

NEW YORK EMA 2012-2015 COMPREHENSIVE STRATEGIC PLAN ANNUAL UPDATE

Progress to
Date: 2011-
2013

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REPORT OVERVIEW

- Background on the Comprehensive Strategic Plan
- Overview of data sources used to measure progress against targets
- Summary of demographics
- Highlights of findings:
 - Objectives and indicators for Ryan White and the EMA
 - Progress towards targets: 2011-2013
 - Goal 1: Increase the number of individuals who are aware of their HIV status
 - Goal 2: Promote early entry into HIV care
 - Goal 3: Promote optimal management of HIV infection
 - Goal 4: Reduce HIV/AIDS disparities
 - Goal 5: Ensure that EMA has a robust plan for cost-effective delivery of HIV services

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BACKGROUND

- Ryan White Part A legislation mandates development of a comprehensive plan for the delivery of HIV-related services
- 2012-2015 Plan created and approved in spring 2012 by the HIV Health and Human Services Planning Council of New York (PC)
 - Indicators and targets developed and finalized by Grantee and PC, based on HRSA guidance, policy initiatives (such as NHAS), the 2009-2012 Plan and available indicator data
- DOHMH provides an annual report on indicator progress, with trends over time

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WHY AN ANNUAL COMP PLAN UPDATE?

- Focuses review on concrete targets
 - Allows for a more strategic HIV services planning conversation
- Highlights trends over time
 - Allows for recognition of progress, plateaus and declines
 - Two levels: EMA-wide and Ryan White Part A clients
 - Allows for reflection on factors that may contribute to changes from year to year
- Enables more rapid adjustments and guides annual planning
 - Allows for use of the Comp Plan as a living document that informs on-going work

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DATA SOURCES FOR INDICATORS

- 1. Required client-level Ryan White Part A data reported by service providers (In eSHARE)**
 - a. Allows analysis according to timing and duration of Ryan White Part A program activity
 - b. Limited by providers' completeness of reporting

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DATA SOURCES FOR INDICATORS (CTD.)

- 2. HIV surveillance data**
 - a. Includes data from provider reporting forms (PRF) and electronic laboratory reporting
 - b. Offers more complete laboratory test data (CD4 counts and viral loads) than other available sources
 - c. Cannot fully represent primary care services or treatment received
 - d. Entails greater reporting lag than other data sources used
 - e. Data for NYC from HIV Surveillance Registry prepared by NYC DOHMH HIV Epidemiology and Field Services Program
 - f. Data for the Tri-County area from NYS AIDS Case Surveillance Registry prepared by NYSDOH Bureau of HIV/AIDS Epidemiology (demographics only)

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DATA SOURCES FOR INDICATORS (CTD.)

- 3. HIV testing data from DOHMH Prevention Program**
 - a. Submitted by all agencies with NYC DOHMH funding for testing
 - b. Generally represents tests conducted, 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 cannot be included in results utilizing data from the NYC HIV Surveillance Registry (Tri-County surveillance data are under the NYS jurisdiction)

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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 PLWH in NYC (ongoing) and Tri-County (into August 2013)
 - 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

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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 PLWH 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 PLWH engaged in medical care
- d. Limited to NYC participants (for the datasets available to NYC DOHMH)

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DEMOGRAPHIC SUMMARY – PLWH 2013*

- 2013 approximations:
 - PLWH: 117,600 NYC and 4,800 Tri-County (Westchester, Rockland, Putnam)
 - HIV+ Ryan White Part A clients: 17,700 NYC and 1,300 Tri-County
- Profiles similar to previous years – no notable changes in demographic distribution
- Majority of PLWH and Ryan White Part A clients were:
 - male
 - black or Hispanic
 - 40-59 years of age
- Compared to all PLWH, Ryan White Part A client population includes a higher proportion of:
 - female clients
 - black clients (and a lower proportion of white clients)
 - clients under age 50
- Compared to Ryan White Part A clients in NYC, client population in Tri-County includes a higher proportion of:
 - female clients
 - white clients
 - clients over age 50

*Note: Tri-county demographic data for 2013 is preliminary and current as of 7/7/2014.

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GENDER – NYC PLWH 2013

Ryan White (NYC)

Gender	Percentage
Male	65%
Female	33%
Transgender	2%

The proportion of females was higher among Ryan White clients when compared to all PLWH in NYC.

All PLWH (NYC)

Gender	Percentage
Male	72%
Female	28%

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GENDER – TRI-COUNTY PLWH 2013*

Ryan White (TriCo)

Gender	Percentage
Male	56%
Female	44%
Transgender	1%

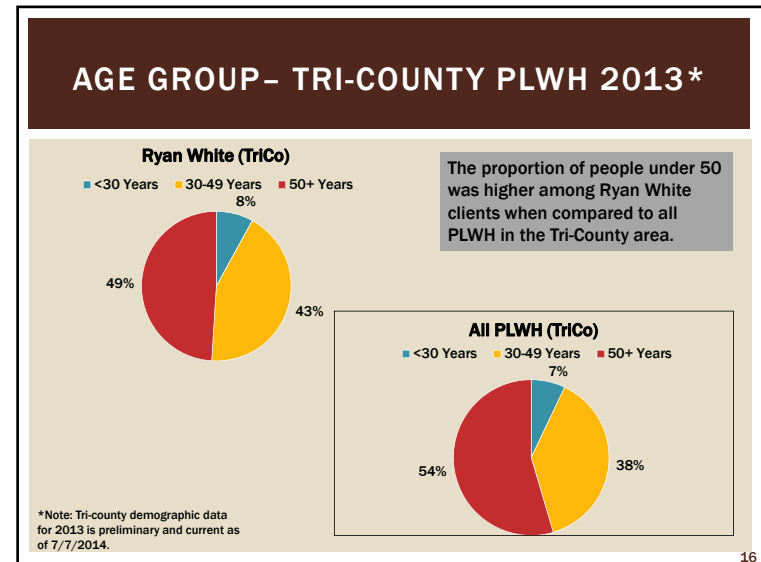
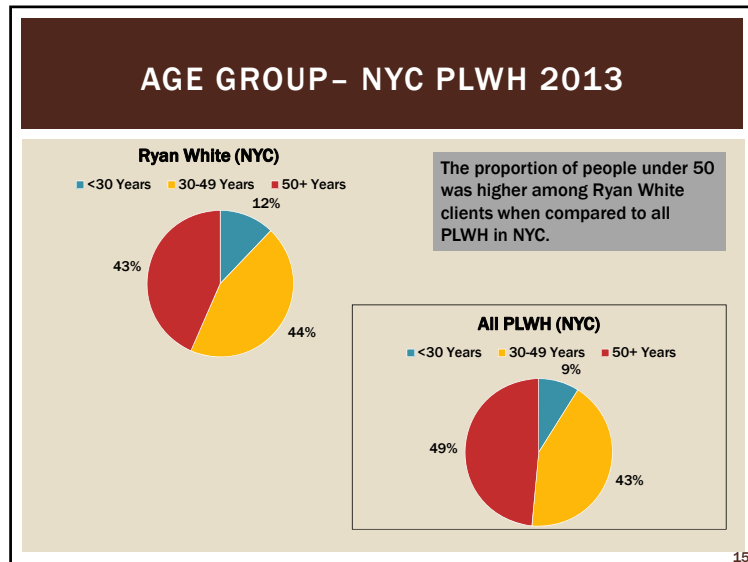
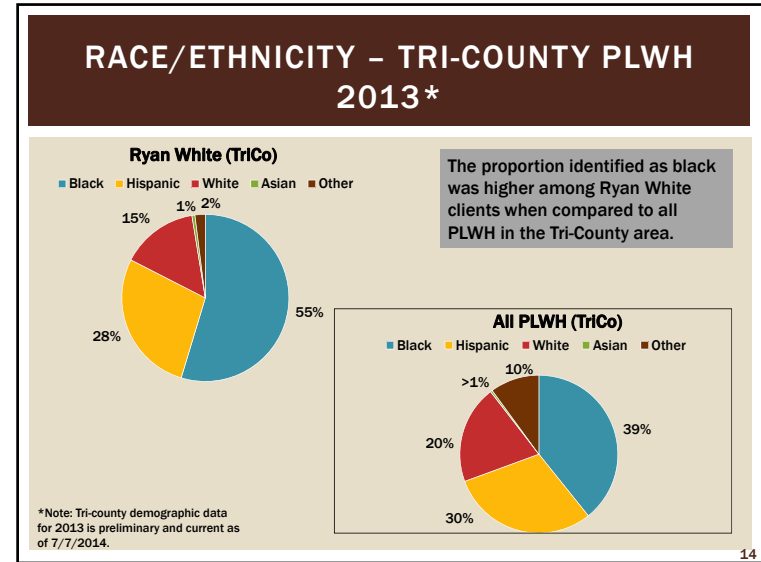
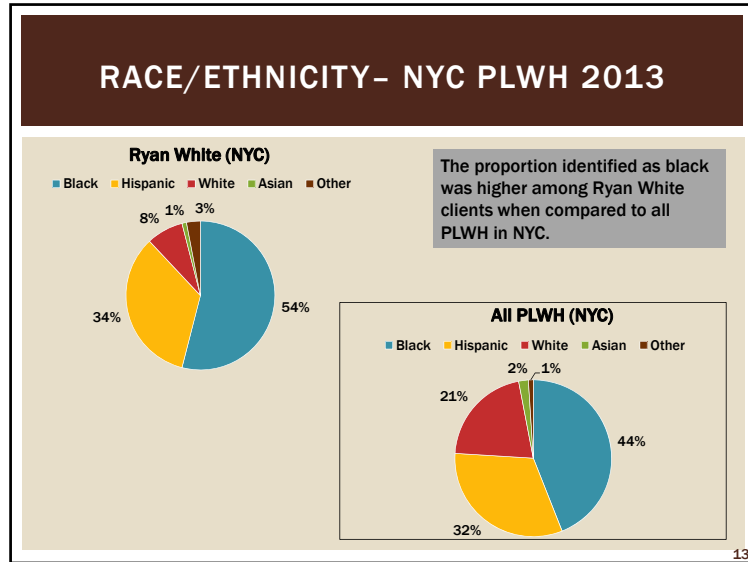
The proportion of females was higher among Ryan White clients when compared to all PLWH in the Tri-County area.

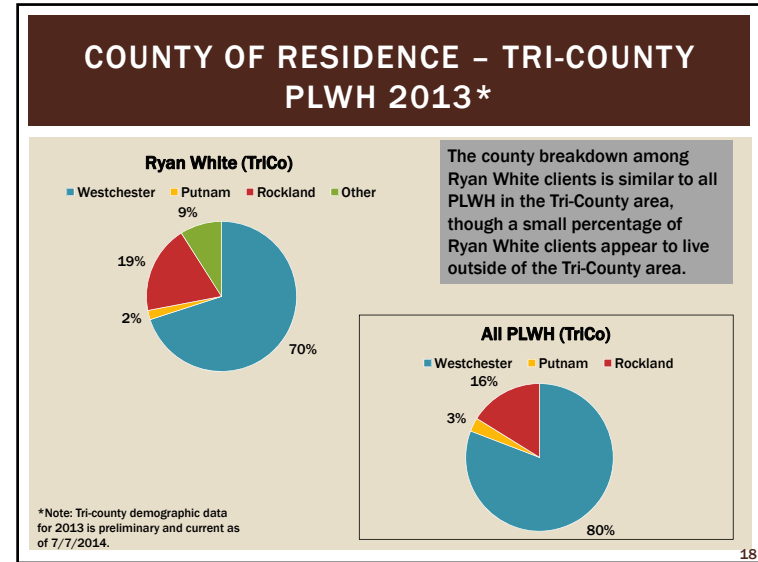
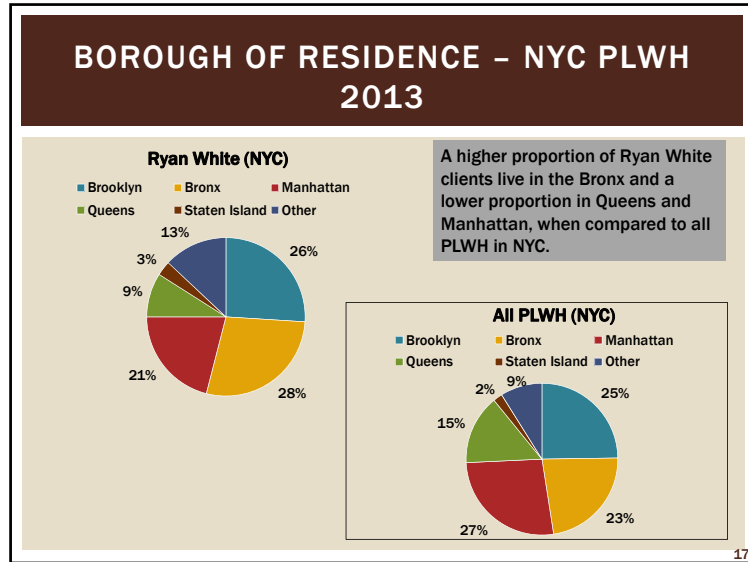
All PLWH (TriCo)

Gender	Percentage
Male	63%
Female	37%

*Note: Tri-county demographic data for 2013 is preliminary and current as of 7/7/2014.

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HIGHLIGHTS FROM 2011-2013: TARGETS AND TRENDS

Indicator	Target Met		Desired Direction	Trend	
	Ryan White	EMA		Ryan White	EMA
HIV Testing	✗	✗	↑	↑	↓
Concurrent Diagnosis	✗	✓	↓	↑	---
Linkage to Care	✗	✗	↑	↑	↑
Retention in Care	✓	✓	↑	↑	---
ART Adherence	✓	✗	↑	↑	---
Viral Load Suppression	✗	✓	↑	↑	↑
Immunological Health	✗	✓	↑	↑	↑
Hospitalizations	✗	✓	↓	---	---
Emergency Dept. Visits	✗	✓	↓	---	---

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- ### HIGHLIGHTS FROM 2011-2013: EMA-WIDE DISPARITIES
- **Gender:**
 - Prompt linkage to and retention in care slightly lower among men
 - Viral load suppression rates consistently lower among women
 - **Age:**
 - Concurrency rates consistently highest among 50+
 - Linkage to and retention in care and rates of viral load suppression lower for younger people
 - **Race/Ethnicity:**
 - Concurrency rates and retention in care consistently higher among those identified as black or Hispanic
 - Linkage to care and rates of viral load suppression lowest for those identified as black
 - **Location:**
 - Concurrency rates tend to be higher among PLWH in DPHO areas
 - Rates of viral load suppression lower for PLWH in DPHO areas
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GOAL 1: INCREASE THE NUMBER OF INDIVIDUALS WHO ARE AWARE OF THEIR HIV STATUS

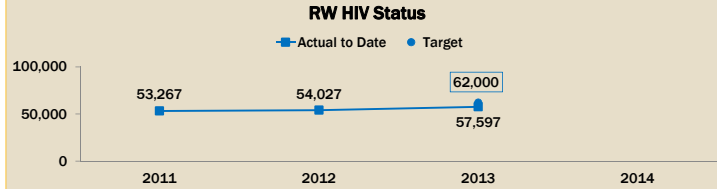
- Objective 1A: To ensure expanded access to voluntary HIV testing across health care and social support service provider settings, by the end of 2013.

Ryan White Indicator	EMA Indicator
An increase to test 62,000 unique individuals annually through Ryan White-funded programs.	An increase in the total number of HIV rapid tests conducted, to reach 300,000 tests annually.

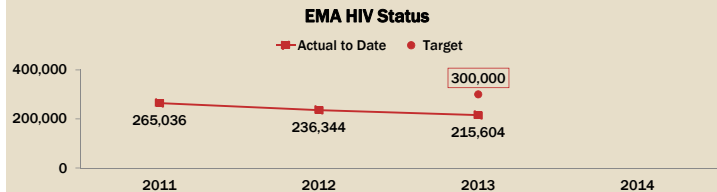
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Objective 1A

- Ryan White Part A (NYC and Tri-County): The number of clients receiving HIV tests has increased overall, though failing to meet the target of 62,000 tested by 2013.



- EMA-wide (NYC only): Analyses indicate a reduction in HIV screening from 2011 to 2013, but this is based only on NYC DOHMH administered testing programs.



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

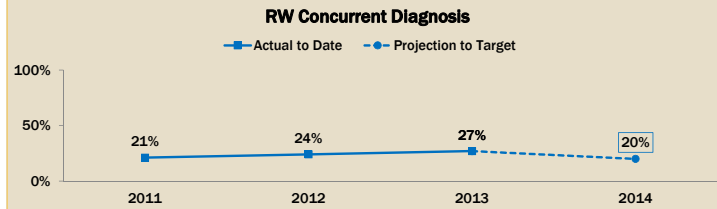
- Objective 1B: To decrease delayed diagnosis of HIV, by the end of 2014.

Ryan White Indicator	EMA Indicator
A reduction in concurrent (AIDS with HIV) diagnoses, to 20% or lower.	A reduction in concurrent (AIDS with HIV) diagnoses, to 20% or lower.

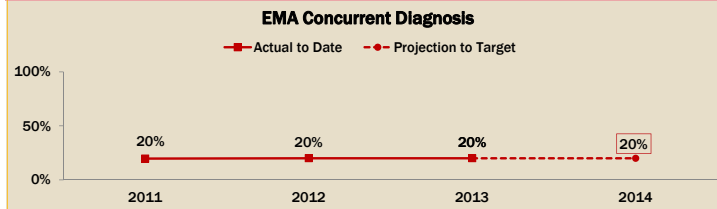
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Objective 1B

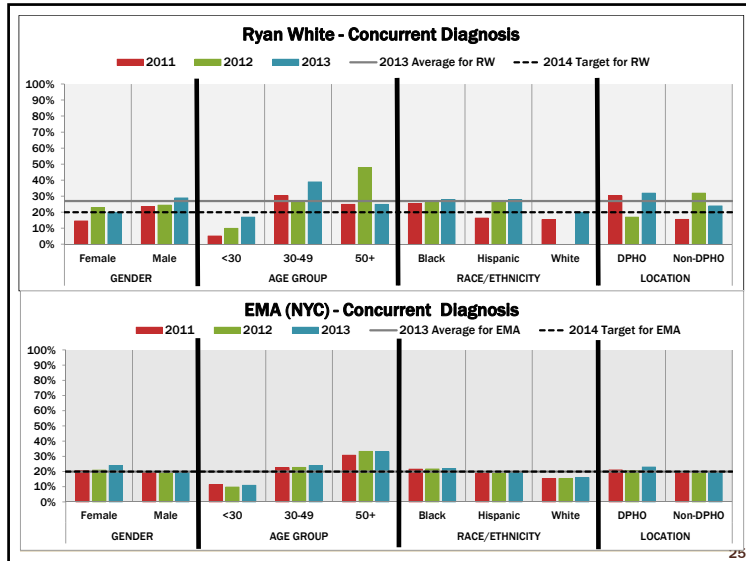
- Ryan White Part A (NYC only): Concurrent diagnoses have increased slightly over time.



- EMA-wide (NYC only): Trends for concurrency have remained stable over time.



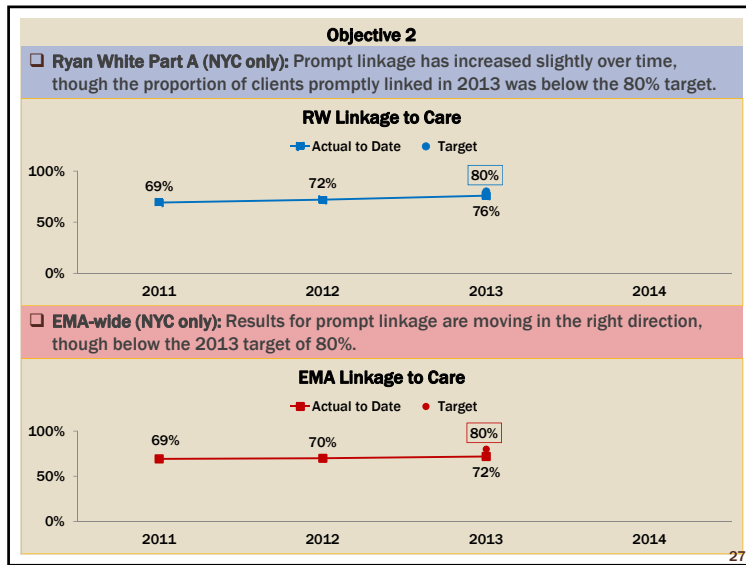
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GOAL 2: PROMOTE EARLY ENTRY INTO HIV CARE

- Objective 2:** To increase the proportion of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis, by the end of 2013.

Ryan White Indicator	EMA Indicator
An increase in the proportion of newly diagnosed clients who show evidence of accessing primary care within three months of HIV diagnosis, to 80%.	An increase in the proportion of newly diagnosed individuals who show evidence of accessing primary care within three months of HIV diagnosis, to 80%.



GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION

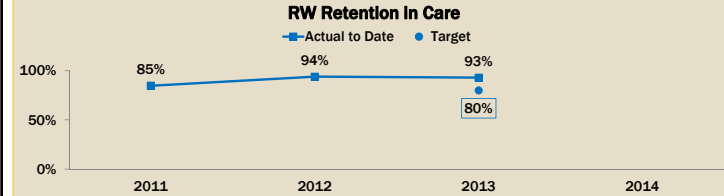
- Objective 3A: To increase retention in HIV care and treatment, by the end of 2013.

Ryan White Indicator	EMA Indicator
Increase to 80% the proportion of clients with evidence of regular care by current minimum standards (at least 2 visits for routine HIV medical care in 12 months, and at least 3 months apart)	Increase to 80% the proportion of PLWH with evidence of regular care by current minimum standards (at least 2 visits for routine HIV medical care in 12 months, and at least 3 months apart)

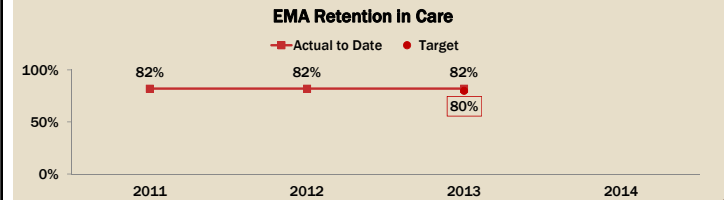
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Objective 3A

- Ryan White Part A (NYC only): Primary care retention has improved slightly, and, for all years measured, has exceeded the target of 80% set for the end of 2013.

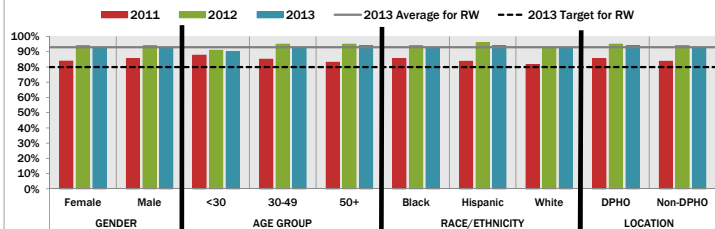


- EMA-wide (NYC only): Primary care retention has remained stable over time, and, for all years measured, has exceeded the target of 80% set for the end of 2013.

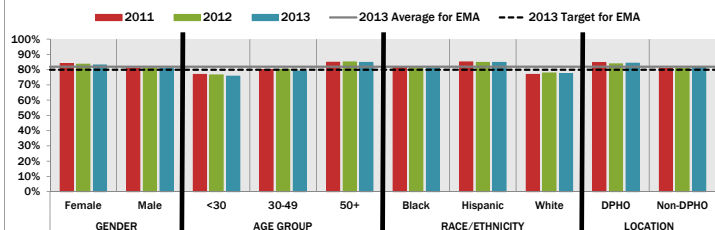


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Ryan White - Retention In Care

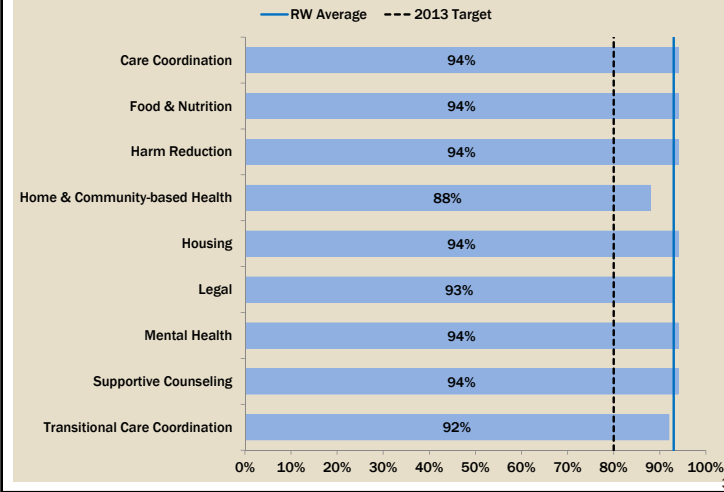


EMA (NYC) - Retention In Care



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Retention in care among clients enrolled in a given Ryan White service category, 2013



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GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION

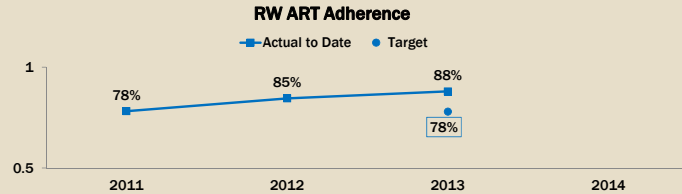
- Objective 3B: To increase the proportion of clients who have an optimal level of ART adherence, by the end of 2013.

Ryan White Indicator	EMA Indicator
Achievement of 95% or greater medication adherence among 78% of MCM clients , meeting minimum program and treatment criteria.	Achievement of 95% or greater medication adherence among 75% of PLWH on ARVs at last update.

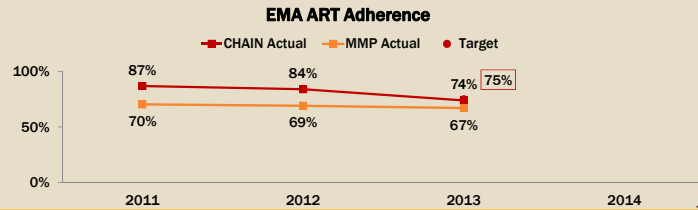
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Objective 3B

- Ryan White Part A (NYC MCM only): Adherence continues to increase over time, and, for all years measured, has met or exceeded the target of 78% set for the end of 2013.



- EMA-wide: Adherence has varied by source over time, with CHAIN (NYC and Tri-County) and MMP (NYC only) showing slightly decreased levels over time and 2013 values below the 75% target.



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GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION

- Objective 3C: To increase viral suppression, by the end of 2014.

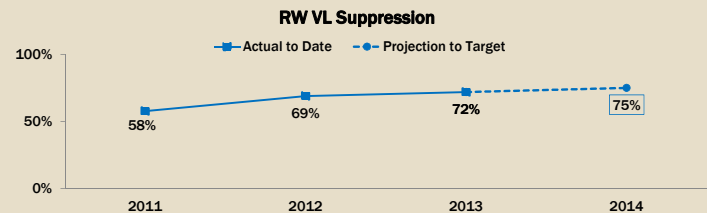
Ryan White Indicator	EMA Indicator
An increase in the proportion of virally suppressed MCM (and Part A overall)* HIV-positive clients to 75%, among those who are continuously enrolled for at least four months and have viral loads documented in the period.	An increase in the proportion of virally suppressed PLWH in the EMA to 75%, among those who have viral loads documented in the period.

* Note: Due to increased availability of surveillance data, we were able to analyze this indicator for Part A clients overall rather than restricting our look just to MCM clients.

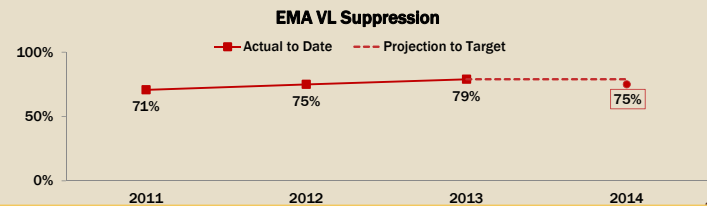
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Objective 3C

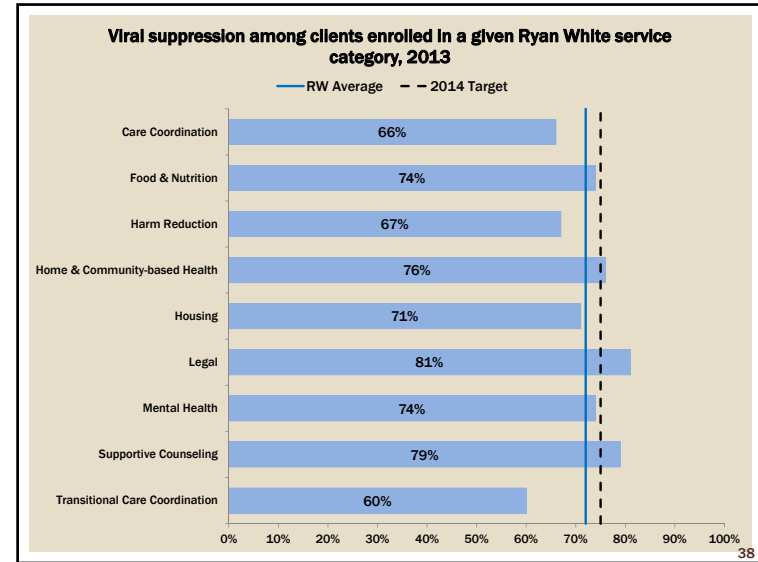
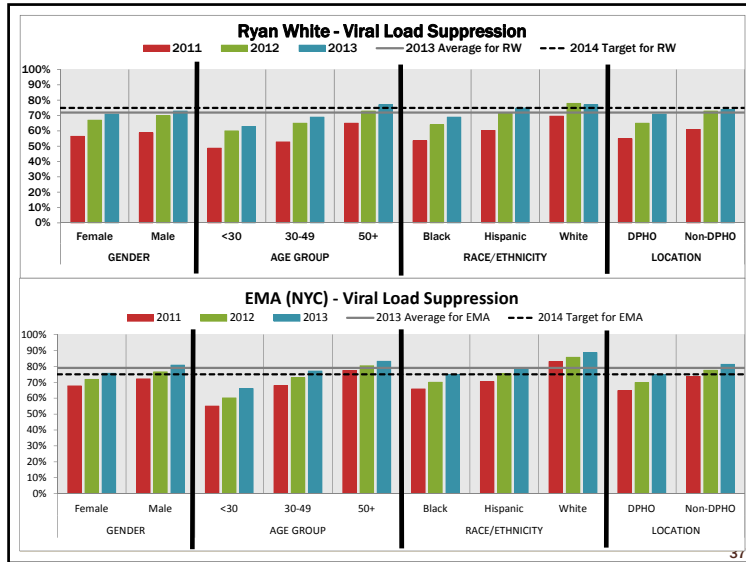
- Ryan White Part A (NYC only): Since 2011, there has been a steady increase in rates of viral load suppression.



- EMA-wide (NYC only): Viral load suppression has been achieved by a higher percentage of PLWH each year, reaching the target in 2012 and exceeding the target in 2013.



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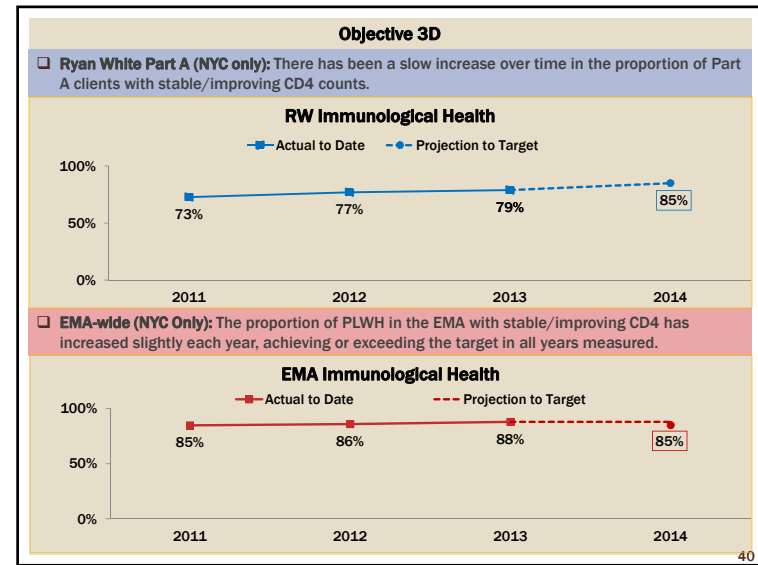


GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION

- Objective 3D:** To improve immunological health (e.g., CD4 count), by the end of 2014.

Ryan White Indicator	EMA Indicator
An increase to 85% in the proportion of MCM* clients whose CD4 counts either remain stable or improve during the 12-month period, among those on ARV treatment and meeting minimum expectations for MCM program engagement (at least one service within a four-month period of enrollment).	An increase to 85% in the proportion of PLWH in the EMA whose CD4 counts either remain stable or improve during the 12-month period, among all those with documented CD4 counts in the period.

* Note: Due to increased availability of surveillance data, we were able to analyze this indicator for Part A clients overall rather than restricting our look just to MCM clients.

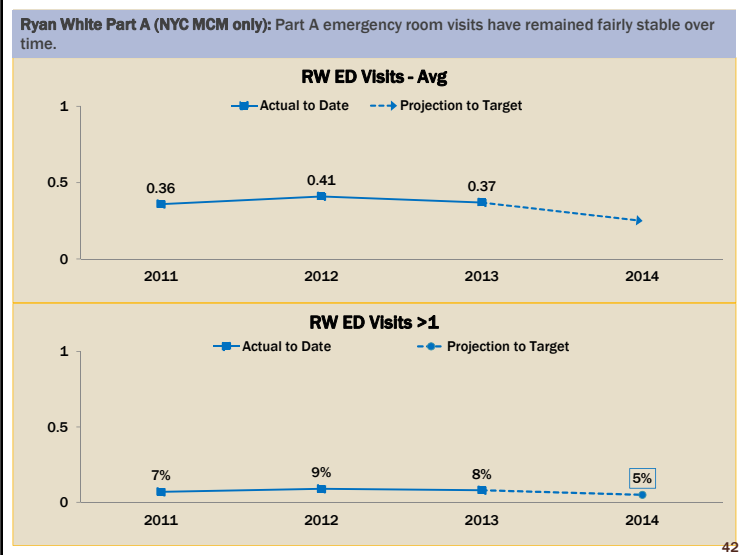


GOAL 3: PROMOTE OPTIMAL MANAGEMENT OF HIV INFECTION

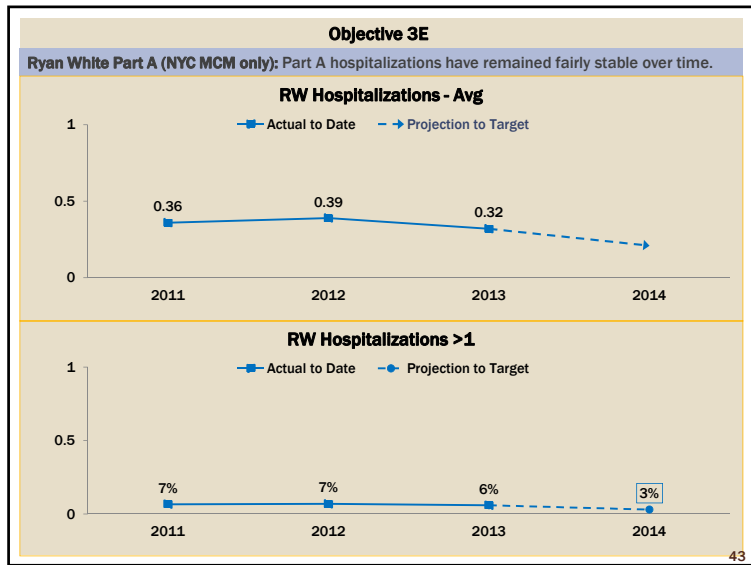
Objective 3E: To decrease reliance on acute care, by the end of 2014.

Ryan White Indicator	EMA Indicator
<ul style="list-style-type: none"> - Any decrease in the mean number of ED visits and hospitalizations experienced annually per MCM client. - A decrease in the proportion of MCM clients who have more than one hospitalization within a 12-month period, to 3% or less. - A decrease in the proportion of MCM clients who have more than one ED visit within a 12-month period, to 5% or less. 	<ul style="list-style-type: none"> - Any decrease in the mean number of ED visits and hospitalizations experienced annually per PLWH. - A decrease in the proportion of PLWH who have more than one hospitalization within a 12-month period, to 3% or less. - A decrease in the proportion of PLWH who have more than one ED visit within a 12-month period, to 5% or less.

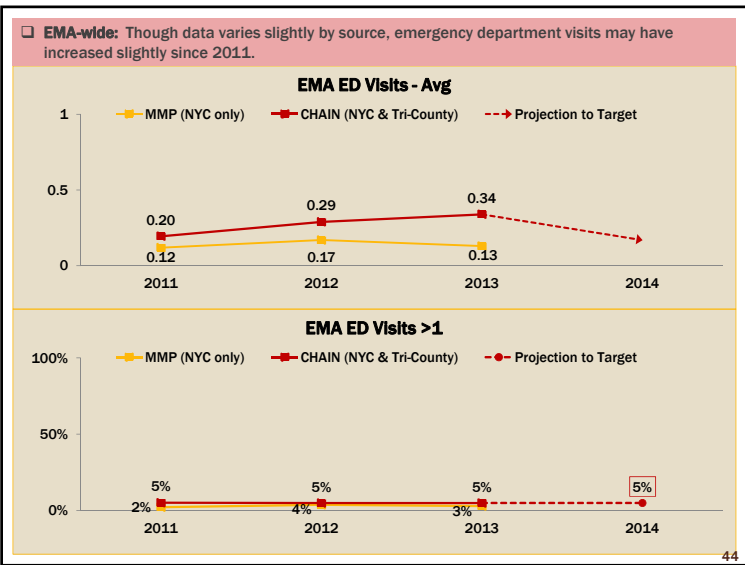
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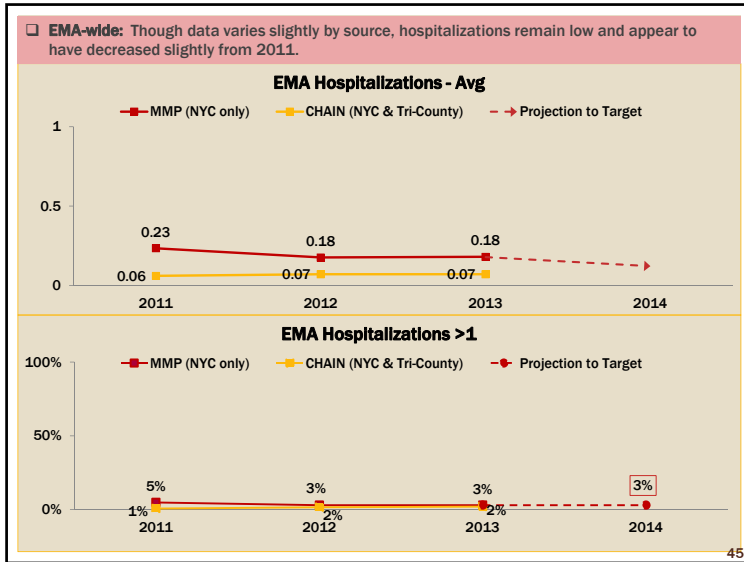
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GOAL 5: ECONOMIC EVALUATION OF RYAN WHITE PART A SERVICES

- Work on the economic evaluation of Ryan White Part A services in the NY EMA continues to move forward:
 - Collaborated with a group of NYU Wagner Capstone students to develop a more analytical methodology for estimating cost per client
 - Conducted sensitivity testing to better understand service utilization and costing trends
 - Developed initial analyses for Care Coordination to explore future cost-effectiveness work
 - Preparing alternative methodologies that utilize reimbursement rates combined with services data instead of using contractual expenditure data
 - Developing service category-level report for June 2015 on cost modeling and future costing work

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ACKNOWLEDGEMENTS

- Thank you to all those who provided data for this presentation:
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 - Public Health Solutions, Inc.

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