruited from agencies providing social services and/or medical care (excluding private physicians' offices)
   c. Offers the strengths of comprehensiveness (in topics) and representativeness of the Part A client population, as well as the ability to look at planning-relevant questions over time
   d. Covers NYC and Tri-County PLWHA accessing services

DATA SOURCES FOR INDICATORS (CTD.)

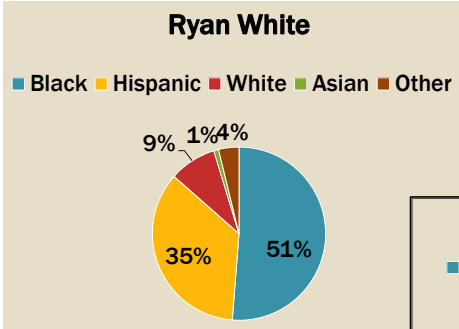
5. **The Medical Monitoring Project (MMP)**
   a. Is a serial cross-sectional study (conducted by NYC DOHMH HEFSP and CDC) of PLWHA in New York City
   b. Draws on interviews with persons recruited from HIV medical facilities (including private physicians' offices)
   c. Offers the strengths of comprehensiveness (in topics) and the probability sampling method for representativeness of PLWHA engaged in medical care
   d. Limited to NYC participants (for the datasets available to NYC DOHMH)

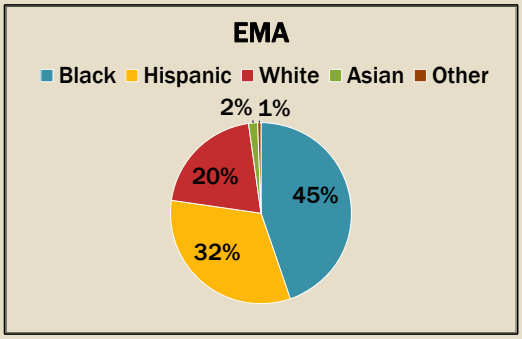
DEMOGRAPHICS – PLWHA 2010



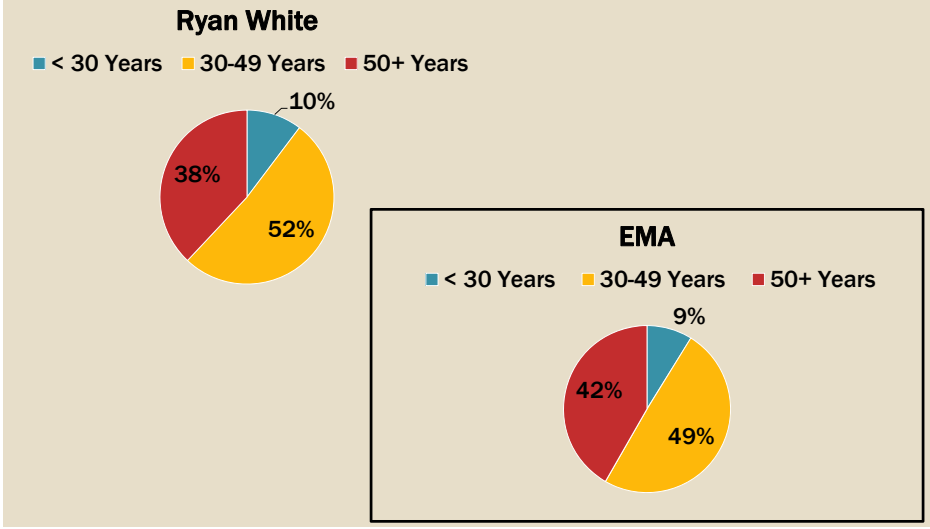


DEMOGRAPHICS – PLWHA 2010

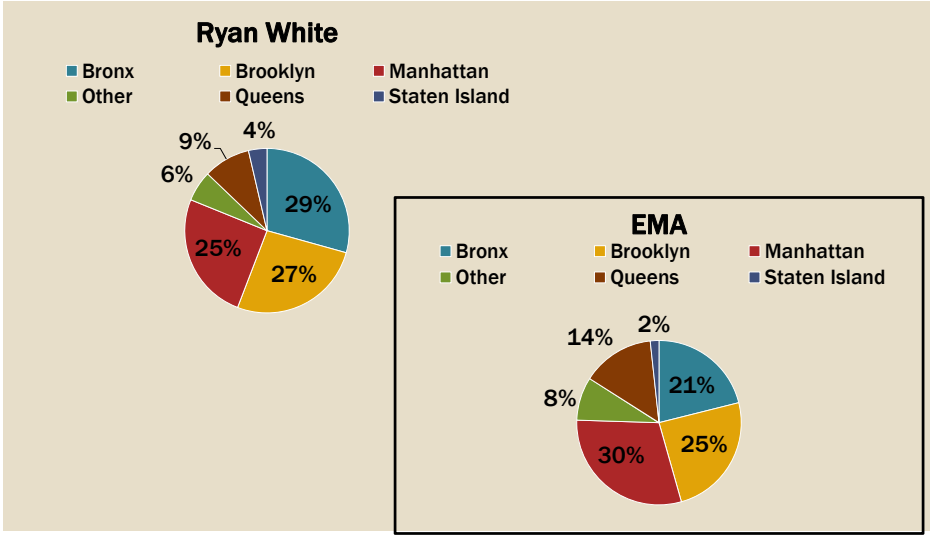




DEMOGRAPHICS – PLWHA 2010



DEMOGRAPHICS – PLWHA 2010



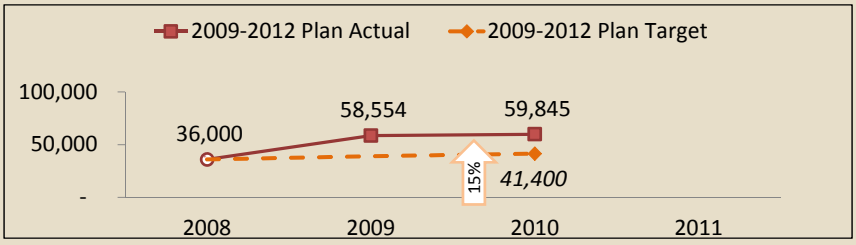
GOAL 1: INCREASE THE NUMBER OF INDIVIDUALS WHO ARE AWARE OF THEIR HIV STATUS

- **Objective 1A:** To increase the number of individuals receiving voluntary HIV rapid testing across health care and social support service provider settings, by 2010.

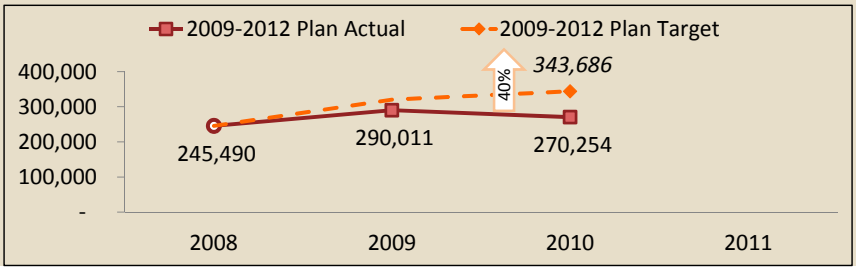
Ryan White Indicator	EMA Indicator
A 15% increase from baseline in the annual total number of unique individuals receiving an HIV rapid test through a Ryan White-funded program.	A 40% increase from baseline in the total number of HIV rapid tests conducted annually.

Objective 1A: HIV Status

- **Ryan White Part A:** The number of clients receiving rapid tests climbed from 2008 to 2010 (mostly from 2008 to 2009, with new programs).



- **EMA-wide:** Analyses indicate a slight reduction in HIV testing EMA-wide from 2009 to 2010, but still an overall increase since 2008.



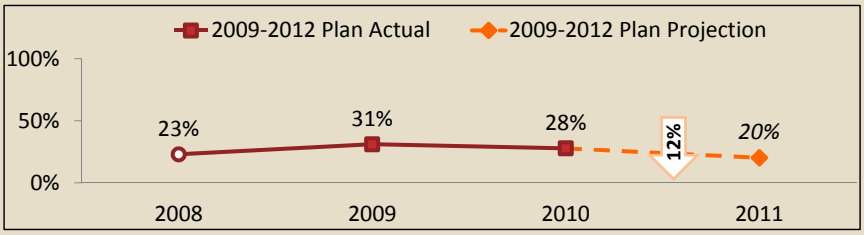
GOAL 1: INCREASE THE NUMBER OF INDIVIDUALS WHO ARE AWARE OF THEIR HIV STATUS

- **Objective 1B:** To decrease delayed diagnosis of HIV, by the end of 2012.

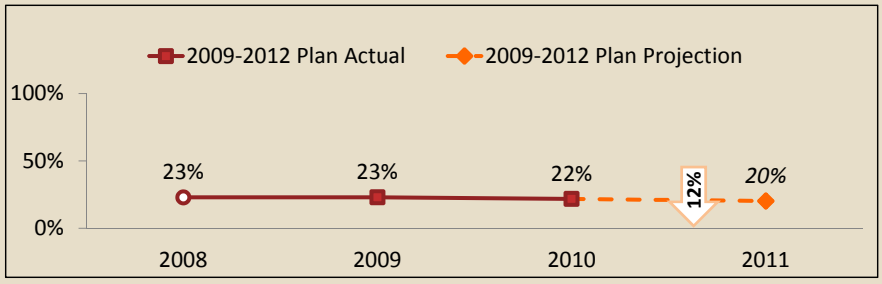
Ryan White Indicator	EMA Indicator
A 12% reduction in the proportion of newly diagnosed Ryan White clients who have a concurrent AIDS diagnosis.	A 12% reduction in the proportion of new/incident HIV diagnoses that are concurrent with AIDS diagnoses.

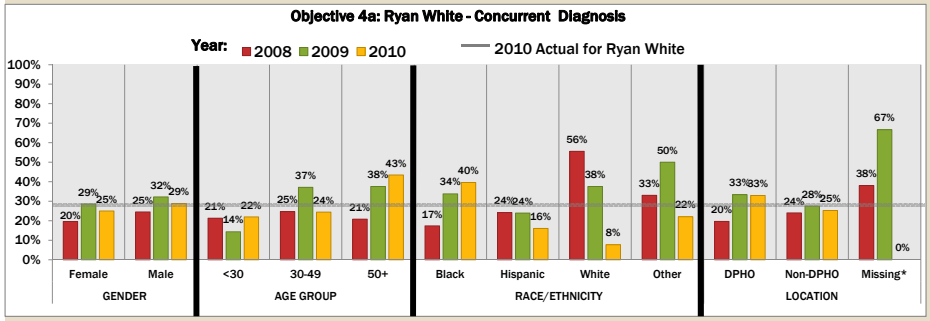
Objective 1B: Concurrent Diagnosis

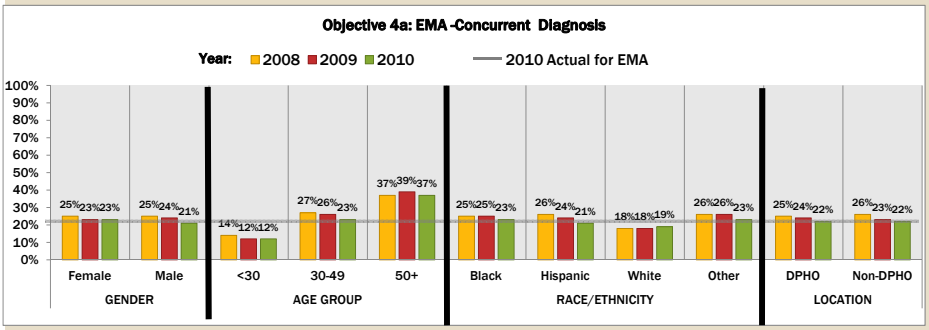
- **Ryan White Part A:** Estimates show reduced concurrency for 2009-10, but 2010 concurrency remained higher than in 2008.



- **EMA-wide:** NYC estimates for concurrency are *gradually* moving in the right direction.







SUMMARY – CONCURRENCY DISPARITIES

- Female Part A clients appeared to have lower concurrency, but no gender disparity appeared for NYC overall.
- In Part A and NYC overall, older age groups experienced higher (worse) levels of concurrency.
- In NYC, newly diagnosed whites had lower (better) levels of concurrency than newly diagnosed individuals in other racial/ethnic groups.
  - For Part A, this difference only appeared for 2010.
- There were no consistent DPHO vs. non-DPHO area of residence differences for NYC overall or Ryan White.

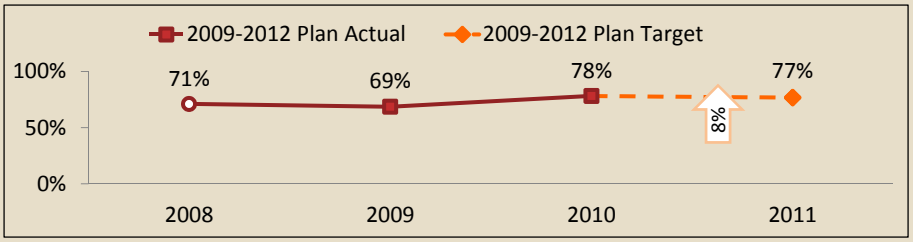
GOAL 2: PROMOTE EARLY ENTRY INTO AND CONTINUITY OF HIV CARE

- **Objective 2A:** To increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis, by 2011.

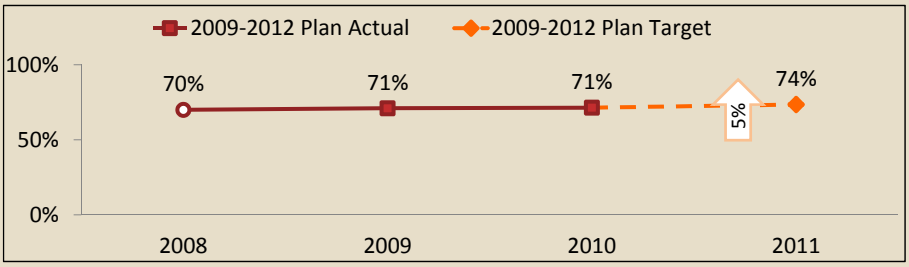
Ryan White Indicator	EMA Indicator
An 8% increase in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis.	A 5% increase in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis.

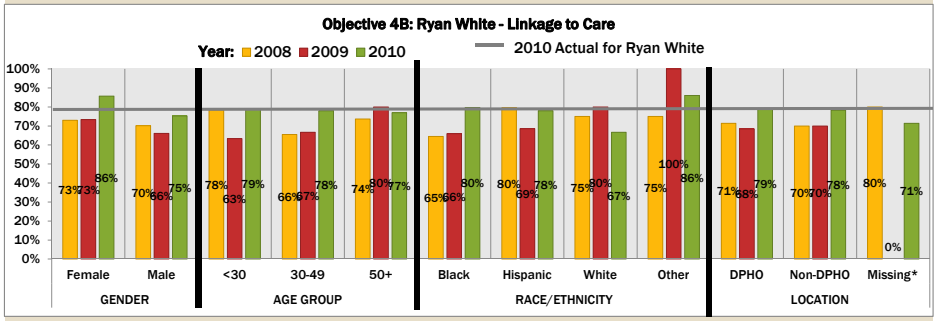
Objective 2A: Linkage to Care

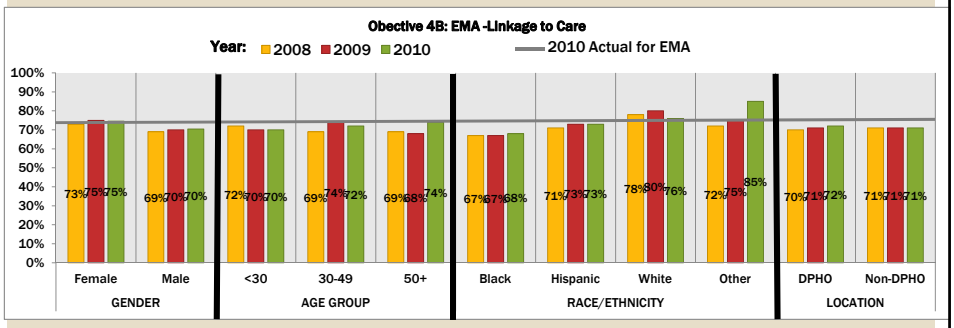
- **Ryan White Part A:** Estimates show increased prompt linkage from 2009-2010.



- **EMA-wide:** NYC estimates for linkage are *gradually* moving in the right direction.







SUMMARY – LINKAGE DISPARITIES

- Female Part A clients and females in NYC overall appeared to do better on linkage.
  - Results for NYC males increased slightly from 2008-2009 and held steady from 2009-2010.
- No clear age pattern emerged; in NYC overall, a higher percentage of diagnoses among the 50+ led to prompt linkage in 2010, but those 30-49 fared best in 2009, and those <30 in 2008.
- NYC data overall showed prompt linkage most often among white and "other" racial/ethnic groups, followed by Hispanic and then black newly diagnosed individuals.
  - This pattern loosely fit 2009 Part A, but did not apply to 2008 and 2010. *(Caution: small N!)*
- There were no consistent DPHO vs. non-DPHO differences for NYC overall, except that non-DPHO-area residents stayed at 71% linkage all three years, while DPHO-area residents climbed from 70-72%.

GOAL 2: PROMOTE EARLY ENTRY INTO AND CONTINUITY OF HIV CARE

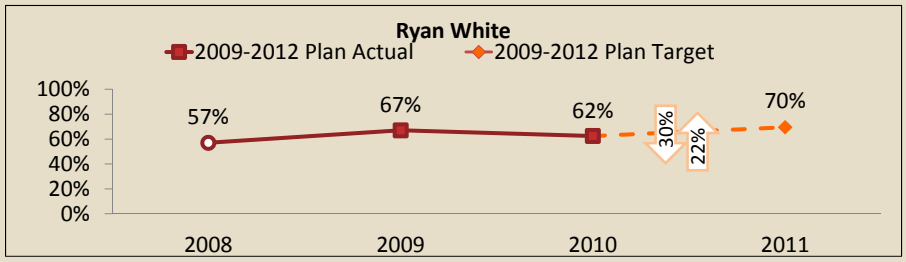
- **Objective 2B: To increase retention in HIV care and treatment, by 2011.**

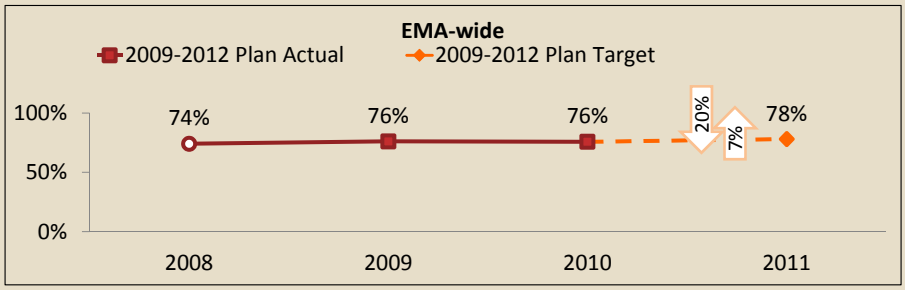
Ryan White Indicator	EMA Indicator
A 30% decrease in the proportion of clients who show a gap in primary care of 4 months or longer, at any time in the 12-month period –	A 20% decrease in the proportion of PLWHA in the EMA who show a gap in primary care of 4 months or longer, at any time in the most recent 12-month period –

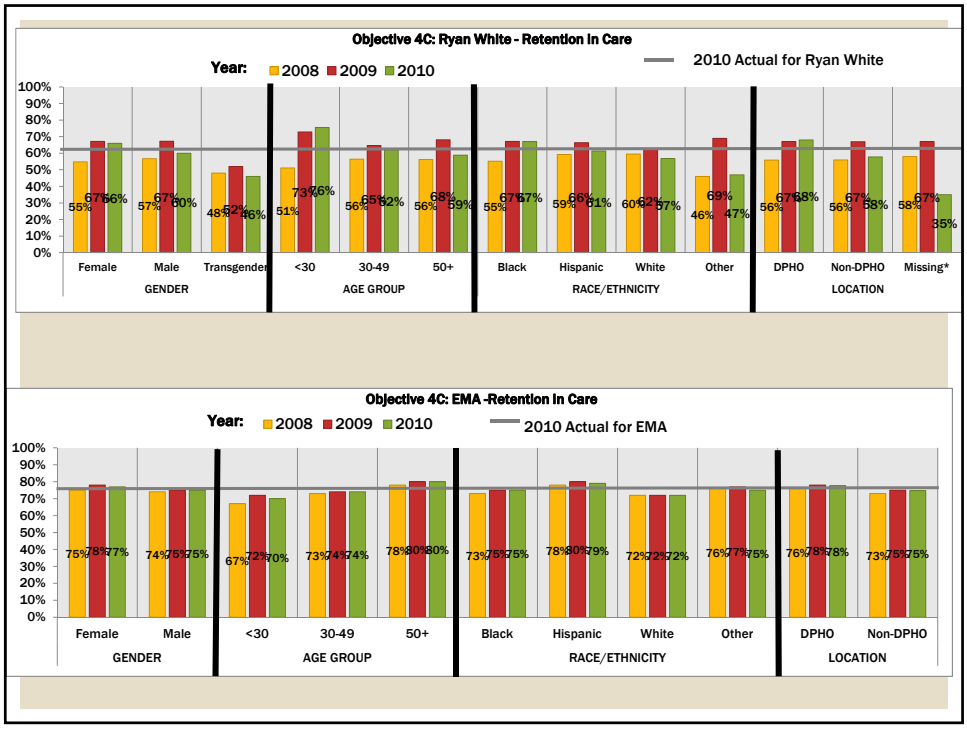
Objective 2B: Retention in Care

- Primary care retention increased from 2008-09 (EMA-wide and Part A*), but then leveled EMA-wide and decreased slightly in Part A.

**Part A provider reporting underestimates primary care visits experienced.*







SUMMARY – RETENTION DISPARITIES

- In NYC overall, female PLWHA had slightly higher retention in care in 2008-10.
  - Part A data suggest, if anything, better retention among females in 2010 (and lowest among transgender clients, but the number of transgender-identified clients is quite small).
- Retention in care increased with age among PLWHA in NYC.
  - For Part A, though, 2009 and 2010 seemed to show a marked increase from 2008 in retention among clients <30, and younger age groups appeared to have higher retention in 2010 (the reverse of the NYC result).
- Hispanic PLWHA in NYC had the highest retention in care, followed by "other," black, and finally white PLWHA.
  - Racial/ethnic patterns were less clear for Part A clients, but black and Hispanic clients appeared to have higher retention than white clients in 2009-2010.
- DPHO-area PLWHA showed greater retention in care each year than non-DPHO-area PLWHA in NYC, though both groups experienced increased retention from 2008-2009 (and then leveled off).
  - No clear DPHO/non-DPHO pattern applied to Part A, but DPHO-area clients appeared to have better retention in 2010.

GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION.

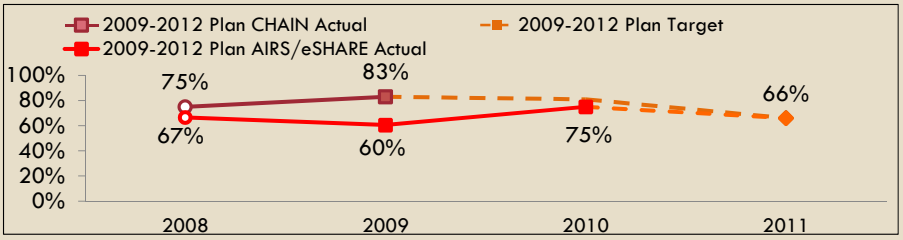
- **Objective 3A: To improve medication adherence to a rate of 95%, by 2011.**

Ryan White Indicator	EMA Indicator
Achievement of 95% or greater medication adherence among **66%** of MCM clients, meeting minimum program and treatment criteria.	Achievement of 95% or greater medication adherence among **50%** of PLWHA on ARVs at last update.

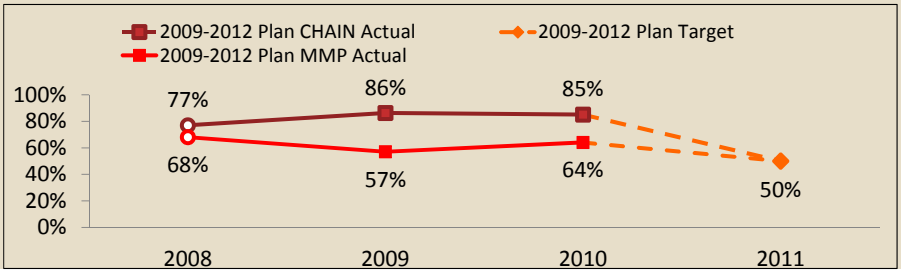
Objective 3A: ART Adherence

- **Ryan White Part A:** Adherence remained relatively high in CHAIN* (75-83%), but Part A providers reported under 70% achieving optimal levels (≥95%) in 2008-09, followed by 75% in 2010.

* Filtered to MCM clients at Part A agencies



- **EMA-wide:** Adherence varied by source, with CHAIN and MMP showing different EMA trends, and CHAIN finding higher percentages achieving optimal levels (≥95%).



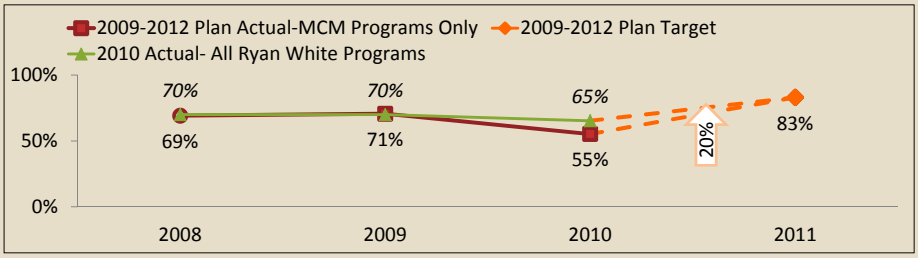
GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION.

- **Objective 3B: To increase viral suppression, by 2011.**

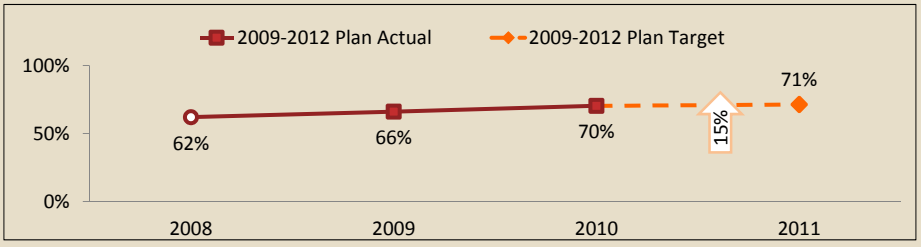
Ryan White Indicator	EMA Indicator
A 20% increase in the proportion of MCM clients who have viral loads documented as counts below 400 or as "undetectable" viral load (no count), among those with documented viral loads in the period, and meeting minimum expectations for program engagement.	A 15% increase in the proportion of PLWHA in the EMA who have viral loads documented as counts below 400 or as "undetectable" viral load (no count), among all those with documented viral loads in the period.

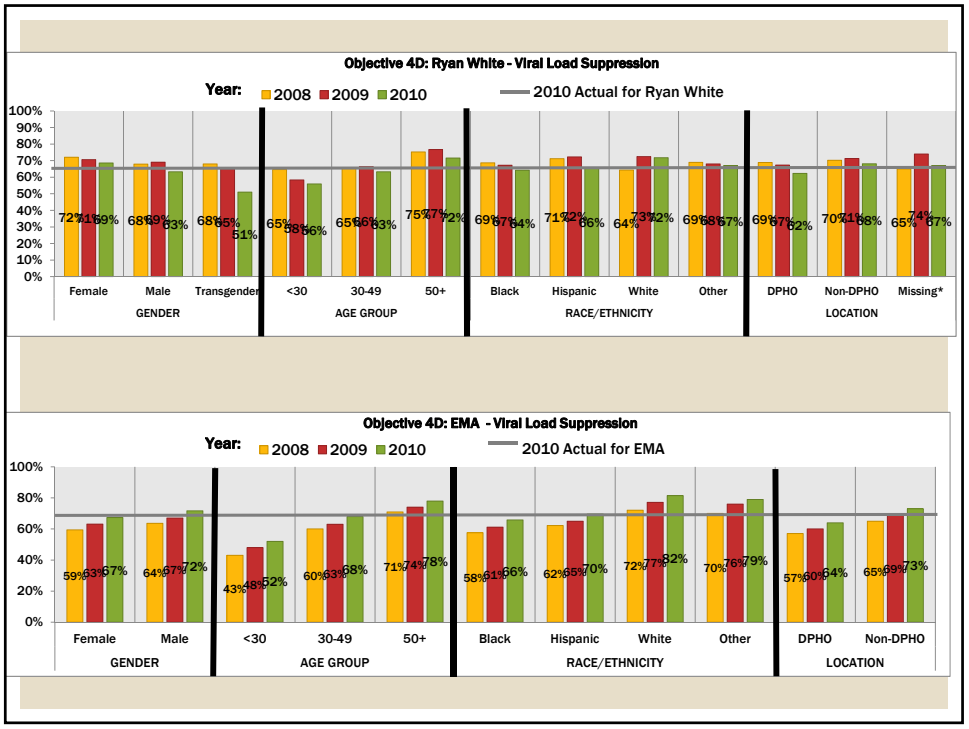
Objective 3B: Ryan White Viral Load Suppression

- **Ryan White Part A:** Data showed a slight increase in sustained viral suppression 2008-2009, but a decrease in 2010. Part A overall results (65%) exceeded Part A MCM (55%) for 2010.



- **EMA-wide:** Sustained viral suppression has been achieved by a higher percentage of PLWHA in the EMA each year since 2008 (62%), and reached 70% in 2010.





SUMMARY – VIRAL LOAD SUPPRESSION DISPARITIES

- In NYC, male PLWHA more often had viral suppression.
  - In Part A, females more often showed viral suppression than male or transgender clients. *(Caution: small transgender N!)*
- Viral suppression increased with age among PLWHA in NYC *and* Part A clients (except for apparently equal proportions in clients <30 and those 30-49 in 2008).
- White PLWHA in NYC were most often virally suppressed, followed by "other," Hispanic, and finally black PLWHA.
  - There was no clear pattern for Part A clients, though the same order (between white, Hispanic and black individuals) seemed to apply for 2009-2010 only.
- Each year, non-DPHO-area PLWHA more often had sustained suppression than DPHO-area PLWHA (in NYC and Part A).

GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION.

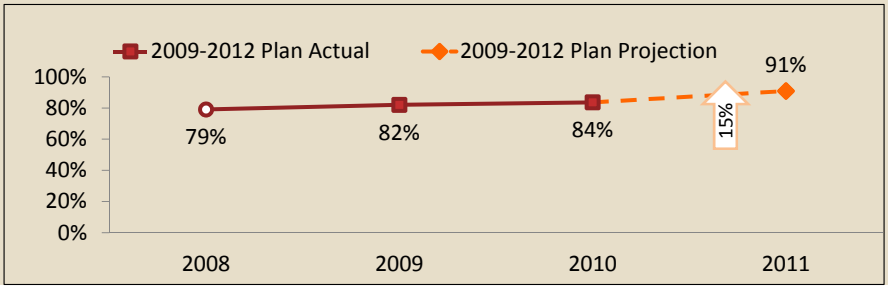
- **Objective 3C: To improve immunological health (e.g., CD4 count), by 2011.**

Ryan White Indicator	EMA Indicator
A 20% increase in the proportion of MCM clients whose CD4 counts either remain stable or improve during the period, and meeting minimum expectations for program engagement.	A 15% increase in the proportion of PLWHA in the EMA whose CD4 counts either remain stable or improve during the period.

Objective 3C: Immunological Health

- **Ryan White Part A:** As with viral suppression, this clinical indicator showed an increase from 2008-09 and a drop in 2010.

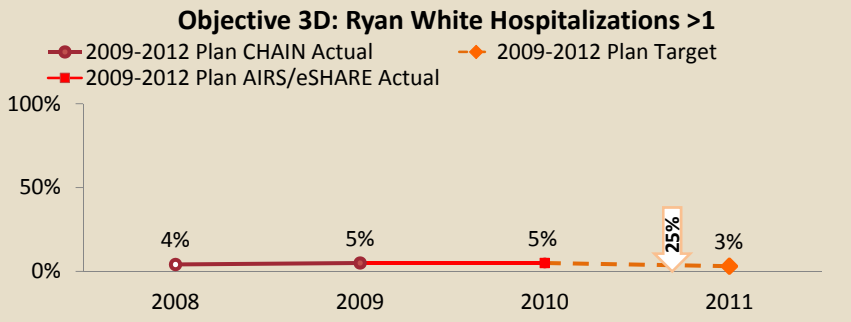
- **EMA-wide:** PLWHA in the EMA with stable/improving CD4 steadily increased each year.

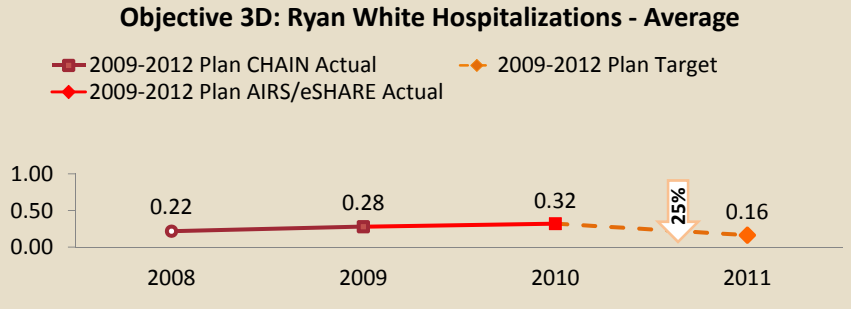


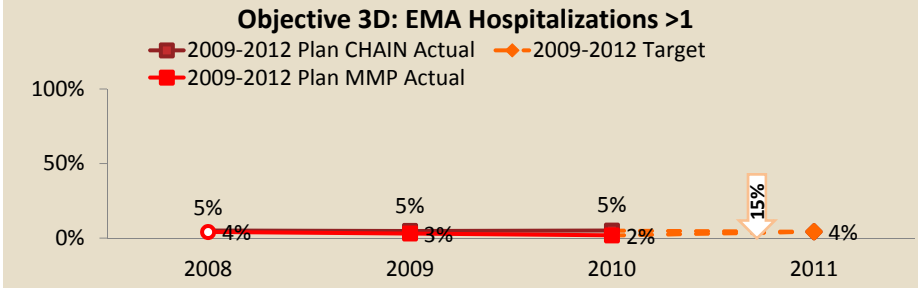
GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION.

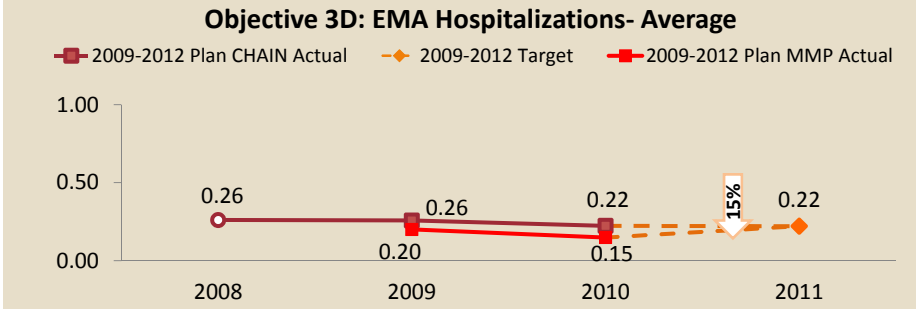
- **Objective 3D: To decrease HIV-related hospitalizations of PLWHA by 2011.**

Ryan White Indicator	EMA Indicator
- A 25% decrease in the mean number of hospitalizations experienced annually per MCM client, **AND/OR** - A 25% decrease in the proportion of MCM clients who have more than one hospitalization within a 12-month period.	- A 15% decrease in the mean number of hospitalizations experienced annually per PLWHA, **AND/OR** - A 15% decrease in the proportion of PLWHA who have more than one hospitalization within a 12-month period.





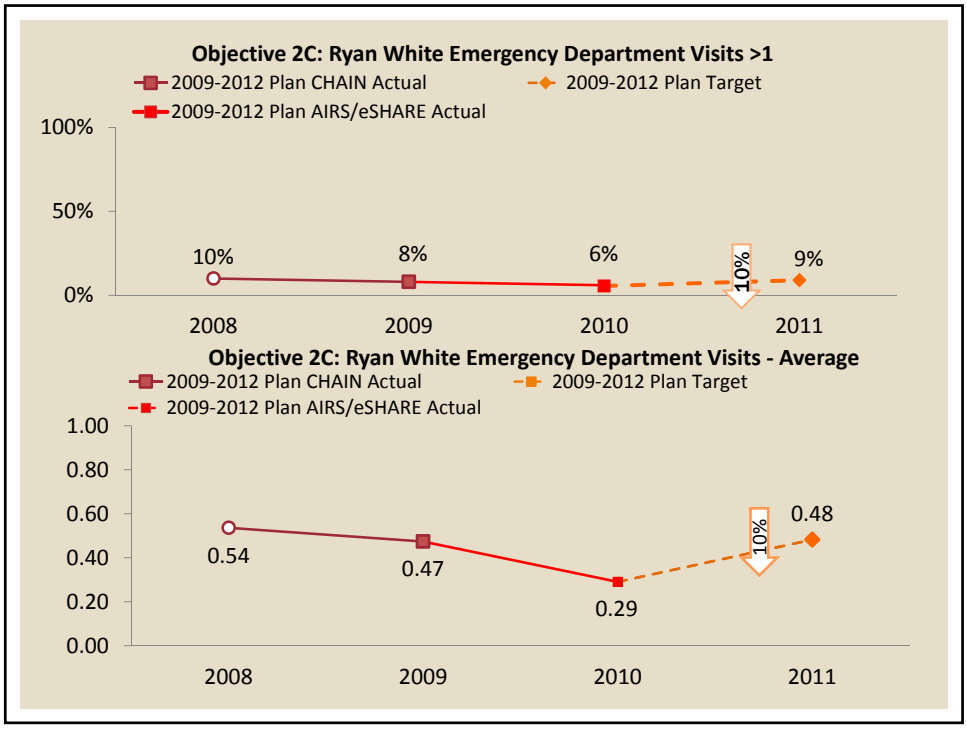


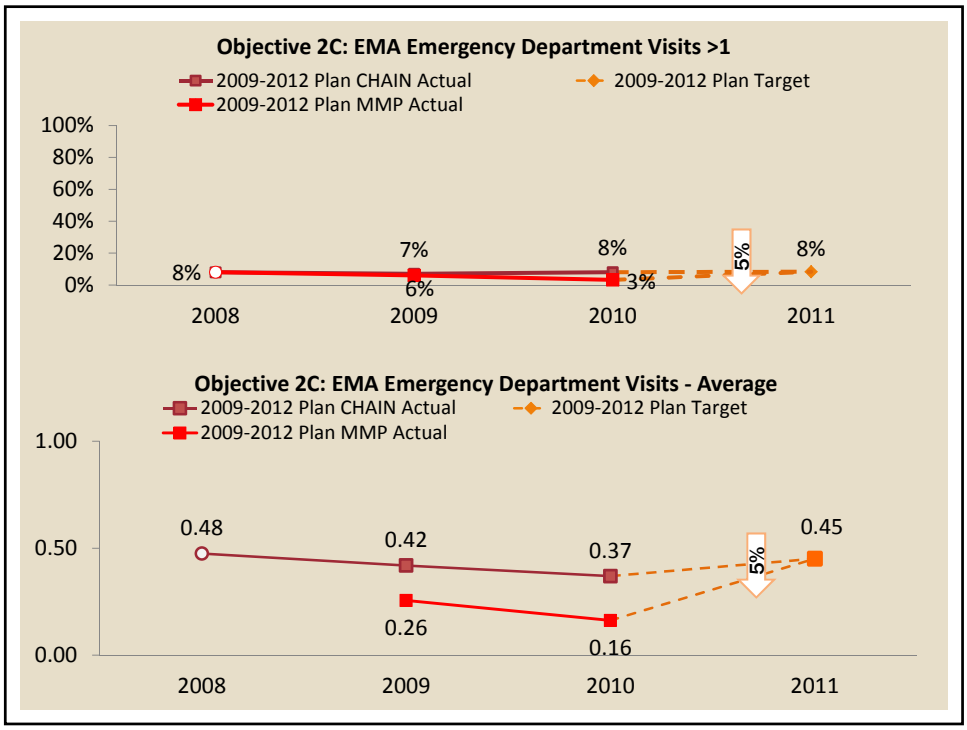


GOAL 2: PROMOTE EARLY ENTRY INTO AND CONTINUITY OF HIV CARE

- **Objective 2C:** To decrease visits to emergency departments (ED), by 2011.

Ryan White Indicator	EMA Indicator
- A 10% decrease in the mean number of ED visits experienced annually per MCM client, **AND/OR** - A 10% decrease in the proportion of MCM clients who have more than one ED visit within a 12-month period.	- A 5% decrease in the mean number of ED visits experienced annually per PLWHA, **AND/OR** - A 5% decrease in the proportion of PLWHA who have more than one ED visit within a 12-month period.


Objective 2C: Ryan White Emergency Department Visits >1
2009-2012 Plan CHAIN Actual
2009-2012 Plan Target
2009-2012 Plan AIRS/eSHARE Actual
100%
50%
0%
10%
8%
6%
10%
9%
2008
2009
2010
2011
Objective 2C: Ryan White Emergency Department Visits - Average
2009-2012 Plan CHAIN Actual
2009-2012 Plan Target
2009-2012 Plan AIRS/eSHARE Actual
1.00
0.80
0.60
0.40
0.20
0.00
0.54
0.47
0.29
10%
0.48
2008
2009
2010
2011


Objective 2C: EMA Emergency Department Visits >1
2009-2012 Plan CHAIN Actual
2009-2012 Plan Target
2009-2012 Plan MMP Actual
100%
80%
60%
40%
20%
0%
8%
7%
6%
8%
3%
5%
8%
2008
2009
2010
2011
Objective 2C: EMA Emergency Department Visits - Average
2009-2012 Plan CHAIN Actual
2009-2012 Plan Target
2009-2012 Plan MMP Actual
1.00
0.50
0.00
0.48
0.42
0.26
0.37
0.16
5%
0.45
2008
2009
2010
2011

SUMMARY – ACUTE CARE UTILIZATION

- Part A acute care utilization did not show a clear trend (if anything, a slight increase in hospitalizations but decrease in ED visits), but the source changed in 2010 (from filtered CHAIN interviews → eSHARE reporting).
- For the EMA, a slight downward trend in acute care utilization appears for MMP, alongside a stable or slight downward trend for CHAIN, depending on the measure (% with >1 event vs. mean #).

GOAL 5: ECONOMIC EVALUATION OF RYAN WHITE PART A SERVICES

- Building on the SUNY Downstate report with recommendations and the Planning Council feedback from mid-2011, CTHP has:
  - Contracted with a consultant from the New York University Medical Center to conduct preliminary modeling of the local Ryan White Part A portfolio
  - Developed a plan for feasible and progressive cost and outcome analyses for the next 3 years that will inform planning discussions
  - Identified next steps for more program-specific modeling efforts once additional data are available via eSHARE
  - Begun drafting a fuller presentation on these efforts, to be shared with specific Planning Council committees soon

HIGHLIGHTS FROM 2008-2010 RESULTS

- Ryan White testing programs substantially exceeded targets by 2009, and approximately 60,000 individuals were rapid-tested in 2010. Citywide testing remained below targets.
- Concurrency was slightly reduced Citywide (to 22%); subgroup analyses suggest delayed diagnosis among older New Yorkers.
- Linkage was slightly improved Citywide (to 71%); subgroup analyses showed traditional racial/ethnic disparities in NYC.
- Citywide retention in care moved upward and then leveled at 76%, not yet at the 78% target; subgroup analyses suggest non-traditional disparities, with better retention among female, DPHO-residing, older and nonwhite PLWHA.

HIGHLIGHTS FROM 2008-2010 RESULTS (CTD.)

- Citywide and in Ryan White MCM, percentages with optimal adherence exceeded the targets. (Note: low targets @ 50-66%)
- Viral suppression nearly reached the 71% target Citywide; subgroup results reflect traditional health disparities, except that suppression (like retention in care) did increase with age.
- PLWHA with CD4 stability/improvement increased each year Citywide, reaching 84% in 2010. Targets for this were set high, at 91% for the EMA and 99% for Ryan White. (Note: baselines were unknown when the 2009-12 Plan was drafted)
- Citywide and Part A results (from different data sources) have generally met or improved upon targets for reducing acute care reliance, with the exception of Ryan White hospitalizations (still appearing a bit above targeted levels).

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THANK YOU!

- Questions?