



Implementation of the National HIV/AIDS Strategy to Improve HIV Prevention and Care

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The National HIV/AIDS Strategy Overview

Goals

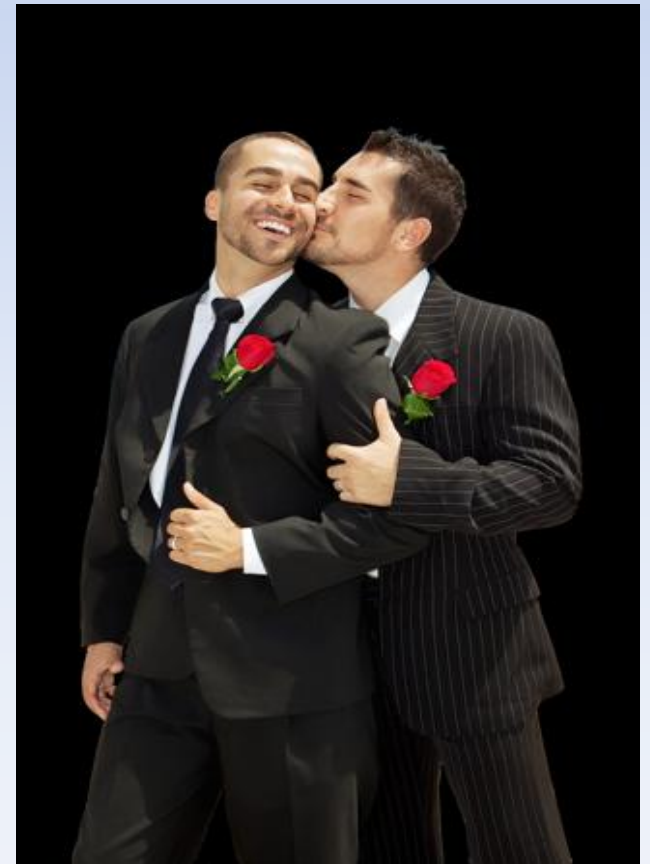
1. Reduce the number of people who become infected with HIV.
2. Increase access to care and optimize health outcomes for people living with HIV.
3. Reduce HIV-related health disparities.

Facets of the Strategy

- Small number of action steps
- 5-year targets
- Emphasis on evidence-based approaches
- Roadmap for all public and private stakeholders responding to the domestic epidemic
- Focus on improving coordination and efficiency across and within Federal, State, local and tribal governments
- Catalyst for all levels of government and stakeholders to develop their own implementation plans for achieving their goals



Addressing Stigma and Discrimination: President Obama Supports Same-Sex Marriage



President Obama's 2013 Budget for HIV



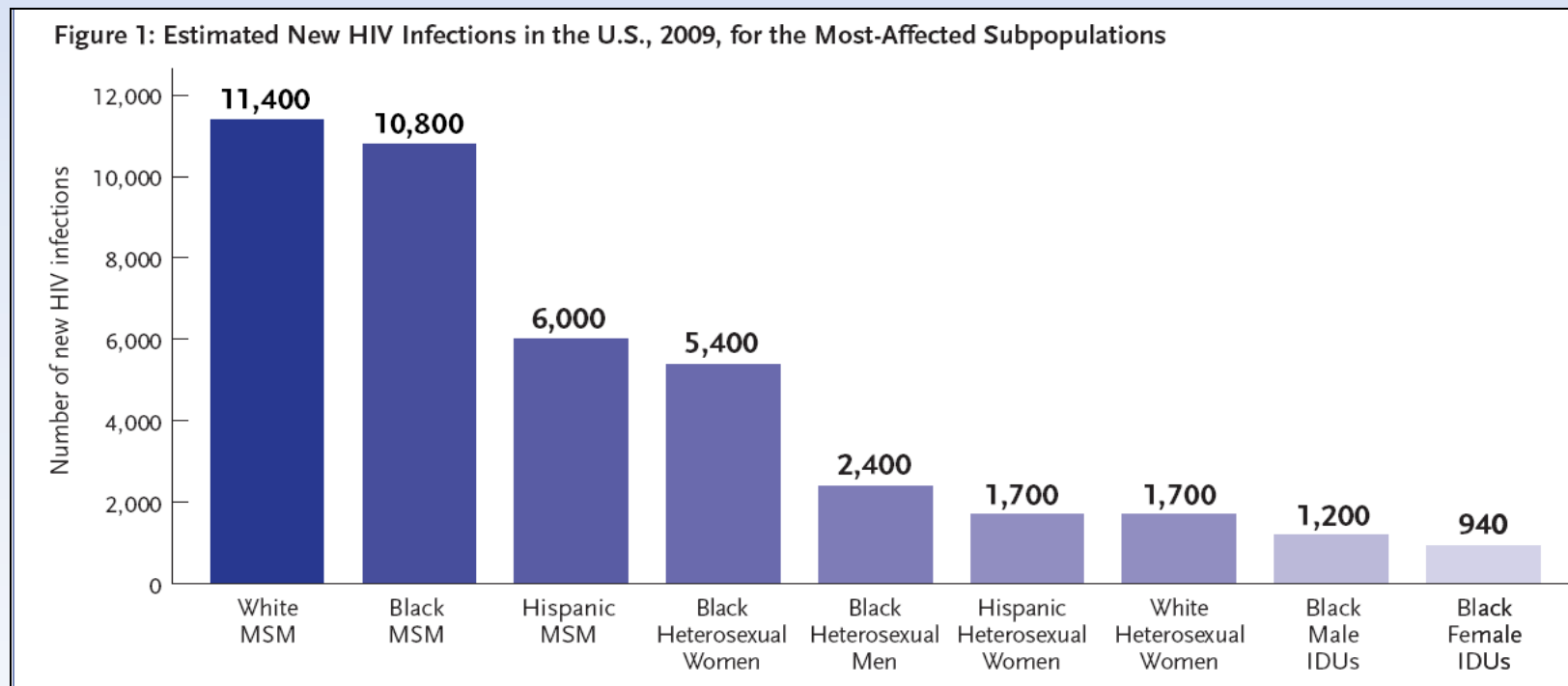
- \$22.3 billion for domestic HIV prevention, care and treatment
- \$766 million increase for HIV/AIDS care and prevention
- \$1 billion for ADAP

Ongoing Challenges to Implementing the National HIV/AIDS Strategy

- Fiscal
 - Cost for biomedical interventions
 - Funding for HIV prevention
- Coordination among agencies
 - Metrics
 - FOAs
 - Traditional siloed approach
- Coordination across Federal, State, and local levels
 - Higher you go, less understanding of issues on the ground
 - Inadequate funding or staffing at each level
- Ability of organizations to adapt to a changing environment
- Political will to place funds where the epidemic is
- Educating providers about HIV prevention and care
 - Adapting a team approach
 - Reluctance to care for HIV+ patients
 - Reimbursement

New HIV Infections in the U.S.

- Estimated 50,000 new HIV infections annually in U.S.
- MSM 64% of new infections; 48% increase young black MSM
- Black women at highest risk among women
- Latinos disproportionately impacted compared to whites

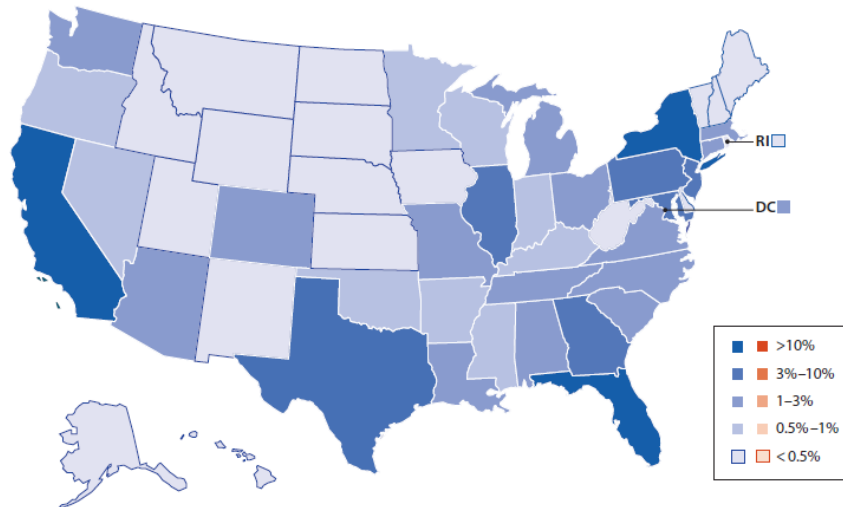


Aligning Resources with the Epidemic

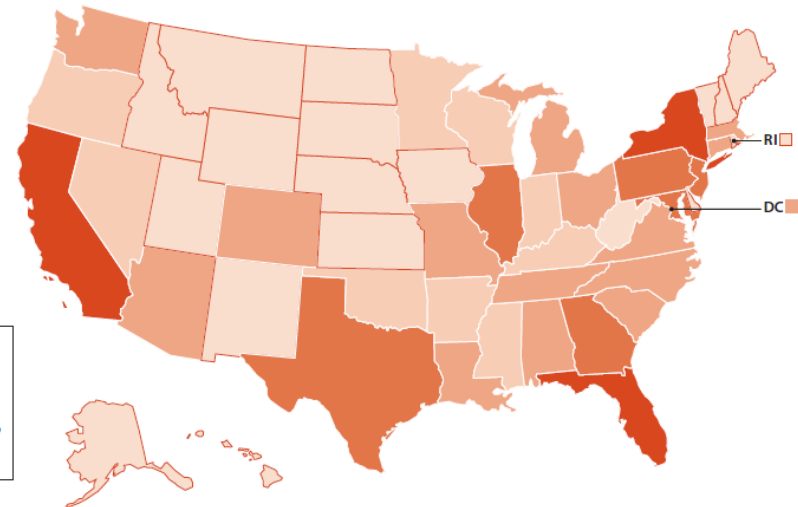
Matching Prevention Funds to the Epidemic¹

When CDC's new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.

Proportion of Americans Living with an HIV Diagnosis (2008)



Proportion of CDC Core HIV Prevention Funding—FY2016²



¹Maps do not include U.S. territories receiving CDC HIV prevention funding.

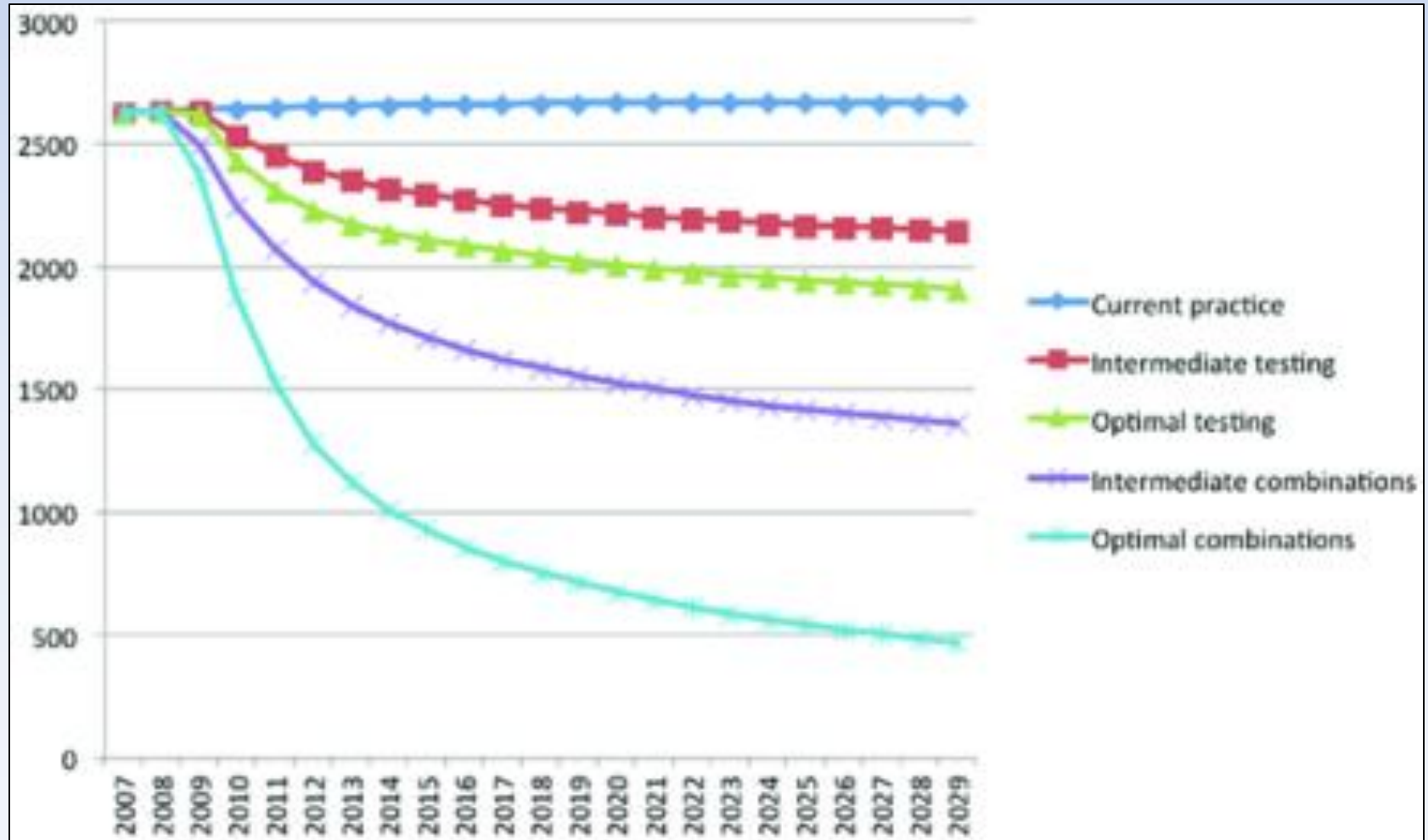
² New funding allocation methodology will be fully implemented by FY2016; this breakdown assumes level overall funding.

Let's Get the Basics Right

- Effective, Evidence-based Approaches We Know Prevent HIV
 - Condom availability
 - Comprehensive drug treatment
 - HIV testing (awareness of status)
 - Circumcision (limited effectiveness in US)
 - Antiretroviral therapy for diagnosed positives
 - Antiretroviral therapy for high risk negatives
 - Serosorting (among positives)
 - Testing pregnant women

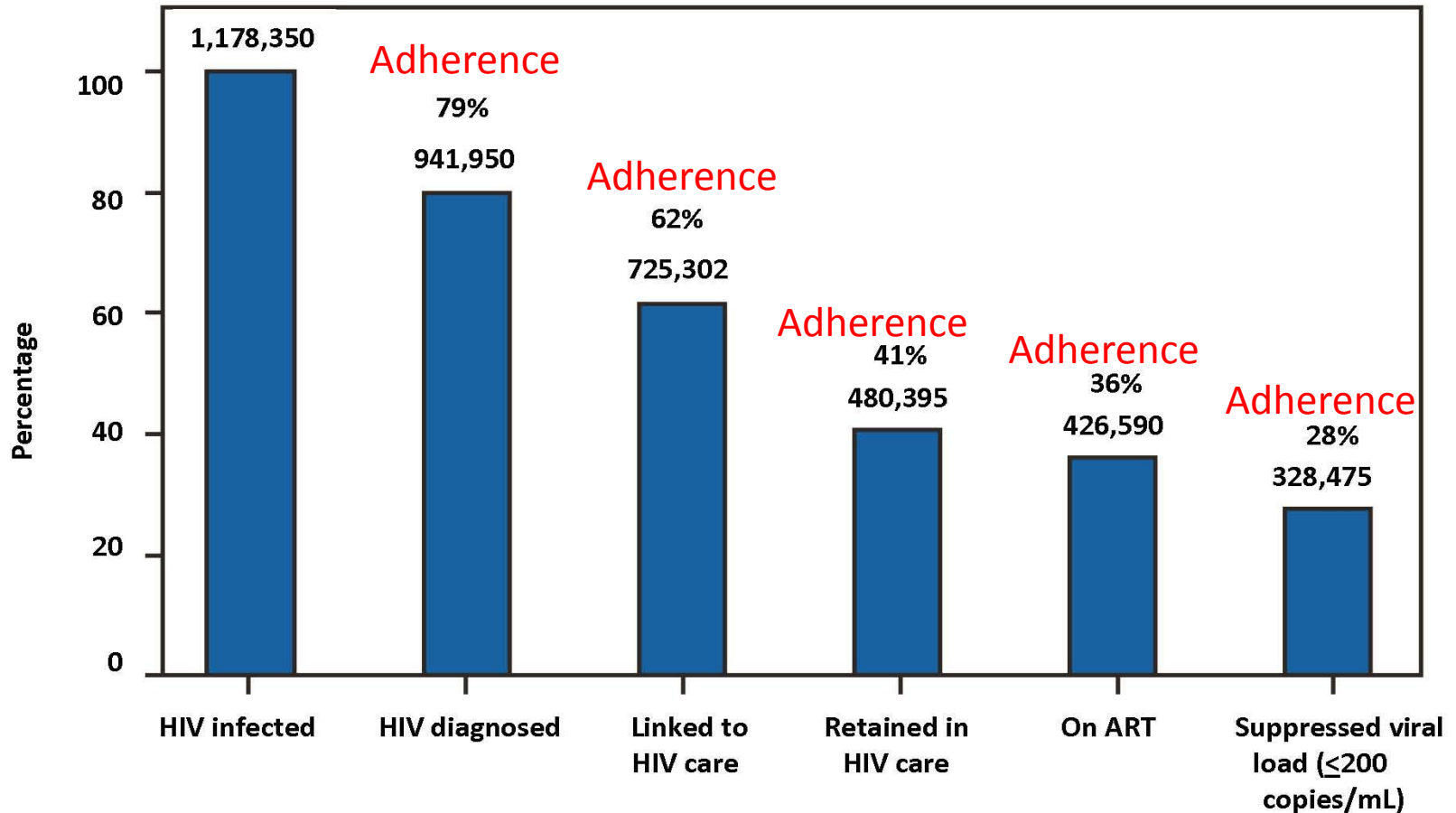
Best combination of HIV prevention approaches that will have population-level effect for specific populations is unknown

Modeling Test and Treat: Annual Number of New HIV Infections

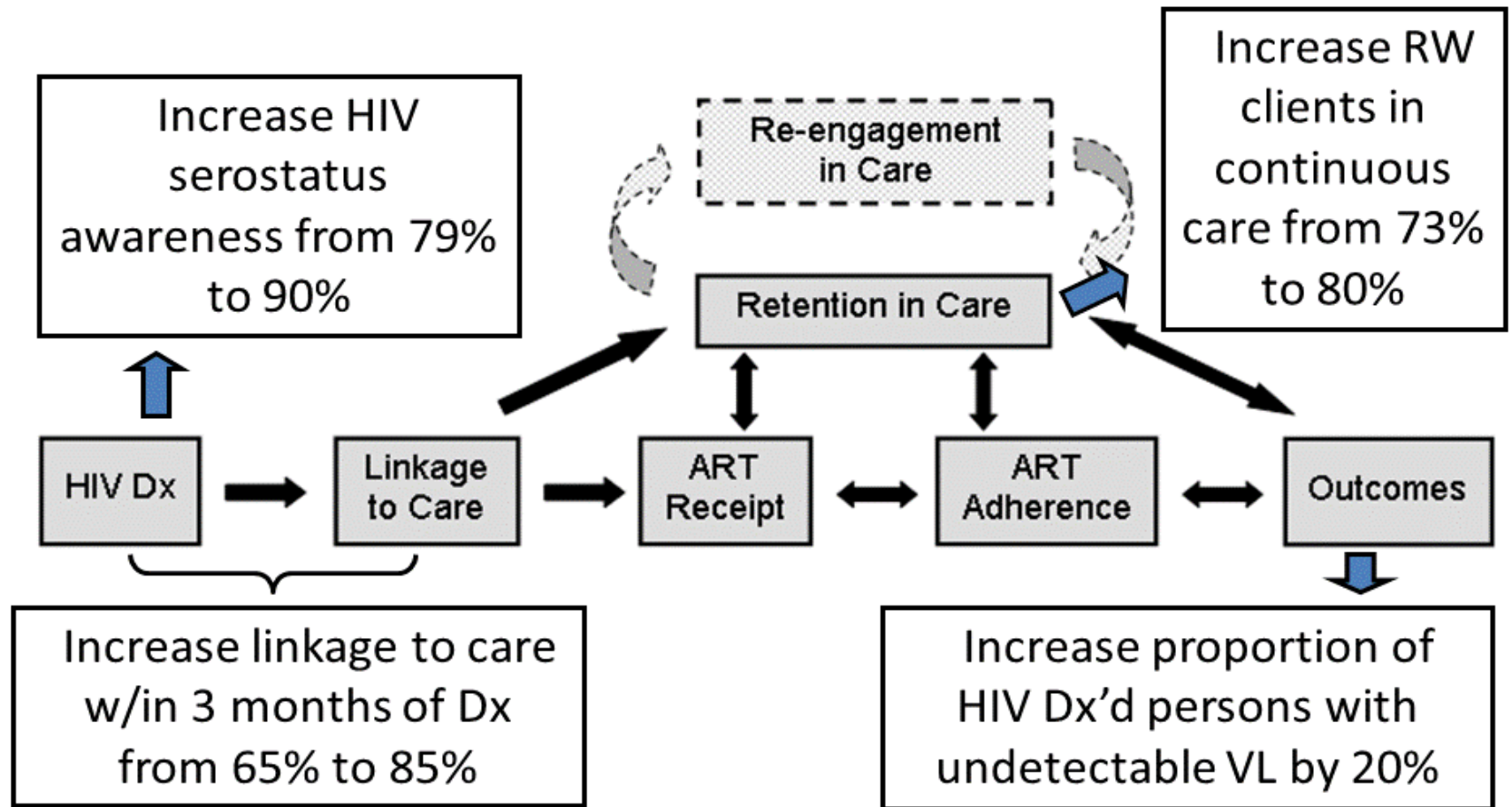


We Must Do Better

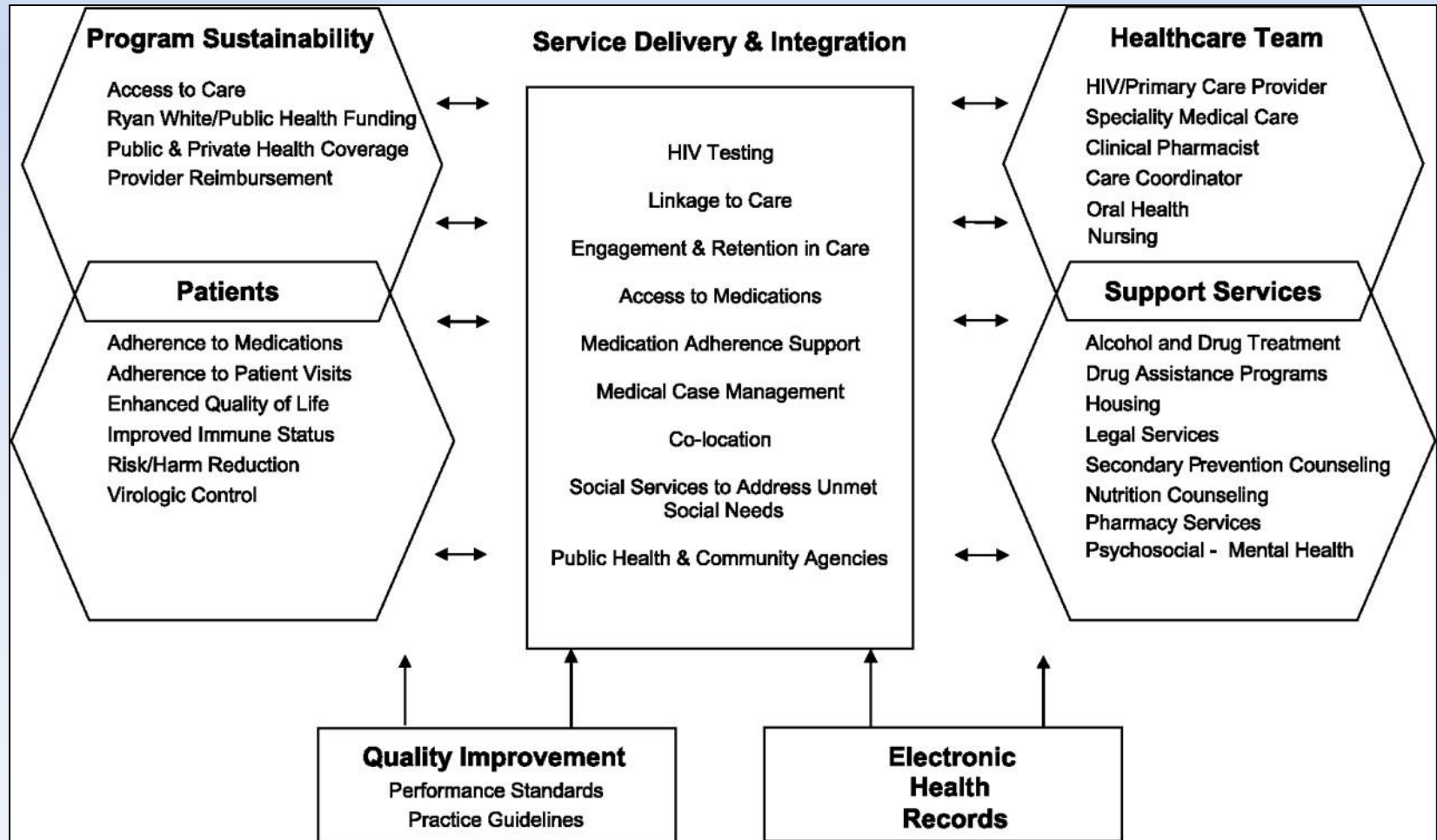
HIV Treatment Cascade



National HIV/AIDS Strategy

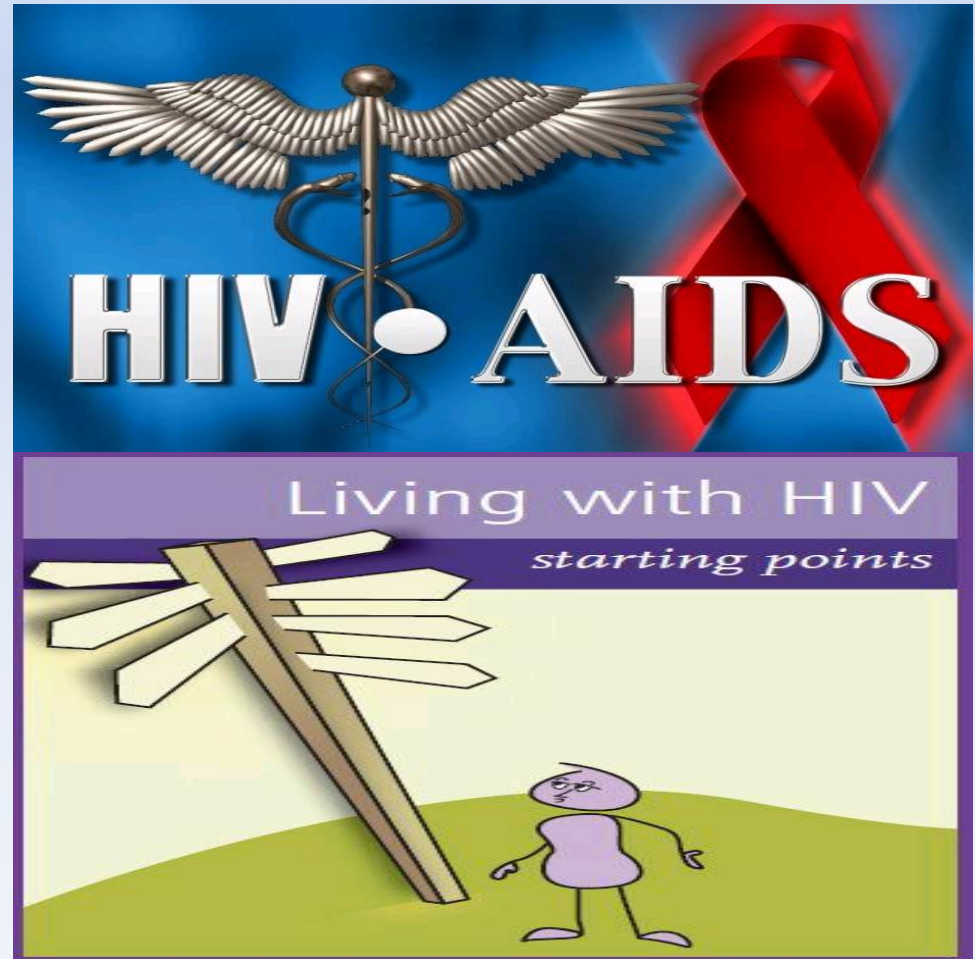


Maximizing the Cascade: Components of Comprehensive HIV Care

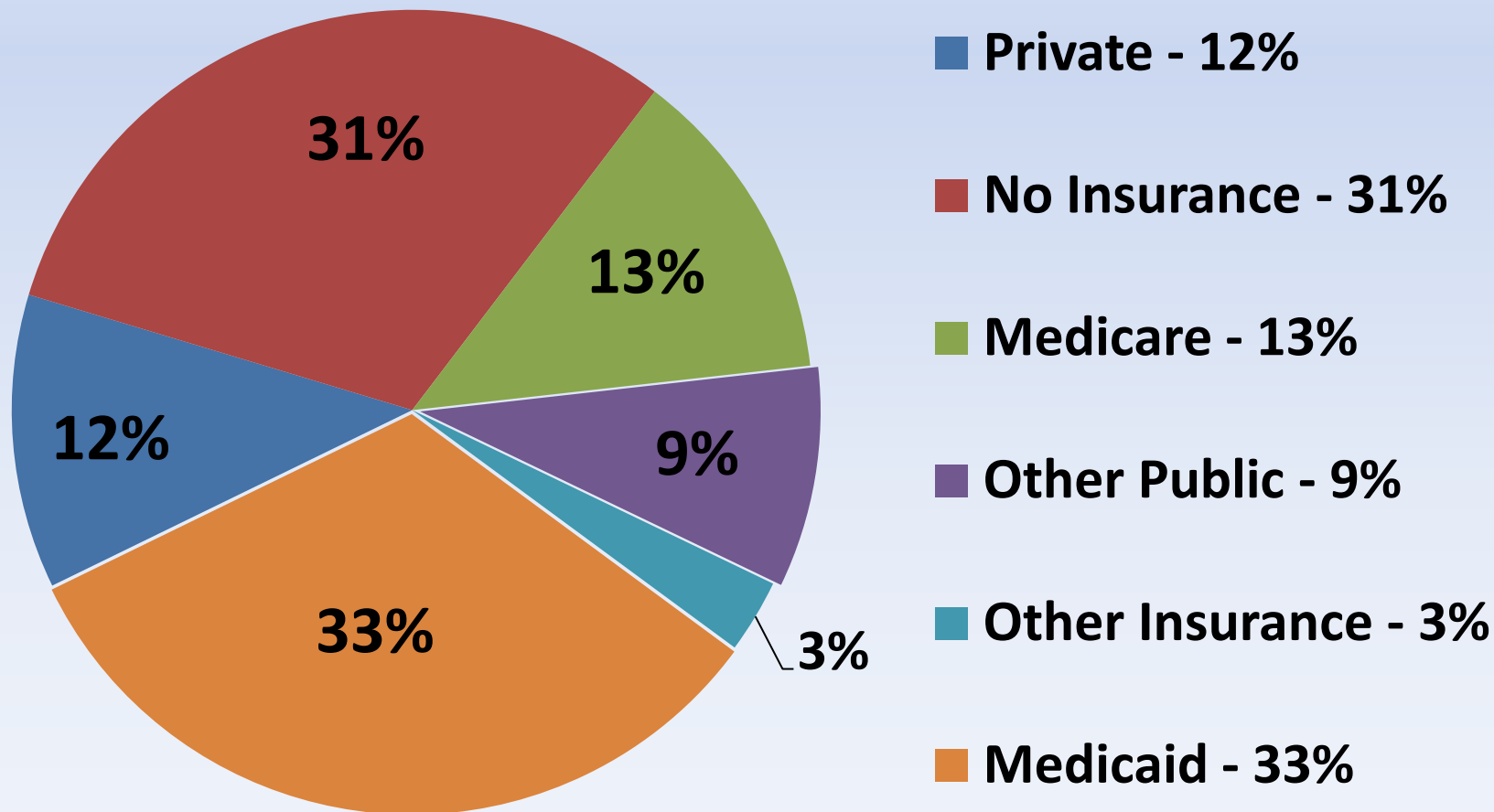


HIV and Health Coverage

- Of PLWHA in the U.S.
 - 13% have private coverage
 - 24% of have no coverage
 - 47% receive Medicaid
 - Approximately 500,000 receive some form of Ryan White services



Insurance Status of HIV-Positive Clients Receiving Ryan White Services 2008

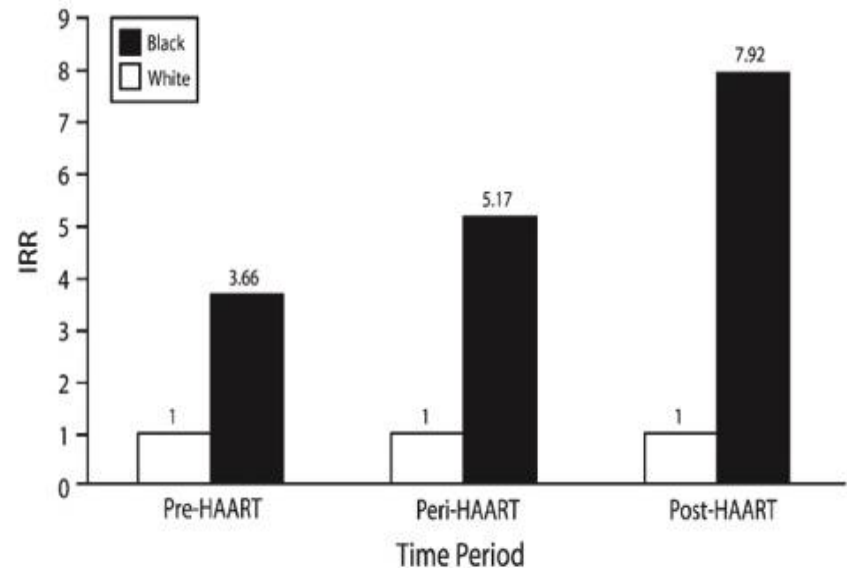


Source: HRSA

Increasing Disparities AIDS Mortality by Race

AIDS deaths have declined
least in the ART era:

- Among black and Latino MSM relative to white MSM (Blair et al., 2002; Hall et al., 2007)
- Among black women compared to white men (44% vs. 79%, respectively; CDC 2009)
- Among Latinos compared to blacks or whites (Cunningham et al., 2010)

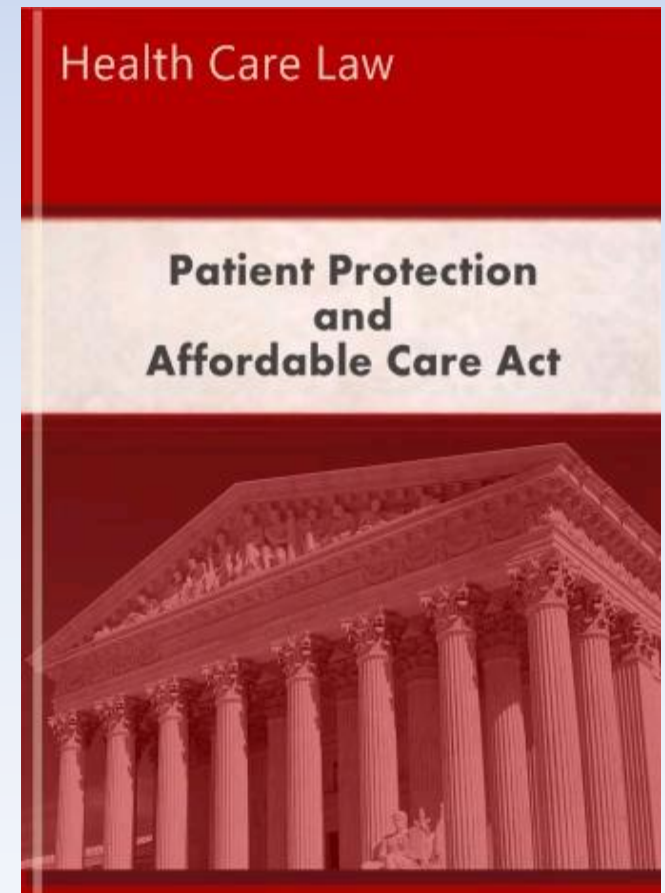


Note. HAART = highly active antiretroviral therapy; IRR = incident rate ratio. For each period, the results from the model were adjusted for age, gender, and urbanicity. Whites were the reference group.

(Levine, 2010)

Toward Health Equity: The Affordable Care Act

- Expands coverage to 32 million Americans
 - 5.4 million Latinos
 - 3.8 million African-Americans



Source: Office of the Assistant Secretary for Planning and Evaluation, 2012

The Affordable Care Act: Meaningful Change Now

- 54 million additional Americans receiving preventive services
- 900,000 young adults insured by remaining on parent's private insurance
- Hundreds of persons living with HIV now covered under Pre-existing Condition Insurance Plans
- ADAP benefits considered contribution toward true out-of-pocket expenses, helping fill "donut hole"
- Insurers cannot rescind coverage except in cases of fraud or intentional misrepresentation
- Expanded National Health Service Corps
 - 3600 providers (2008) to 10,000 (2011)
 - Increased patients served from 3.7 to 10.5 million

Affordable Care Act: 2014

- No denial of coverage for pre-existing conditions
- Expands Medicaid eligibility to 133% of Federal poverty level
- People without access to employer-sponsored insurance or Medicaid will be able to buy private coverage from Affordable Insurance Exchanges
- Increased resources to community health centers (\$11 billion over next 5 years)
- Shift to electronic health records

More Change: Inclusive Treatment Recommendations

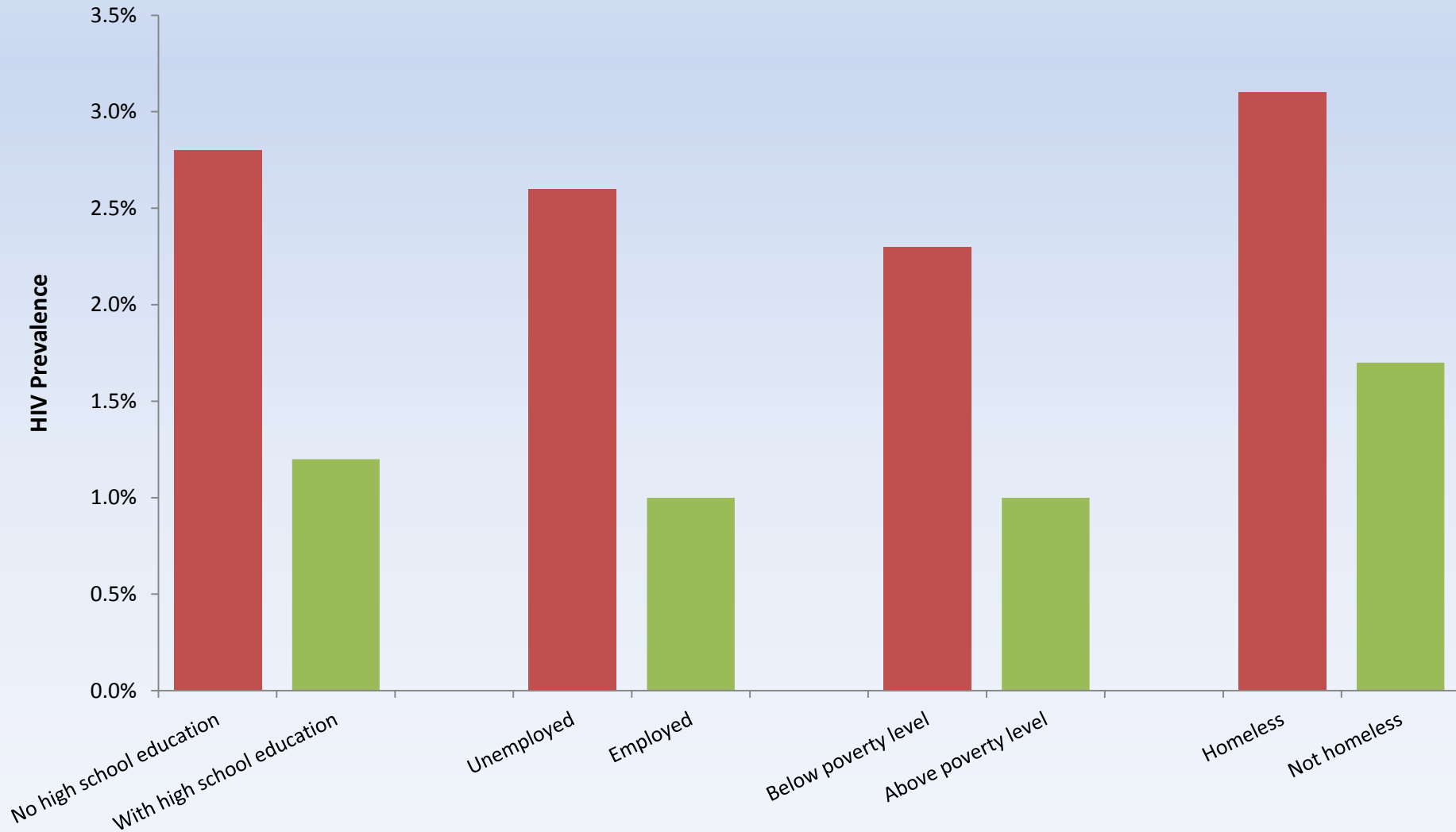
- Spring 2010: SFDPH recommends offering treatment to all
- December 2011: NYC DOHMH recommends offering treatment to all
- March 2012: DHHS panel recommends therapy for all HIV-infected patients



Ongoing Challenges: Adherence to Care 13 U.S. Areas

- 5,137 persons dx with HIV in 2008
- 63% had 2 or more visits 3 months apart within 12 months of dx
- Blacks and Latinos less likely to be in established care than whites (54.3%, 69.4% vs 74.7%)
- Females exposed through heterosexual contact more likely to be in care than MSM, heterosexual men, IDU (male or female)

HIV Infection Among Heterosexuals in Urban Areas, by Socio-Economic Indicators

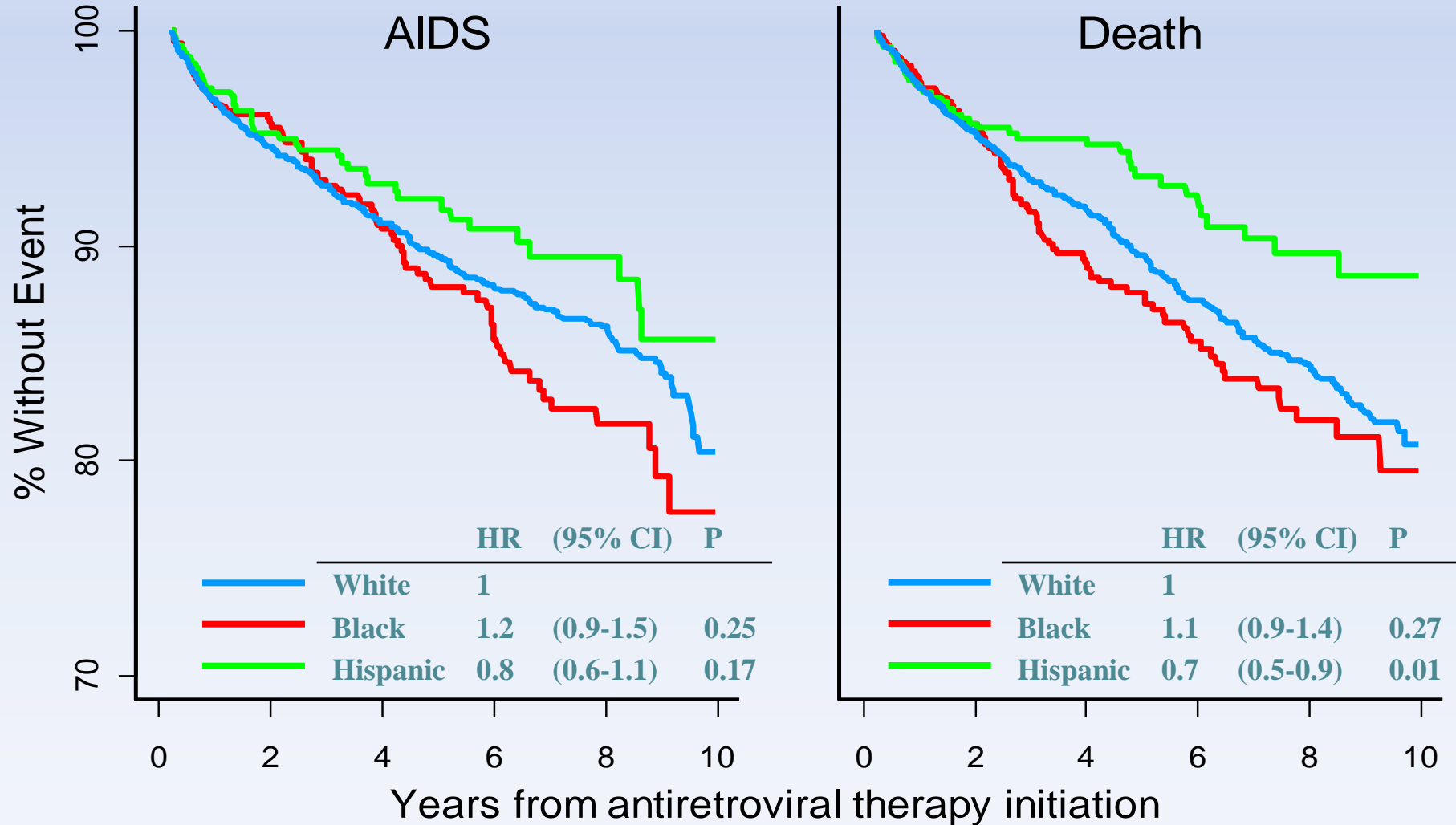


*CDC. Characteristics Associated with HIV Infection Among Heterosexuals in Urban Areas with High AIDS Prevalence --- 24 Cities, United States, 2006--2007. MMWR 2011;60:1045-1049.

Kaiser Cohort Study

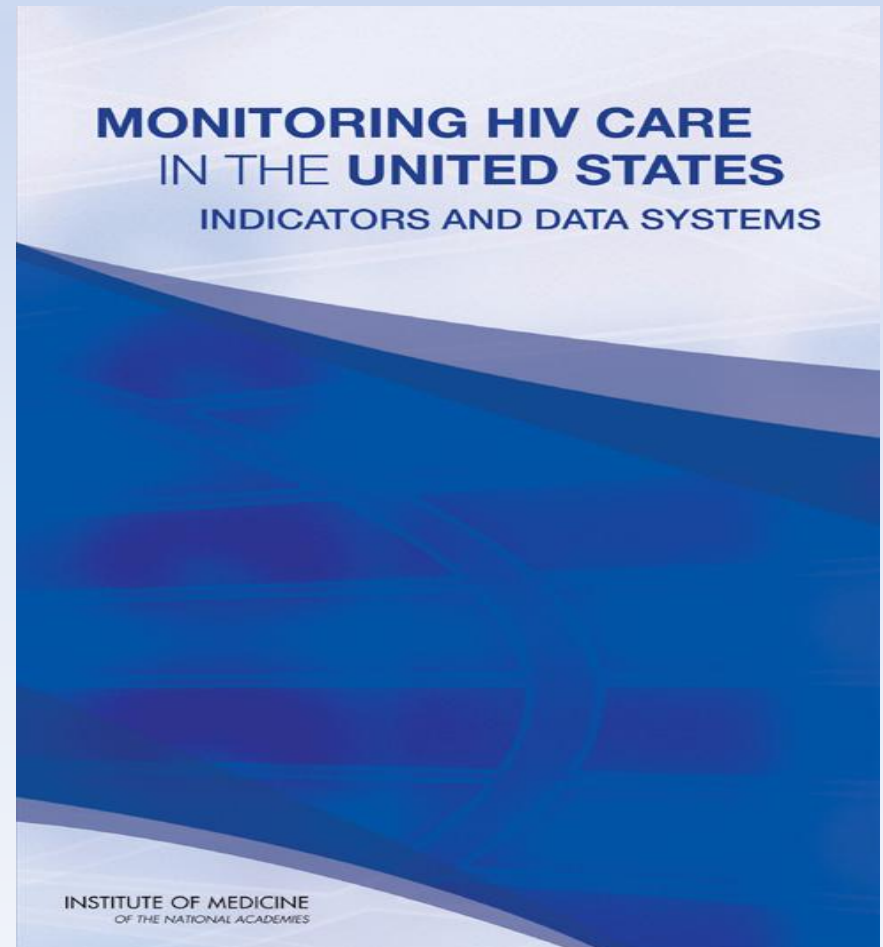
- KP Northern California cohort study of PWAs
- Black and Latino patients more likely to live in census tracts characterized by lower education and SES
- Latinos had less access to public health insurance
- ART adherence over 2 year period highest among whites compared with blacks or Latinos
- Mean CD4 highest among whites compared to blacks or Latinos
- How did this translate into AIDS-related events or death?

Time to AIDS-Related Events or Death



Measuring HIV-related Outcomes: Towards a National Consensus

- Parsimony
- Harmony
- Achievable
- Sustainable
- Usable



Measuring outcomes: VA System

Table 2. National and Facility Rates for 10 National Quality Forum Measures for HIV/AIDS Care

73 Facilities With ≥ 100 HIV Caseload				
Measure	Eligible, No.	National Rate, %	Minimum Facility Rate, %	Maximum Facility Rate, %
Medical Visit	21564	83	73	96
HBV Screening	17904	97	88	100
HCV Screening	17904	98	92	100
HBV vaccination	16606	81	53	98
TB screening	16526	65	30	94
Syphilis screening	17904	54	8	97
CD4 lymphocyte count	17904	93	81	100
Potent ART	14508	91	75	99
HIV RNA control	15537	73	28	91
PCP prophylaxis	2709	72	20	93

Abbreviations: ART, antiretroviral therapy; HBV, hepatitis B virus; HCV, hepatitis C virus; HIV, human immunodeficiency virus; PCP, *Pneumocystis pneumonia*; TB, tuberculosis

Implementation Questions at the Ground Level

- Are resources being allocated to the populations at greatest risk?
- Are these populations being engaged in all components of the implementation process?
- Are the interventions evidence-based, scaleable, sustainable, and effective?
- What is the optimal combination of interventions?
- How do we tailor interventions at the local level, while also maintaining the integrity of “evidence-based”?
- Do we have and use metrics to measure program success?
- How long do we take to declare success or failure of a program?

State Models: Expanding Access to Care for Persons Living with HIV

- Texas is part of the National Academy for State Health Policy (NASHP) Medicaid Safety Net Learning Collaborative.
- Funded by the Health Resources and Services Administration (HRSA)
- Goal is to advance Medicaid policies that support care for vulnerable populations.
- Diverse team includes representatives from the State Medicaid program, HIV experts from State Health Services, and staff from Harris County Public Health
- Proposed program activities:
 - Providing assistance to Ryan White providers in managing changes in care delivery and coverage eligibility
 - Promoting care coordination and preventing potential gaps in services that are essential to people living with HIV
 - Improving cross-collaboration between the Texas Medicaid program and the Department of State Health Services.



Local Models Maximizing the Cascade: DC Recapture Blitz

Purpose: To re-engage people living with HIV in care who are 'lost to care'

Define: Loss to care: Not in care for more than 6 months

Methods: Primary Medical Care Providers send list of clients not seen in their clinics to Health Dept. These lists are matched to HIV databases.

- Providers are given “yes” or “no” for those found to be in care in another location
- 90 day “blitz”; Providers prioritized for recapture of those whose last activity was > 6 months



Implementation Takes Time: SF HIV Prevention Shift

- 2010 - February – Prevention Plan published
- 2010 - February- November - extensive community dialogue and planning
- 2010 - November - RFP released
- 2011 - February - applications due
- 2011 - May - awards issued
- 2011 - June - August - program negotiations; planning for client transitions
- 2011 - September 1 - new contracts start
- 2012 – Start reduction in CDC contract



NHAS Implementation Dialogues

- *Incorporating Prevention and Care Research Into HIV Programs*
 - Birmingham, AL
- *Building Capacity within the HIV Workforce so that it Delivers What We Need Today and Tomorrow*
 - Seattle, Washington
- *Sustaining the Community-Based Response to HIV*
 - Philadelphia, PA
- *Fostering Collaboration Between all Public and Private Stakeholders at the State and Local Level*
 - Baton Rouge, Louisiana
- *Maximizing Impact in Low-Prevalence Jurisdictions*
 - De Moines, Iowa

Ongoing Implementation Needs

- Continued collaboration among Federal, State, local government and private partners
- Flexibility at local level regarding implementation while maintaining alignment with NHAS principles
- Technical assistance to prepare HIV workforce for ongoing changes in environment
- Support for shift from process-oriented to outcome-oriented metrics
- Adherence studies along the cascade
- Research to determine best ways to move forward among multiple options

Cascade Research: Federal Coordination

- Convene interagency consultation to discuss and identify all cascade research being conducted within each Federal agency, e.g. NIH, CDC, HRSA, SAMHSA
- Create and maintain an inventory of all Federal “linkage-to-care” research, organized by the population targeted & timelines for scaled-up implementation
- Create an online database of Federal, evidence-based, population-specific “linkage-to-care” strategies to help local communities

Upcoming White House Consultations June 2012

- Blacks and the HIV epidemic
- Latinos and the HIV epidemic

Goals:

1. To determine if Federal and other investments in epidemic are aligned with epidemiologic data
2. To meaningfully engage implementers in use of evidence-based, community-supported, culturally-competent, effective interventions
3. To determine the needs and capacities of organizations serving blacks and Latinos to adapt to the changing HIV prevention and care environment
4. To discuss how to build and sustain black and Latino leadership in addressing national and local HIV epidemics



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NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES



Vision for the National HIV/AIDS Strategy

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”



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