State of Service and Science: 25 Years of History & the Future

Ending AIDS: A Deep South Summit
April 17, 2015

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Health Resources and Services Administration
Setting the Stage
Our Past and Present
Ryan White (1971-1990)

Ryan White CARE Act

Ryan White Treatment Extension Act 2009
### State of Service – Past & Present

<table>
<thead>
<tr>
<th>External Factors</th>
<th>Client Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economy</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>Housing</td>
<td>Homophobia</td>
</tr>
<tr>
<td>Geography</td>
<td>Racism</td>
</tr>
<tr>
<td>Workforce</td>
<td>Stigma</td>
</tr>
<tr>
<td>Healthcare system</td>
<td></td>
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<tr>
<td>Politics/Policy</td>
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</table>
Role of RWHAP with ACA

- Funds a **system of care** that benefits everyone living with HIV
- Provides a **safety net** for people living with HIV (PLWH) who have little or no income
  - Provides **services** for those that may not be eligible for other forms of assistance
  - Provides **coverage** for needed services that may not be covered by other types of insurance
  - Provides an **entry way to medical care** and assist in enrolling in other more comprehensive coverage
Three Focus Areas

Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system.

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| Incentives    | Promote value-based payment systems  
• Test new alternative payment models  
• Increase linkage of Medicaid, Medicare FFS, and other payments to value  
Bring proven payment models to scale |
| Care Delivery | • Encourage the integration and coordination of clinical care services  
• Improve population health  
• Promote patient engagement through shared decision making |
| Information   | • Create transparency on cost and quality information  
• Bring electronic health information to the point of care for meaningful use |
Example 1: Prevalence-Based HIV Care Continuum, 2011

- 86% Diagnosed
- 80% of those diagnosed in 2011
- 40% Engaged in care
- 37% Prescribed ART
- 30% Viral suppression

*Linkage to care measures the percentage of people diagnosed with HIV in a given calendar year who had one or more documented viral load or CD4+ test within three months of diagnosis. Because it is calculated differently from other steps in the continuum, it cannot be directly compared to other steps and is therefore shown in a different color. See Table 1 on page 4 for more details.


# RWHAP clients with at least 1 medical visit  % Retained  % Virally Suppressed

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>Southern Region</th>
<th>Alabama</th>
</tr>
</thead>
<tbody>
<tr>
<td># clients</td>
<td>301,109</td>
<td>101,566</td>
<td>4,325</td>
</tr>
<tr>
<td>Retained</td>
<td>81.0%</td>
<td>80.9%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Virally Suppressed</td>
<td>78.6%</td>
<td>75.6%</td>
<td>74.3%</td>
</tr>
</tbody>
</table>

Retained in care: had at least 1 OAMC visit before September 1 of the measurement year and had at least 2 visits 90 days or more apart

Viral suppression: had at least one OAMC visit, at least one viral load count, and last viral load test <200
### Retention in Care

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>Regional</th>
<th>Alabama</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013 Retention</strong></td>
<td>80.9%</td>
<td>80.8%</td>
<td>89.1%</td>
</tr>
<tr>
<td>White</td>
<td>79.6%</td>
<td>81.2%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Black</td>
<td>79.9%</td>
<td>80.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td>MSM</td>
<td>80.3%</td>
<td>81.4%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>82.2%</td>
<td>81.1%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Male</td>
<td>79.3%</td>
<td>80.4%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Female</td>
<td>77.2%</td>
<td>82.0%</td>
<td>90.7%</td>
</tr>
</tbody>
</table>

**Retention in Care**: had at least one OAMC visit before September 1, 2013, and had at least 2 visits 90 days or more apart

**National Figures**: all states minus Alabama

**Regional Figures**: Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas
**Viral Suppression by Race Ethnicity**

- **National**
  - White VS: 84%
  - Black VS: 74%
  - Hispanic VS: 81%
  - Total: 79%

- **Regional**
  - White VS: 82%
  - Black VS: 71%
  - Hispanic VS: 81%
  - Total: 71%

- **Alabama**
  - White VS: 81%
  - Black VS: 71%
  - Hispanic VS: 84%
  - Total: 84%
Viral Suppression by Risk

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>National</th>
<th>Regional</th>
<th>Alabama</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>80%</td>
<td>76%</td>
<td>77%</td>
</tr>
<tr>
<td>Black MSM</td>
<td>72%</td>
<td>69%</td>
<td>73%</td>
</tr>
<tr>
<td>IDU</td>
<td>79%</td>
<td>76%</td>
<td>73%</td>
</tr>
</tbody>
</table>

79%
Viral suppression: had at least one OAMC visit, at least one viral load count, and last viral load test <200
What Works Well?
Working Together
Coordinated Planning

• Develop a coordinated jurisdictional response to HIV
• Avoid duplication of processes
• Share knowledge, data and processes
• Share financial and human resources (more economical)
• Increase collaboration and communication
What Works: Data to Care

Utilizing data to:

- Analyze disparities and gaps in care
- Assess impact of interventions
- Decide on funding allocations
  - Based on gaps
  - Based on performance
Peer Navigators

• Facilitate medical and psychosocial care of the client by bridging providers and clients
• Foster trust and understanding with clients distinct from the provider or case manager role
• Serve as a role model, providing reliable information and emotional and/or practical support to enrolled clients
• Encourage clients to remain in care and adhere to medications
Building Community Partnerships - Pharmacies

- Engage pharmacy staff in treatment adherence guidance and instruction during clinic visits
- Use “bubble packs” for clients with low health literacy for complex regimens
- Monitoring adherence quarterly through refill trends and viral load elevations associations
- Manage of co-morbidity pharmacological use
Care and Prevention in the U.S. (CAPUS)

• Fund state-level collaboration and coordination across agencies and organizations addressing the needs of people living with and affected by HIV
• Address social, economic, clinical, and structural factors influencing HIV health outcomes
• Increase knowledge of serostatus among racial/ethnic populations
• Optimize linkage to, retention in, and re-engagement with care and prevention services
Moving Forward
Maximize Resources

- **Coordination**: who should we be connecting with to inform and guide services
- **Collaboration**: who can we engage to ensure availability of services
- **Data**: how can we better use the available data to identify and address gaps in services and resources
- **Innovation**: how can we leverage advances in service delivery and technology like telemedicine and social media
• State Profiles:  
http://hab.hrsa.gov/stateprofiles/

• TARGET Center:  
https://careacttarget.org/

• RWHAP Project Officer: more than monitoring grants; provides technical assistance too
Thank You!

Contact Information

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