Accomplishments and Reflections - 2019

CHPC

CONNECTICUT HIV PLANNING CONSORTIUM

August 21, 2019

Purpose

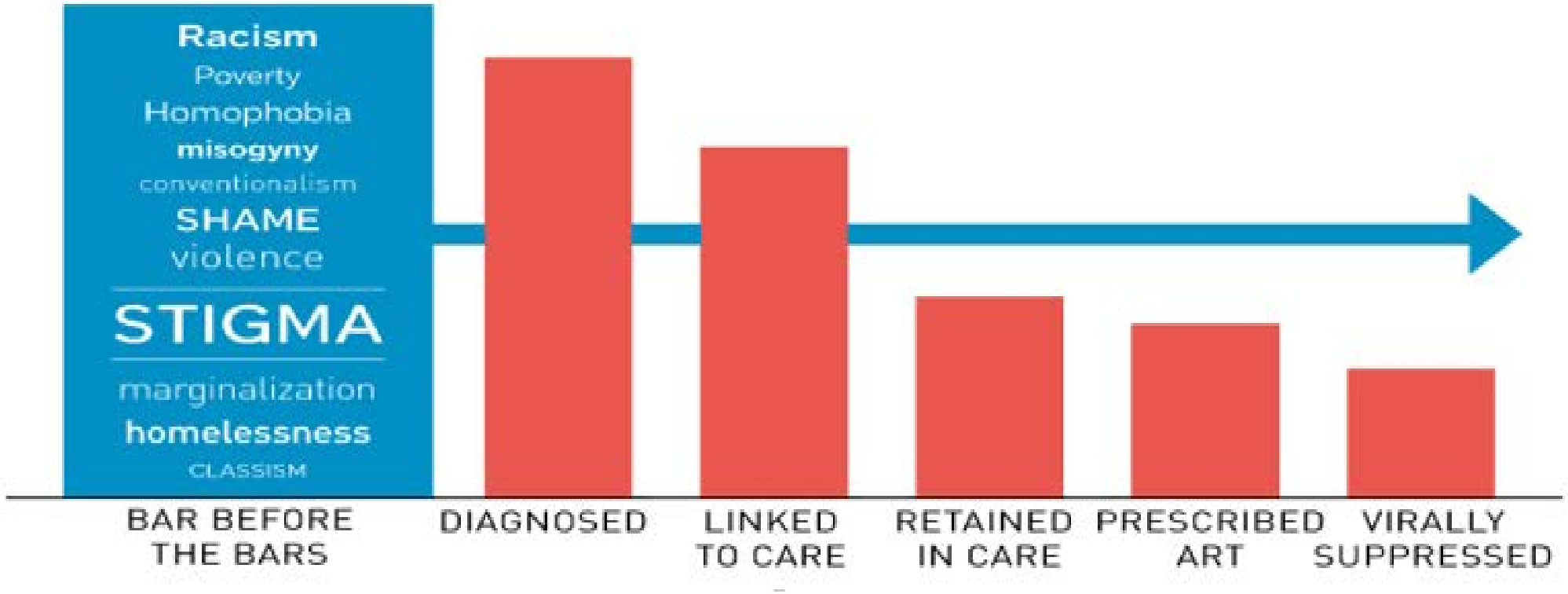
- Reflect on our 2019 journey to implement the Statewide Integrated HIV Prevention and Care Plan
- Celebrate our success stories
- Discuss any “AHA!” moments
- Identify areas for improvement

Format

- Hear from all of the CHPC “voices”
- Mini presentations
  - CHPC Indicators
  - CHPC Committees
  - HIV Funders / Partners
  - CHPC Co-Chairs
- Interactive discussion
- Feedback form contains space for each person to write down their accomplishment

Conceptual Framework for the Work

Prevention---------- CHPC GOALS----------Treatment as Prevention



Connecticut's statewide goals intentionally align with National HIV/AIDS Strategy goals.

		CHPC MISSION		
		Create coordinated statewide care and prevention system…	… That reduces the rate of new HIV infections, and…	… Connects those living with and affected by HIV/AIDS to appropriate services.
NHAS GOALS	**1.** Reduce new HIV infections	X	X	X
	2. Increase access to care, improve health outcomes for PLWH	X	X	X
	3. Reduce HIV-related disparities & inequities		X	X
	4. Achieve a more coordinated response to the epidemic	X		X

HIV in Connecticut
CHPC 2019 Annual Epidemiological Update

Suzanne Speers, MPH, Epidemiologist

www.ct.gov/dph/hivsurveillance

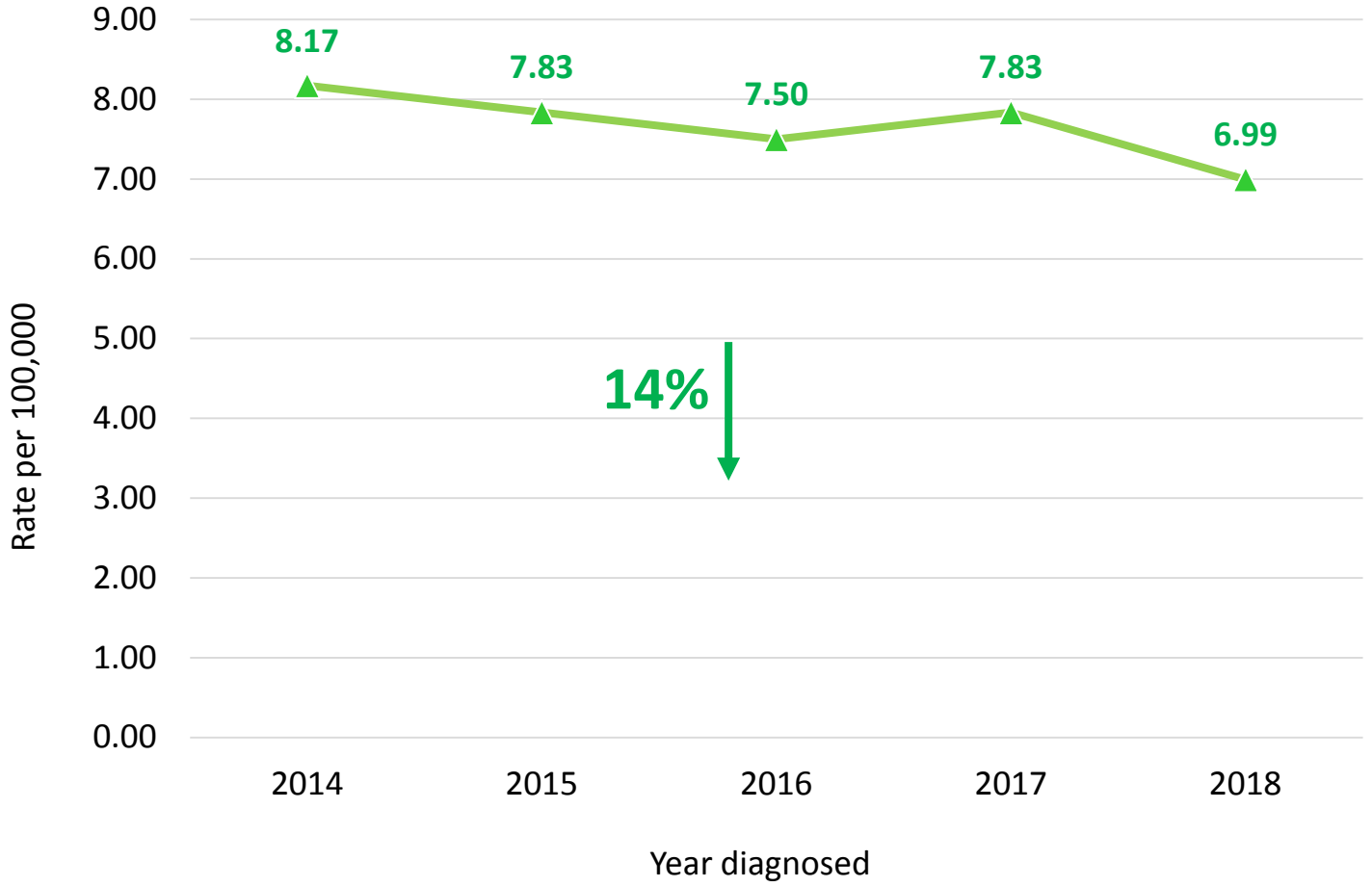
Connecticut Statewide Progress Indicators

Indicator 1	HIV Positivity Rate: Number of newly diagnosed in the 12-month calendar year per 100,000 people
Indicator 2	Seropositivity Rate: Percent of OTL & ETI HIV positive tests in the 12 month calendar year
Indicator 3	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 calendar year.
Indicator 4	Linkage to HIV Care (Biological): Number of persons who attended a routine HIV medical care visit within 1 months of HIV diagnosis.
Indicator 5	Retention in HIV Medical Care (Service/Access): Number of patients who had at least one HIV medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.
Indicator 6	Late HIV Diagnoses (Late Testers) (Biological): Number of people who had their first HIV positive test less than 3 months before receiving AIDS diagnosis.
Indicator 7	Partner Services: TBD
Indicator 8	Housing Status (Service/Access): Number of persons with an HIV diagnosis who were stably housed in the 12-month calendar year.
Indicator 9	Number of SSP clients served, Number of syringes collected, Number of syringes distributed
Indicator 10	Disparities in New HIV Diagnoses: Number of newly diagnosed in the 12-month calendar year for each of the following groups: Men who have sex with men (MSM), Black/African American/Latino men and women.
Indicator 11	PrEP-to-Need Ratio (PnR): The number of people taking PrEP during the year divided by the number of people newly diagnosed with HIV during the year.

HIV Rate

Numerator: Number of newly diagnosed HIV cases

Denominator: Connecticut population



2021 Goal:
218

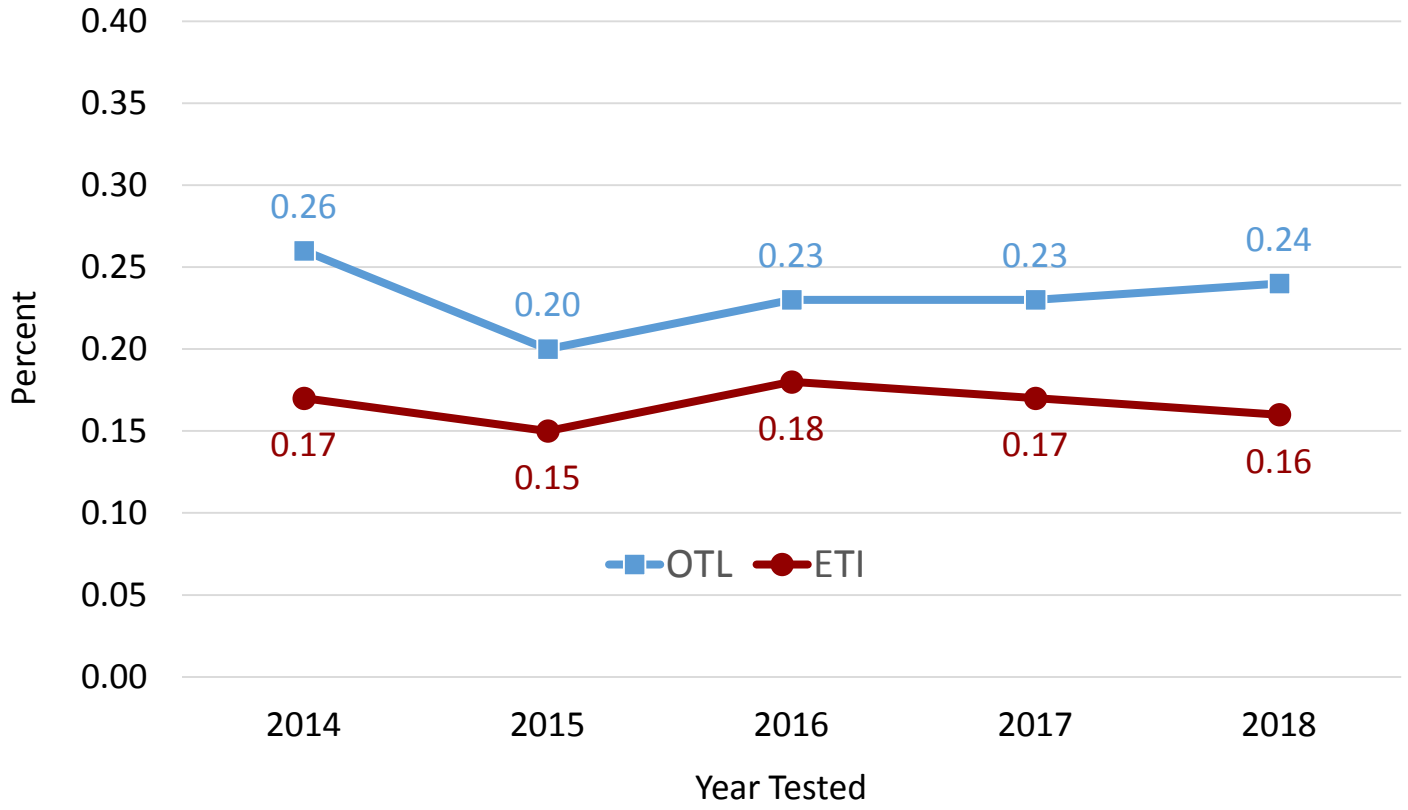
Year	# cases
2014	291
2015	277
2016	266
2017	281
2018	250

Source: Preliminary HIV surveillance data through June 2019 and 2010 census

Seropositivity Rate

Numerator: Number of Positive HIV Test Results from State Funded OTL and ETI Programs

Denominator: All HIV Tests Results Drawn from State Funded OTL and ETI Programs



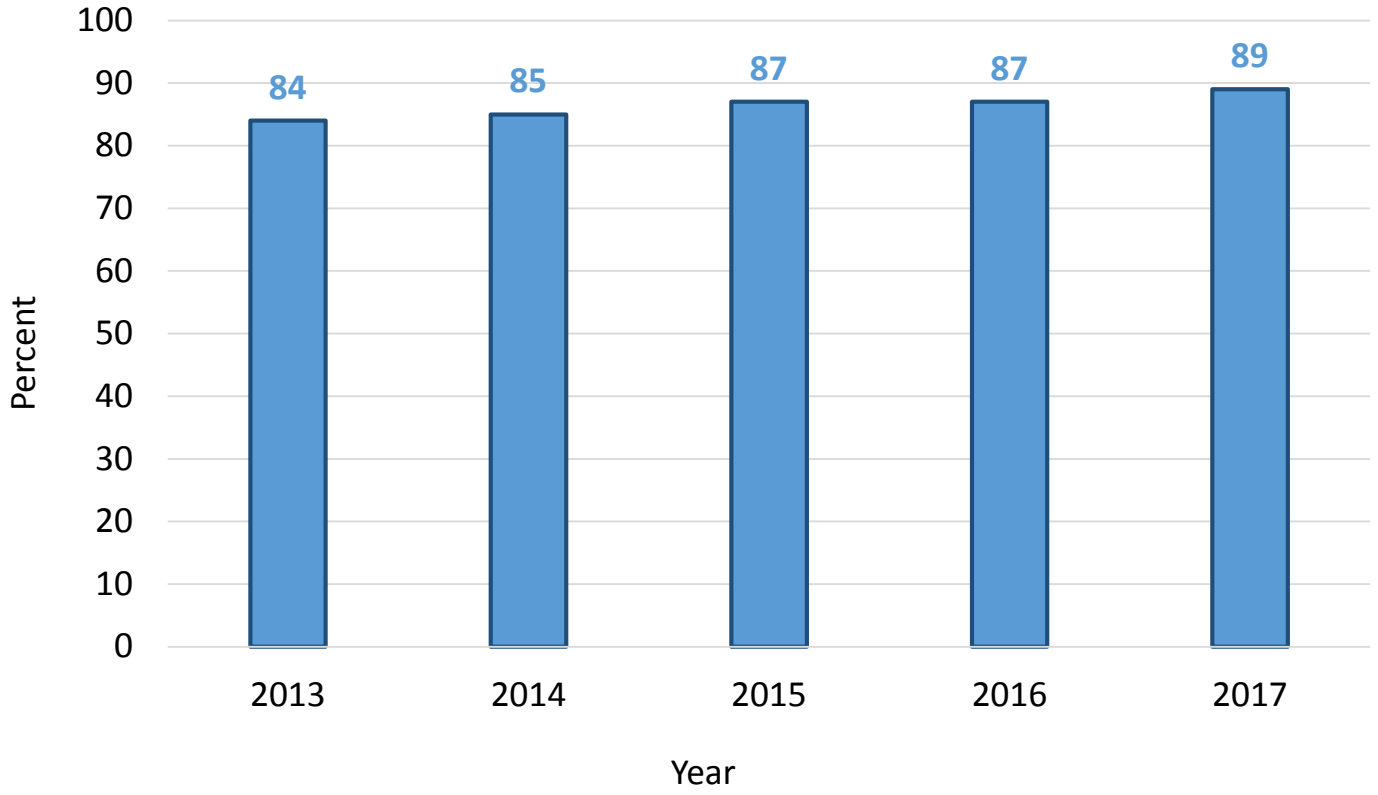
2021 Goal:
ETI: **0.2%**
OTL: **0.3%**

OTL: Outreach, Testing and Linkage = targeted HIV testing in non-healthcare settings
ETI: Expanded Testing initiative = routine HIV testing in healthcare settings
Source: EvaluationWeb data provided by HIV Prevention Program in August 2019 and preliminary HIV surveillance data reported through June 2019

Viral Load Suppression

Numerator: PLWH, ≥13 years old, currently living in CT, with a viral load <200 copies/mL

Denominator: PLWH, ≥13 years old, currently living in CT, who had at least one care visit during the past calendar year



2021 Goal:
90%

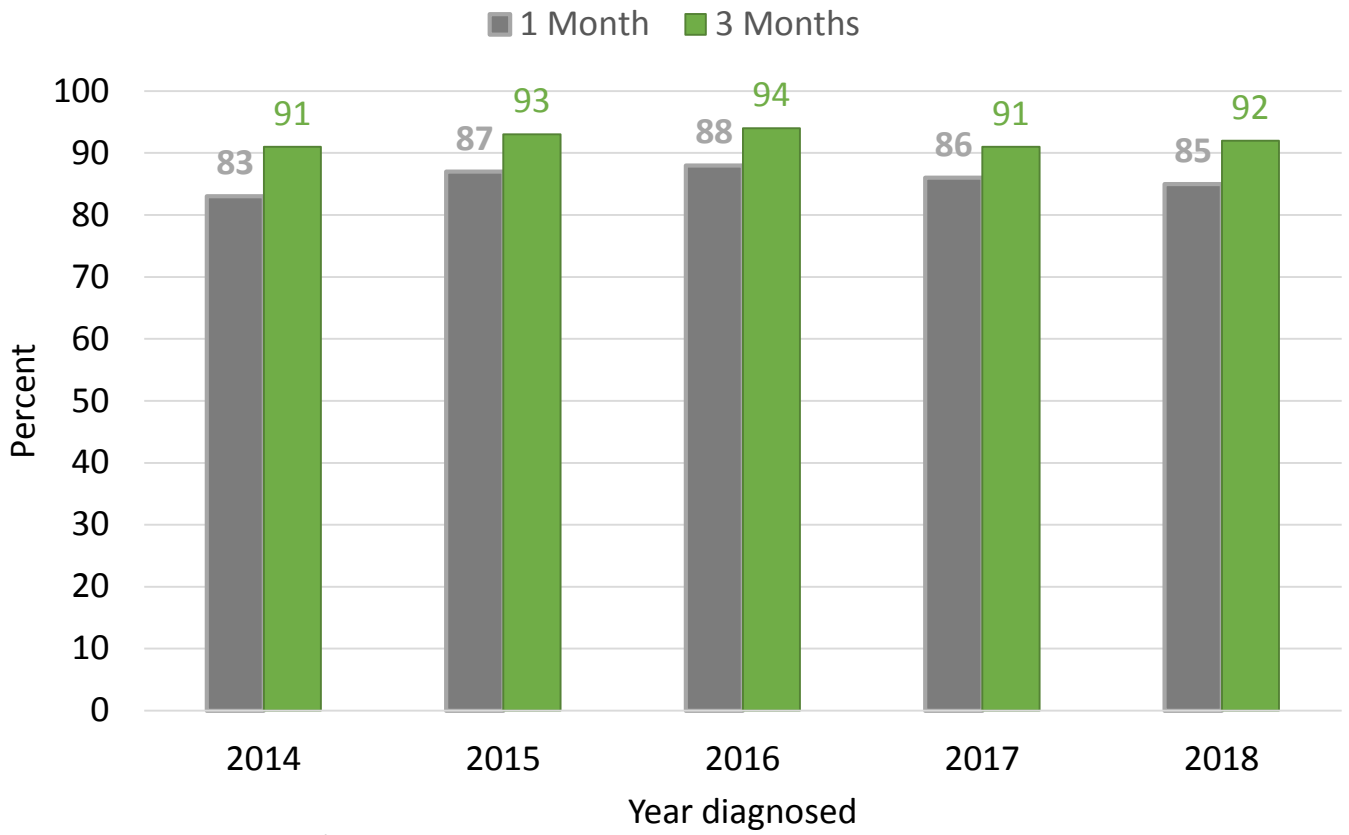
Note: Suppression based on latest viral load recorded during the time period analyzed
Percentage reflects persons receiving HIV care during the specified year among persons who were ≥13 years old on the last day of the specified year, residing in Connecticut based on last known address, diagnosed with HIV infection through the prior specified year and living with HIV through the specified year.
Source: Preliminary HIV surveillance data through June 2019

Linkage to Care

Numerator: Adults and adolescents newly diagnosed with HIV who attended a routine HIV care visit within 3 months of diagnosis

New for 2019: *Adults and adolescents newly diagnosed with HIV who attended a routine HIV care visit within 1 month of diagnosis*

Denominator: Number of adults and adolescents newly diagnosed with HIV in calendar year



2021 Goal: linkage at 3 months: **95%**
1 month: **TBD**

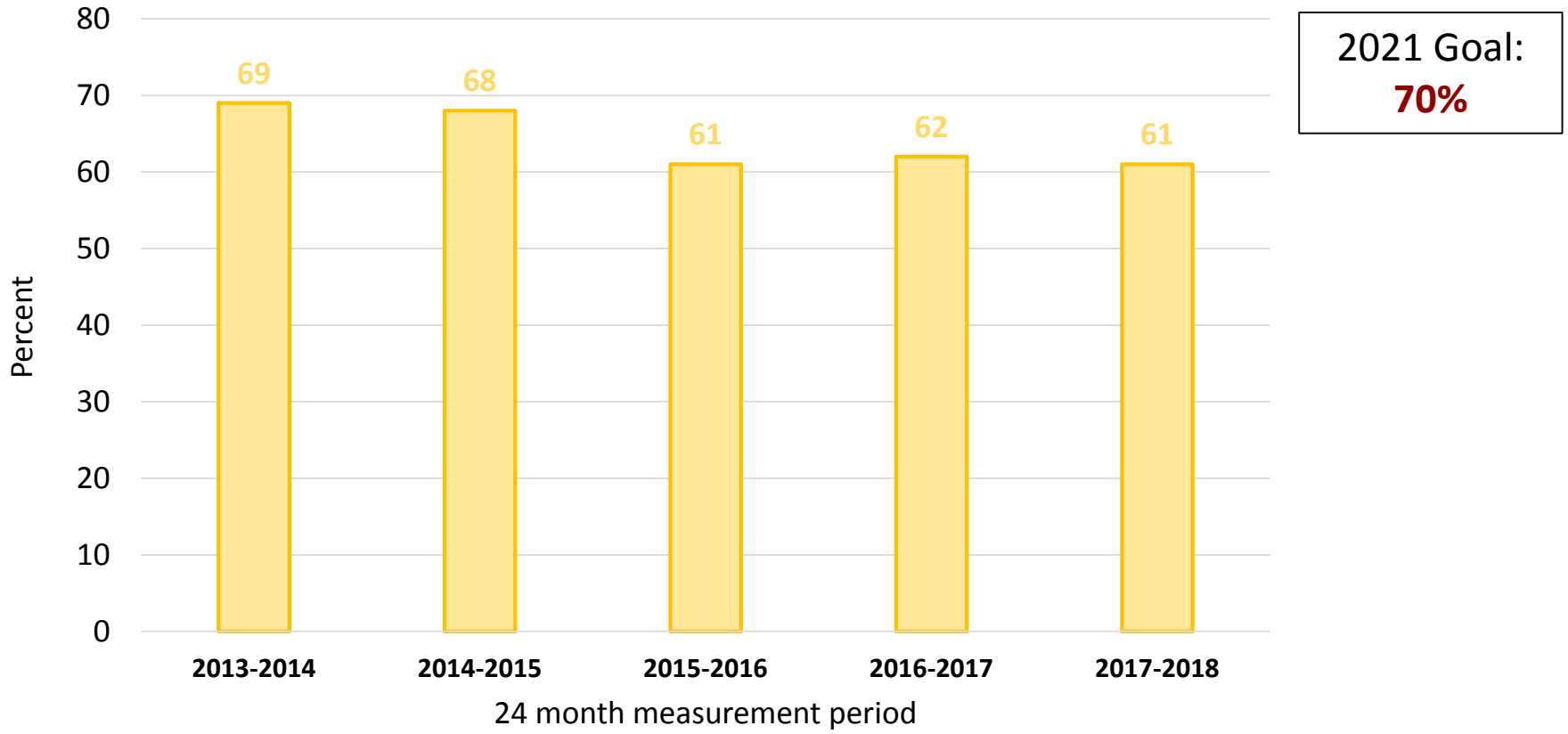
NHAS 2020 Goal: **85% within 1 month**

NHAS = National HIV/AIDS Strategy
Source: Preliminary HIV surveillance data through June 2019

Retention in Care

Numerator: Number of PLWH who had at least one visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between 1st visit in the prior 6 month period & the last medical visit in the subsequent 6 month period

Denominator: Number of patients with a diagnosis of HIV with at least 1 visit in the first 6 months of the 24 month measurement period



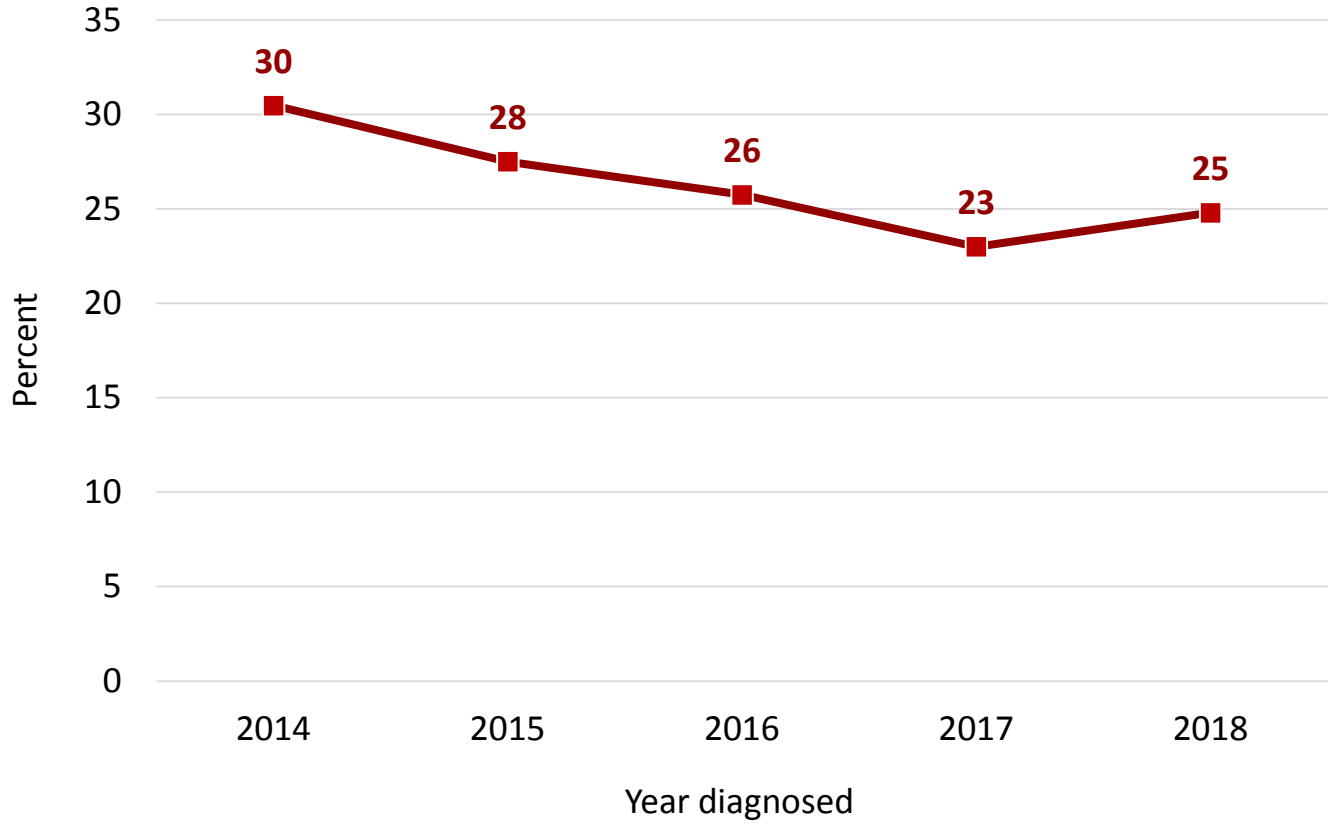
2021 Goal: **70%**

Note: 2017-2018 may be overestimated because 2018 death ascertainment is not completed
Source: Preliminary HIV surveillance data through June 2019

Late Testers

Numerator: People presenting with or diagnosed with AIDS within 3 months of their initial HIV diagnosis

Denominator: Newly diagnosed cases in the preceding 12 months



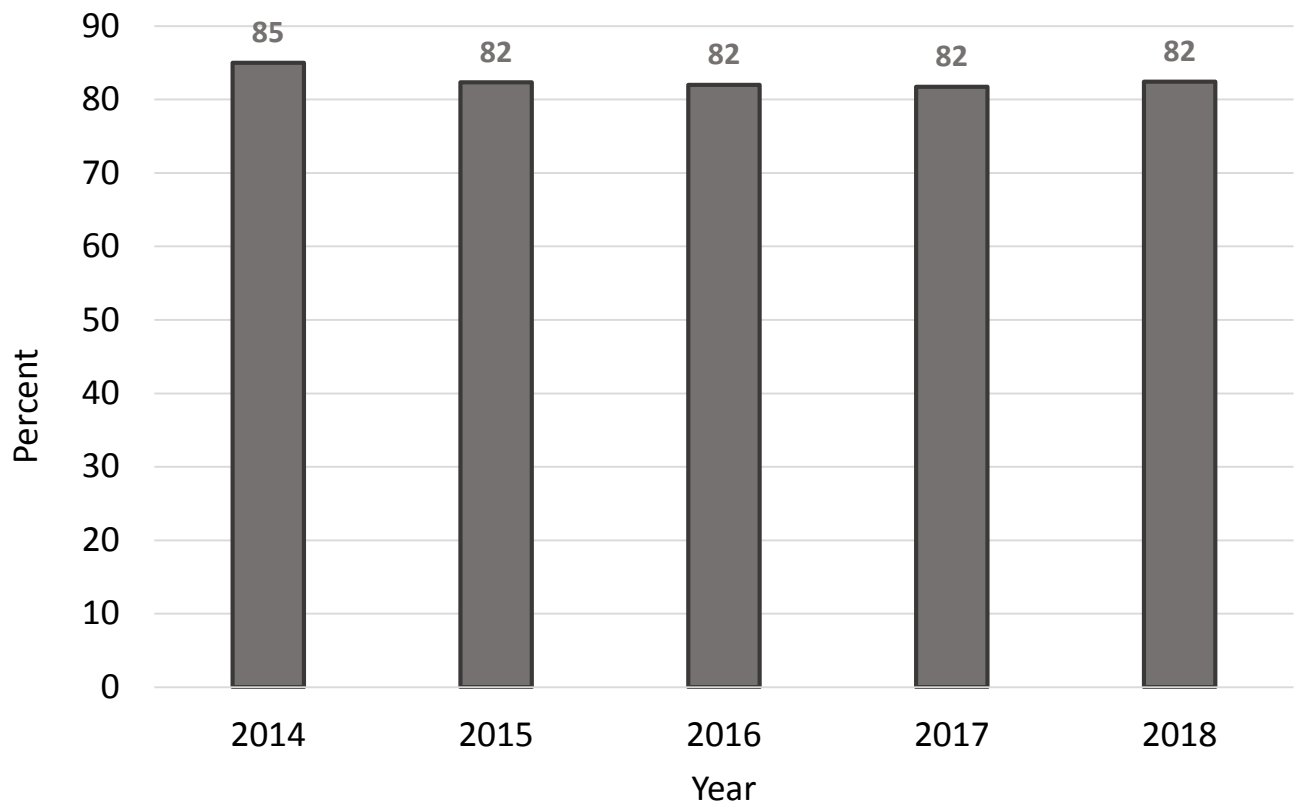
2021 Goal:
25%

Source: Preliminary HIV surveillance data through June 2019

Housing Status and Stability

Numerator: Ryan White clients who were stably housed

Denominator: Ryan White clients receiving HIV services in calendar year

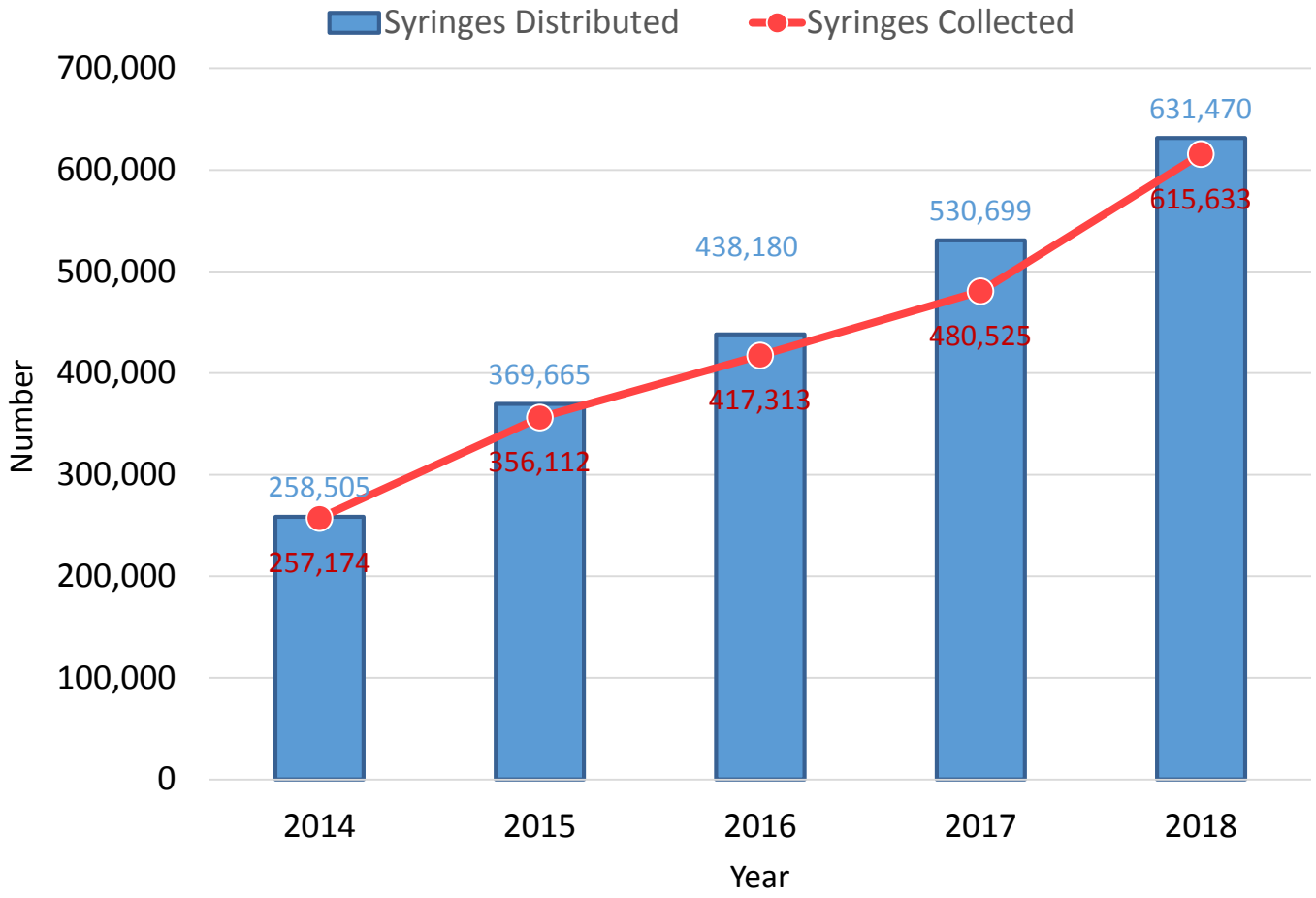


2021 Goal:
85%

Source: CareWare data provided by Health Care & Support Services, August 2019

Syringe Service Programs (SSP)

Number of SSP clients served, Number of syringes collected, Number of syringes distributed



2021 Goal:

Clients served: **4,000**

Number of syringes collected: **450,000**

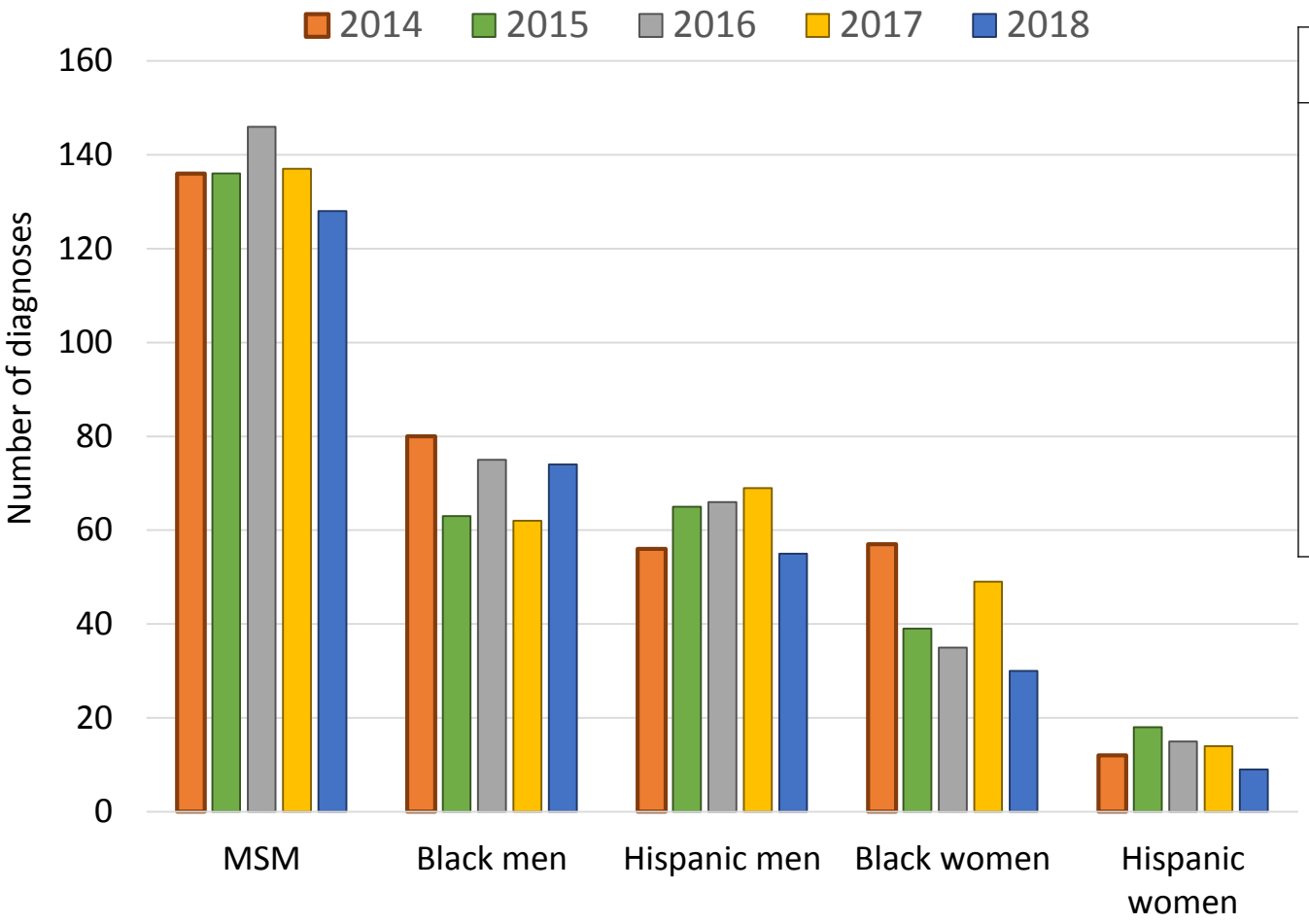
Number of syringes distributed: **500,00**

Year	Clients
2014	2,905
2015	3,643
2016	3,853
2017	3,903
2018	3,949

Source: HIV Prevention XeringaX Database, provided August 2019

Health Disparities

Reduce the number of newly diagnosed in the calendar year for each of the following groups: MSM, Black/African American men, Hispanic/Latino men, Black/African American women, and Hispanic/Latino women



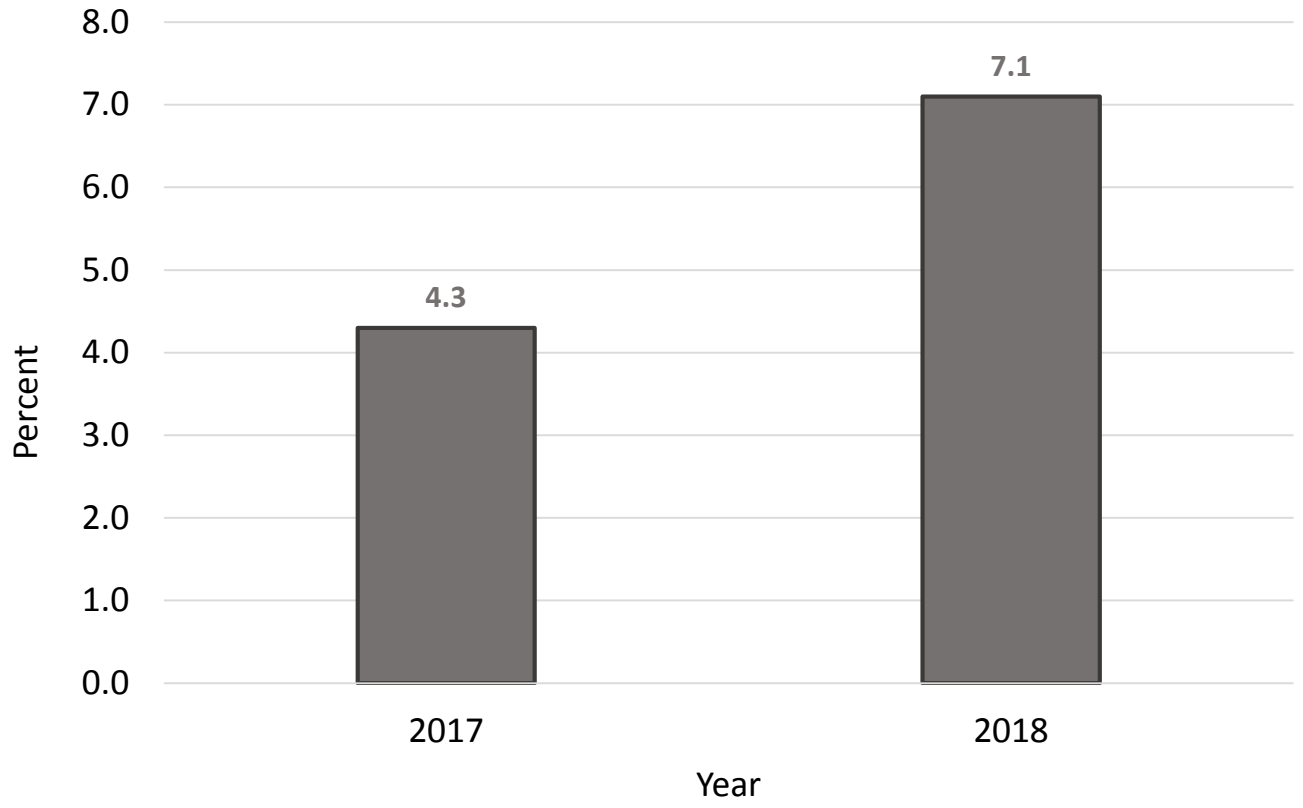
2021 Goal: -15%		
	2015	2021
MSM	136	114
Black Men	63	52
Hispanic Men	65	54
Black Women	39	32
Hispanic women	18	14

Source: Preliminary HIV surveillance data reported through June 2019

PrEP-to-Need Ratio (PnR)

Numerator: Number of people taking PrEP in the calendar year

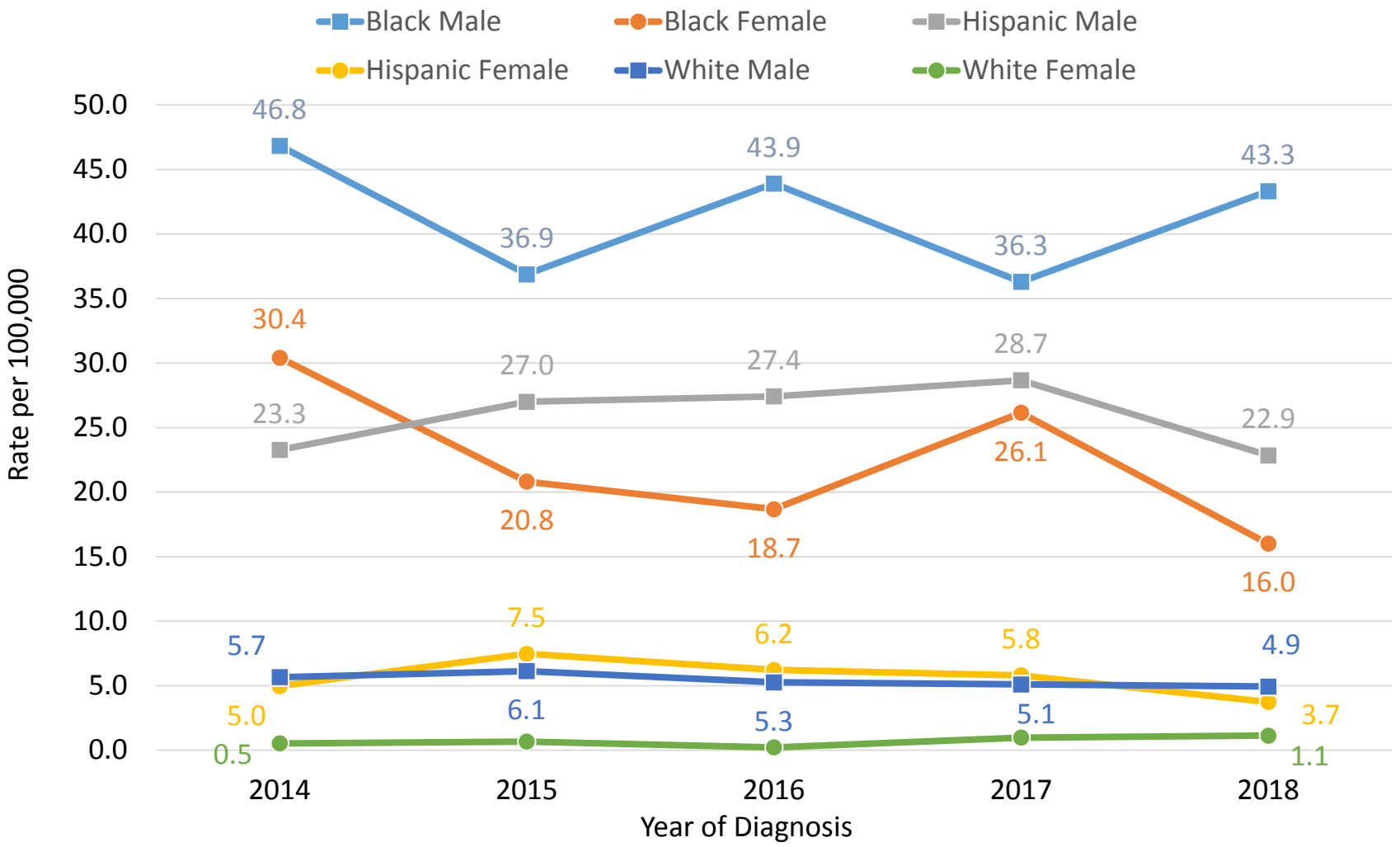
Denominator: Number of newly diagnosed cases of HIV in calendar year



2021 Goal:
5.1

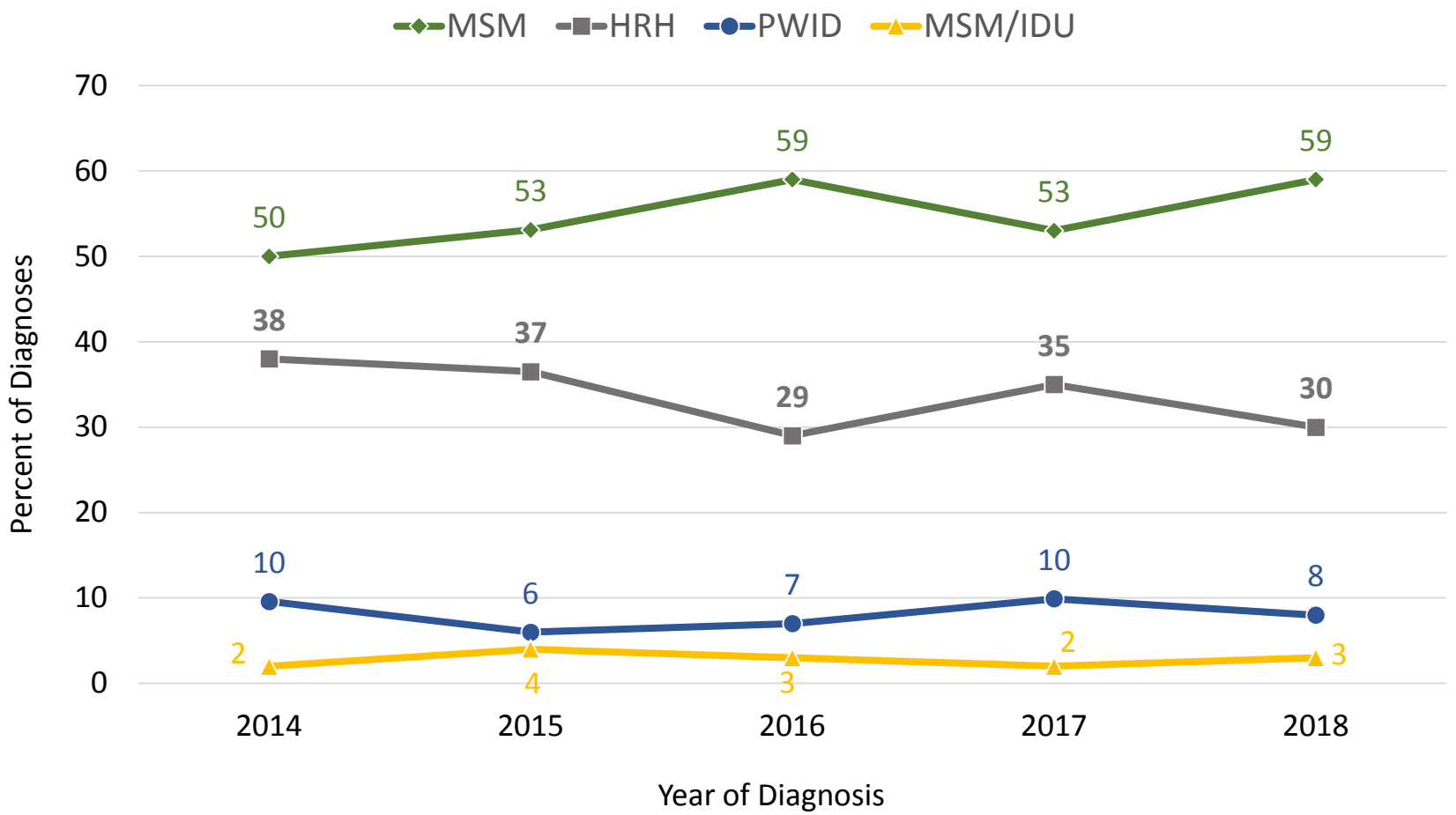
Source: AIDSVu: https://aidsvu.org/state/connecticut/ accessed August 13, 2019. Data underestimates the number of PrEP users in the US, please see methods: https://aidsvu.org/data-methods/

Trends in HIV Diagnosis by Race and Sex at Birth, Connecticut, 2014-2018



Note: Reported numbers less than 12, which is the case for white females in the years 2014-2016 and Hispanic females in the year 2018 and accompanying rates and trends based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30% and are considered unreliable.
Source: Preliminary HIV surveillance data through June 2019 and State-level Bridged Race Estimates for Connecticut, 2010

Trends in HIV Diagnosis by Transmission Category, Connecticut, 2014-2018

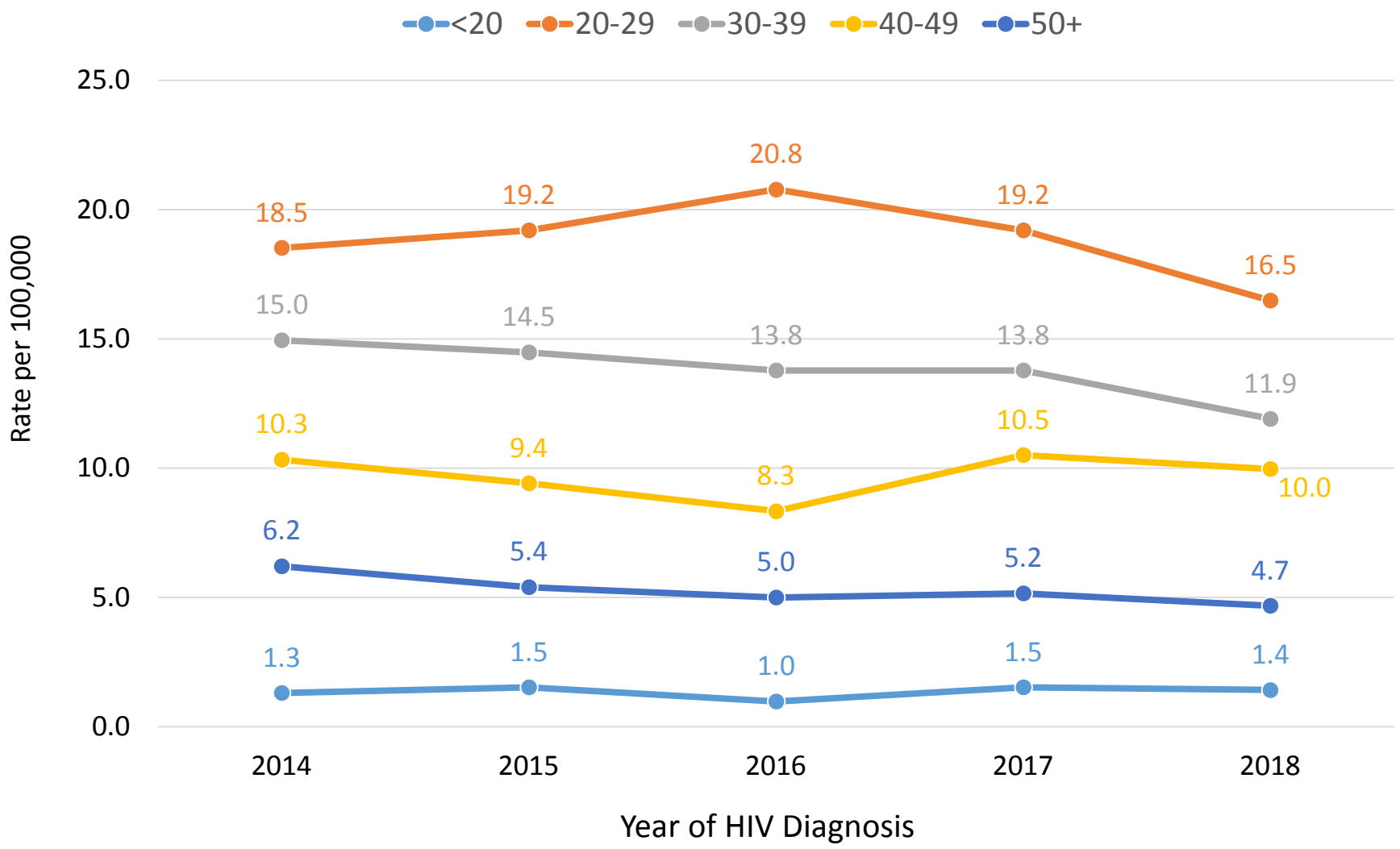


Note: Risk determined using multiple imputation method. These numbers don't represent actual cases in persons with HIV disease; rather they represent point estimates of cases diagnosed that have been adjusted for multiple imputation of cases in persons initially reported without an identified risk.

MSM = men who have sex with men; High Risk Heterosexual (HRH) = a person who had sexual contact with a HIV positive person or a person at high risk for HIV; PWID = persons who inject drugs; MSM/IDU = men who have sex with men and inject drugs

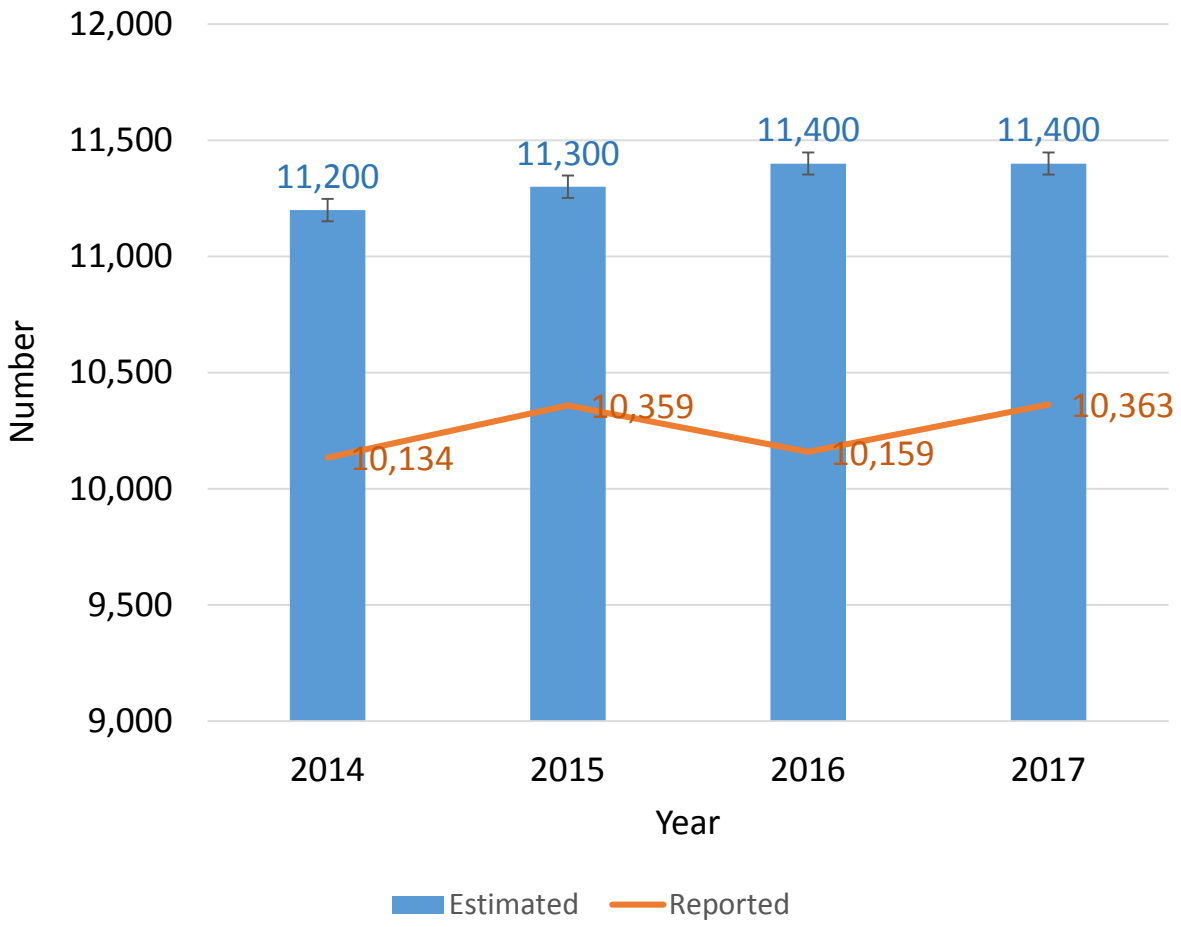
Other risks and/or perinatal risk ≤2 cases per year. Source: Preliminary HIV surveillance data through June 2019

Trends in HIV Diagnoses by Age Group, Connecticut, 2014-2018



Source: Preliminary HIV surveillance data through June 2019 and State-level Bridged Race and Age Group Estimates for Connecticut, 2010

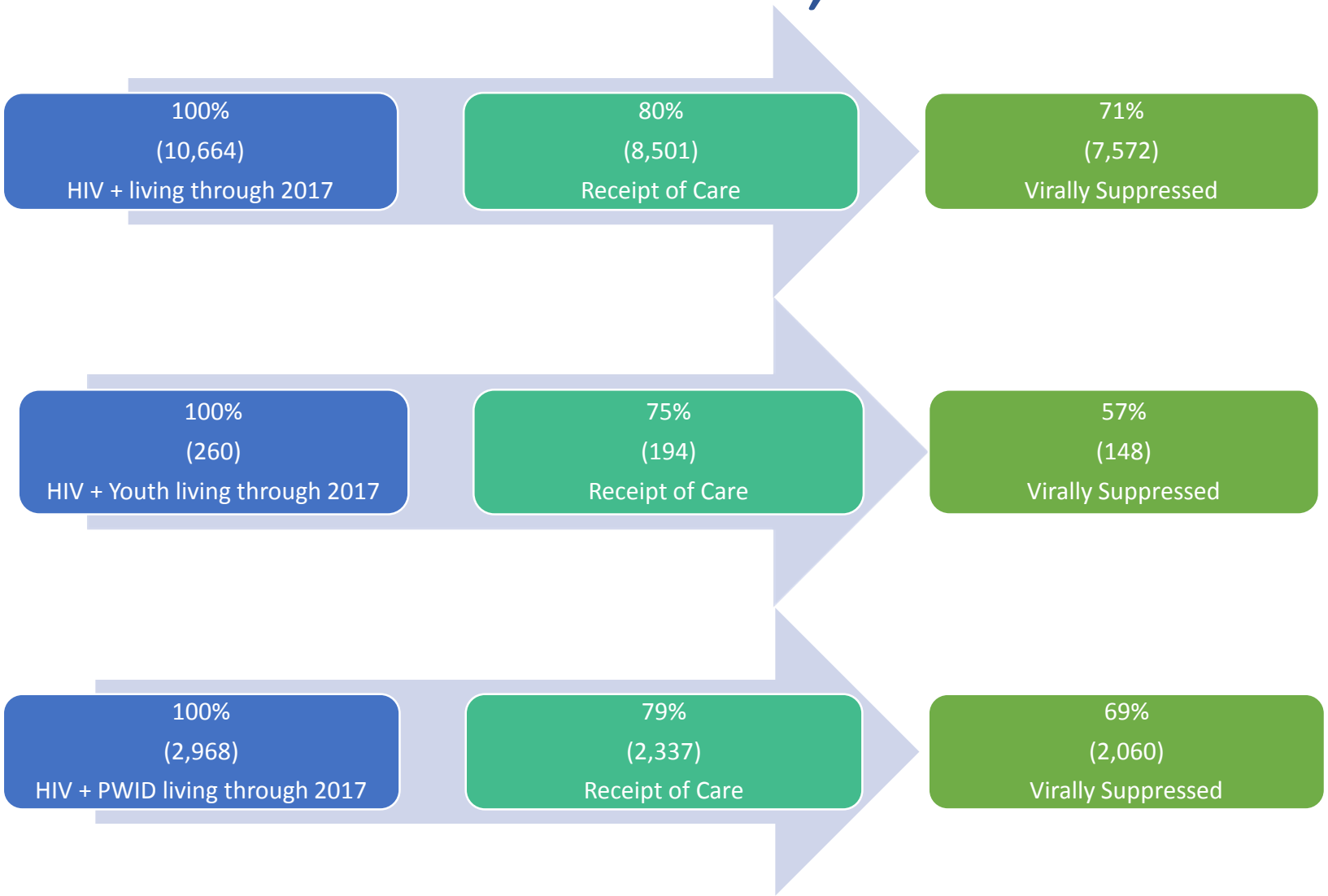
Estimated HIV Prevalence among Adults and Adolescents, Connecticut, 2014-2017



Year	Estimated % Persons Living with Diagnosed HIV	95% CI
2014	90.4	81.2-100
2015	91.6	81.5-100
2016	89.5	78.7-100
2017	90.7	78.8-100

Note: NHAS 2020 goal: Increase the number of HIV+ individuals aware of their status to 90%
Source: Preliminary HIV surveillance data through June 2019

HIV Care Continuum, by Select Populations, Connecticut, 2017



Note: National HIV/AIDS Strategy, 2020: Increase the proportion of HIV diagnosed individuals whose virus if effectively suppressed to 80%, with emphasis on youth and persons who inject drugs. Source: Preliminary HIV surveillance data through June 2019

People Living with HIV, Connecticut, 2017

Age Group	%
<20	0.5
20-29	6.5
30-39	11.9
40-49	20.6
50+	**60.5**

Based on last known address as of December 2017
Source: Preliminary HIV surveillance data through June 2019
CDC graphic: https://www.cdc.gov/hiv/images/library/awareness

Transmission Category	%
MSM	**30.0**
HRH	27.6
PWID	27.5
MSM/IDU	2.4
Pedi	1.9
Other/Unknown	10.6

Quality and Performance Measures (QPM) Team

Committee Charge

- Review and discuss data
- Develop indicators to track our progress in HIV prevention and care
- Help improve the quality of HIV prevention and care

Team

- Nilda Fernandez, chair
- Susan Major, DPH liaison
- 8 meetings in 2019
- 29 participants (average)
  - 6 CHPC members
  - 23 public

2019 Major Accomplishments: Indicators

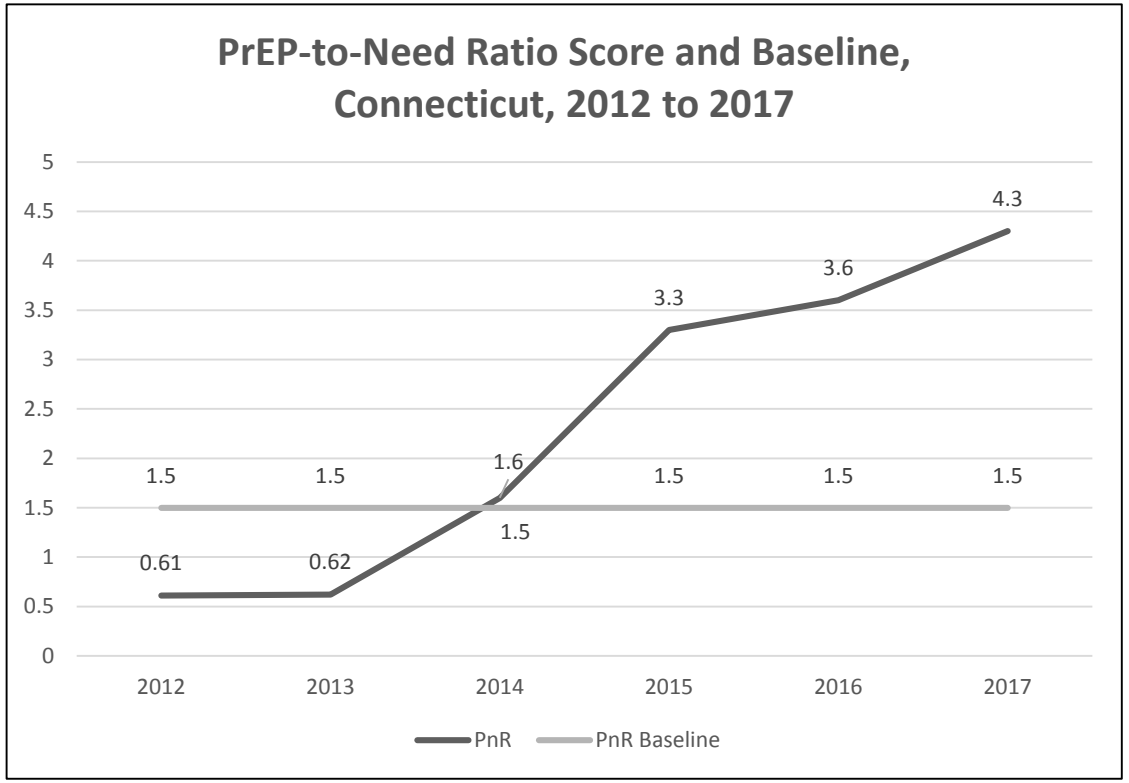
- Added a PrEP indicator
- Removed Indicator #7: Antiretroviral Therapy (ART) Among Persons in HIV Medical Care
- Changed Indicator #4: Linkage to HIV Care to: “Percent of persons who attended a routine HIV medical care visit within 1 month of HIV diagnosis”

PrEP-to-Need Ratio (PnR) is the ratio of the number of PrEP users to the number of people newly diagnosed with HIV.

PnR serves as a measurement for whether PrEP use appropriately reflects the need for HIV prevention in a geographic region or demographic subgroup.

Connecticut PnR

$$\frac{\text{1,214 (Number of People Taking PrEP in 2017)}}{\text{281 (Number of People HIV Newly Dx in 2017)}} = 4.3$$



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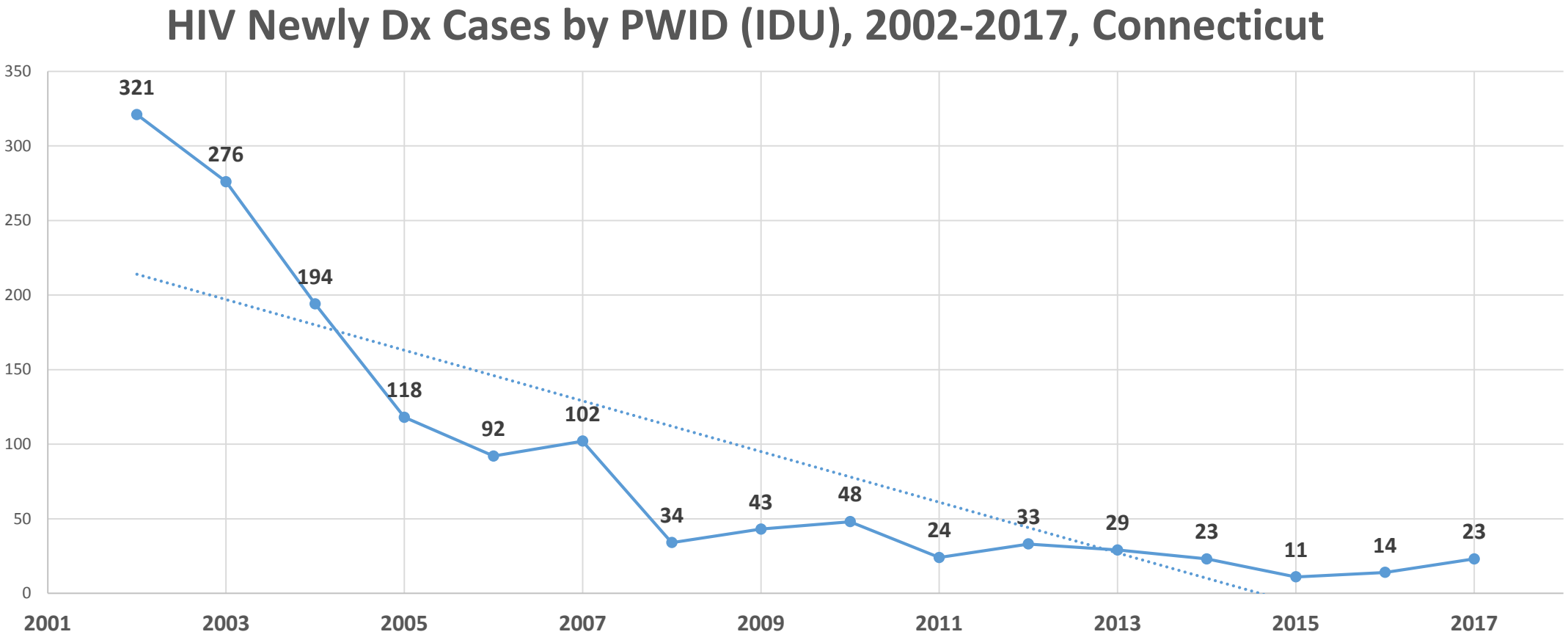
2019 Major Accomplishments: Quality

Getting to Zero through Quality Management: A 2019 Summit

- September 18, 2019 at the Chrysalis Center
  - Address the intersection of housing & HIV, and Hepatitis C & HIV
  - Share best practices in the field
  - Inspire participants to engage in quality management and quality improvement projects
- Register at www.eventbrite.com

QPM 2019 "AHA" Moment



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What's Ahead for QPM in 2020?

- Take a "deep dive" on STD data before deciding on an STD indicator
- Review additional PrEP data from multiple sources (Medicaid, DPH, national)
- Review new Syringe Services Program data
- Consider other measures for Indicator #8: Partner Services

Needs Assessment Projects (NAP)

Committee Charge

- Assist in collecting, compiling, and analyzing data to support CHPC planning tasks
  - PLWH need assessment survey
  - PLWH focus groups
  - HIV workforce survey
  - Special studies (e.g., peer support framework)

Team

- Chair Laura Aponte (current) and Barry Walters (interim to April)
- Significant DPH support - Mukhtar Mohamed; Michael Ostapoff; Ramon Rodriguez Santana; Sue Speers; Sue Major; Gina D'Angelo; Marianne Buchelli
- 8 meetings in 2019
- 16 participants per meeting (average)
  - 5 CHPC members
  - 11 public

2019 Major Accomplishments

- 2018 PLWH Needs Assessment Survey
  - Results presentation to CHPC
  - Deeper analysis of stigma and mental health questions by age groups
- Design of PLWH follow-up focus group questions
  - Priority population: 18 to 28
  - Newly or recently infected
- 2019 HIV Workforce Needs Assessment Survey
  - Initial design
  - Pilot study

2019 "AHA" Moment in the Committee

Core messages from analysis of mental health & stigma questions

1. The vast majority of survey respondents in every age group had revealed their HIV status to a non-medical provider, indicating that PLWH may be more likely to disclose their status than previously thought.
2. Younger PLWH may be less likely to seek professional help – through counseling, therapy, and/or medications – to manage their thoughts, feelings, and behaviors. HIV-positive youth and young adults may therefore be at a greater risk of self-medicating through drug use and adopting other unhealthy behaviors to deal with issues related to their mental health.
3. On average, PLWH in the youngest age group, 20-29, are more engaged with peer support models, and show greater interest in becoming trained to be a peer support staff person.

What's Ahead for 2020?

- Review results and present findings of 2019 Focus Groups
- Review results and present findings of 2019 HIV Workforce Needs Assessment Survey
- Define role in prevention needs assessment projects and start projects

Membership & Awareness Committee (MAC)

Committee Charge

- Ensure diverse, reflective CHPC membership
- Ensure diverse participation in CHPC process
- Retain existing CHPC members
- Raise awareness of HIV/AIDS community planning & HIV/AIDS care & prevention

Team

- Co-chairs Clara Langley O'Quinn & Stephen Feathers
- 8 meetings in 2019
- 10 CHPC members per meeting (average)
- 6 public participants per meeting (average)

2019 Major Accomplishments

- Increased ability to understand member attendance issues – will inform member retention efforts

- Supported planning process for Needs Assessment focus groups – participant recruitment strategies & focus group questions

- 16 applications for 2020 membership (12 new & 4 expiring members)

2019 Major Accomplishments

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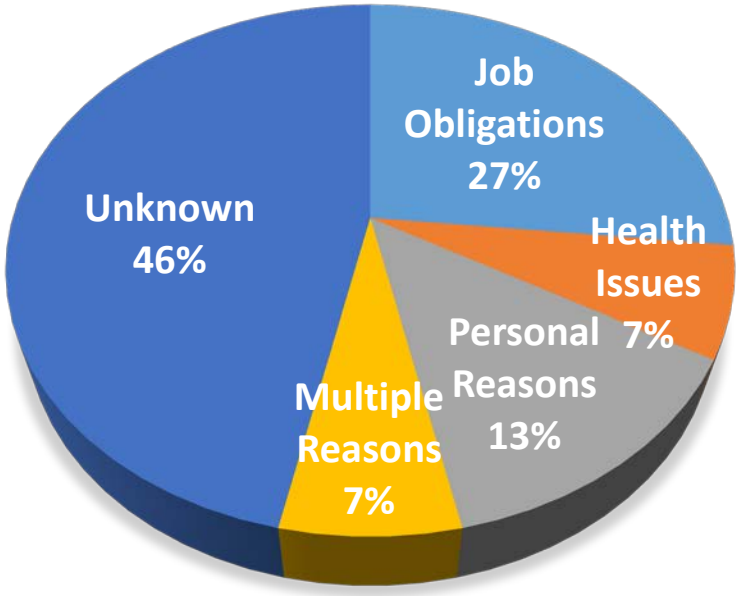
2019 “AHA” Moment in the Committee

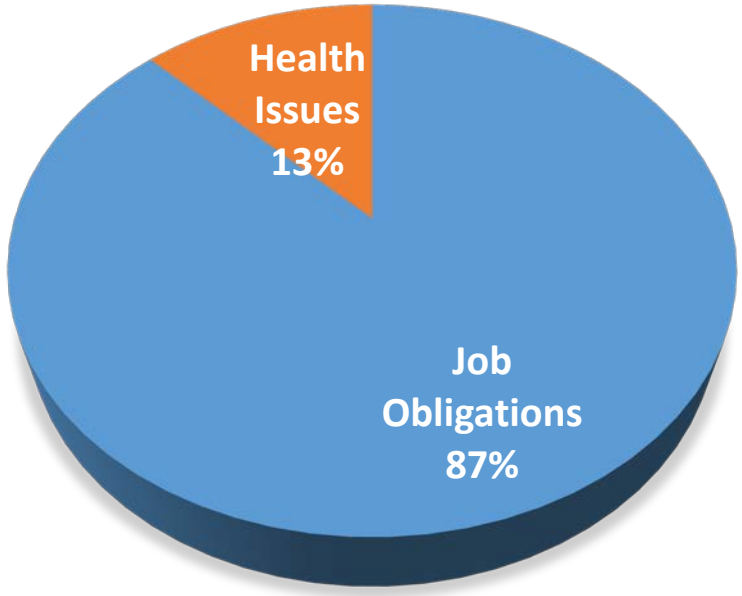
Reasons for Member Discharges

(2015-2018; n = 15)



Reasons for Member Resignations

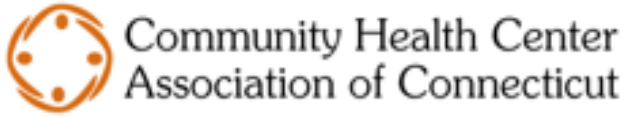
(2017-2018; n = 8)



What's Ahead for 2020?

- Apply member retention lessons learned
- Work with G2Z to bring appropriate voices to the table
- Re-examine awareness platforms (newsletter, website, social media)

HIV Funders Group & Partners



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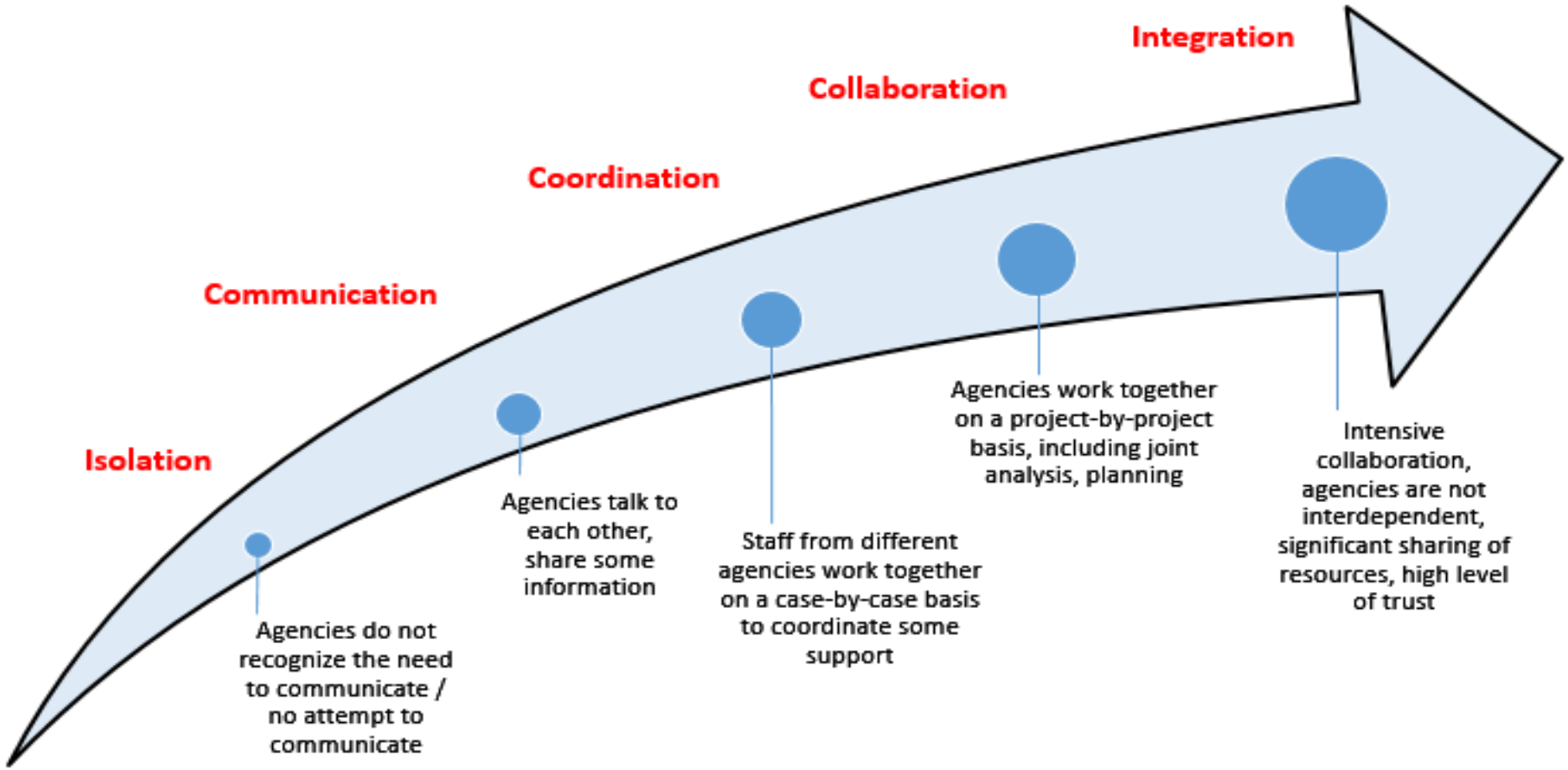
Encourage Communication, Coordination & Collaboration



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Support CHPC Priority Projects

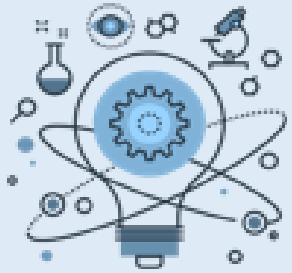
Planning

- Needs assessment
- Gap analysis
- Financial resources inventory
- Workforce analysis

Monitoring

- CHPC indicators
- Progress on statewide plan implementation
- Quality improvement

Innovation



- Workforce development
- Getting to Zero
- Housing
- Other supportive services

Highlights: Agency-Specific Initiatives

Ryan White Part As

- Getting to Zero capacity building
- Continuous quality improvement

Ryan White Part B (DPH)

- Expanded Services
- Free Cd4, viral load testing available to eligible Ryan White clients through the state lab
- CADAP
  - Advisory Group
  - Hired a pharmacist / manager
  - Web-based platform
- **Ryan White Part Cs**
- **Ryan White Part D**
- **Ryan White F**
- **HOPWA**

DPH (Prevention)

- Getting to Zero Campaign (G2Z)
- Positive Prevention CT
- Routine Testing (Expanded)
- Outreach Testing and Linkage
- Drug User Health Programs (Expanded)
  - Syringe Services, Harm Reduction Education, Overdose Prevention Education and Naloxone Distribution
- Partner Services
- Data to Care (D2C)
- PrEP
- Community Mobilization
- Effective Behavioral Interventions
- National Partnerships (e.g. Prevention Access Campaign's U=U)

CHPC Co-Chair Reflections 2019

Co-Chair Leadership Roles

- Provide oversight and guidance to the CHPC and the project staff
- Maintain CHPC values and productive meeting climate
- Participate on:
  - Executive Committee
  - CHPC Committees
  - HIV Funders Group
- Other miscellaneous tasks

Team

- Gina D'Angelo
- Blaise Gilchrist
- Barry Walters

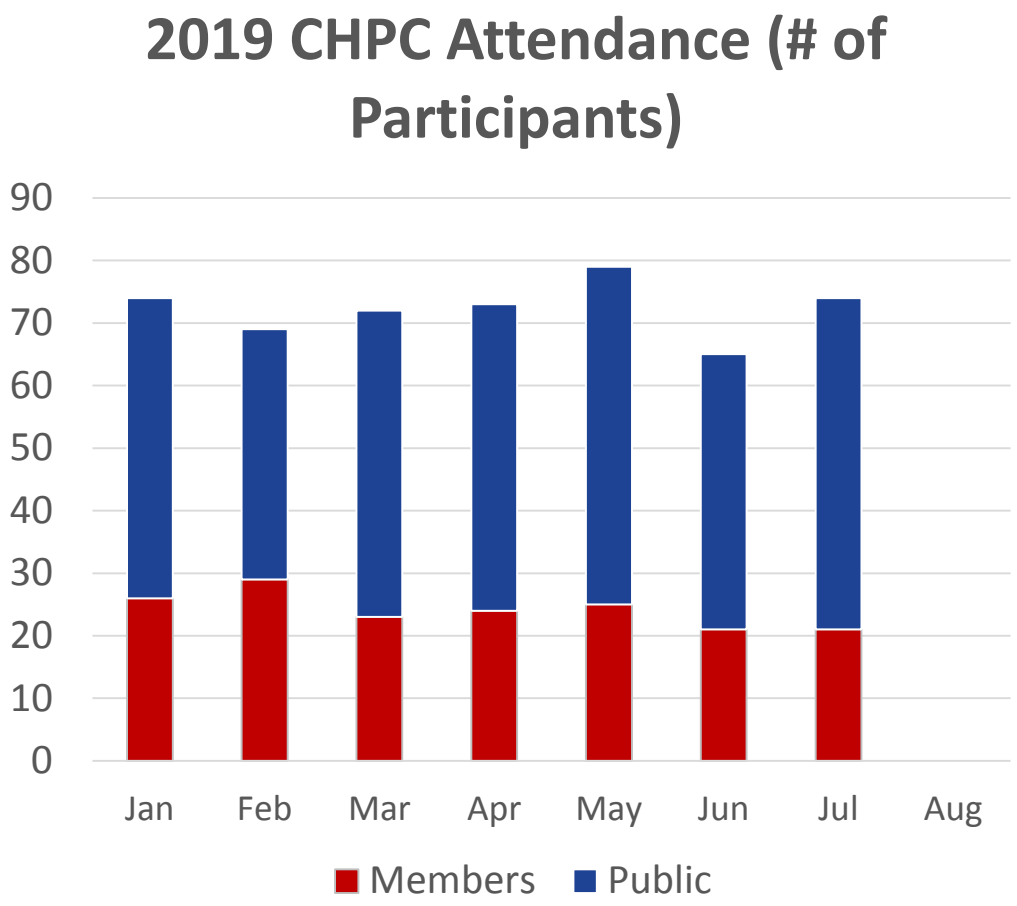
Activities

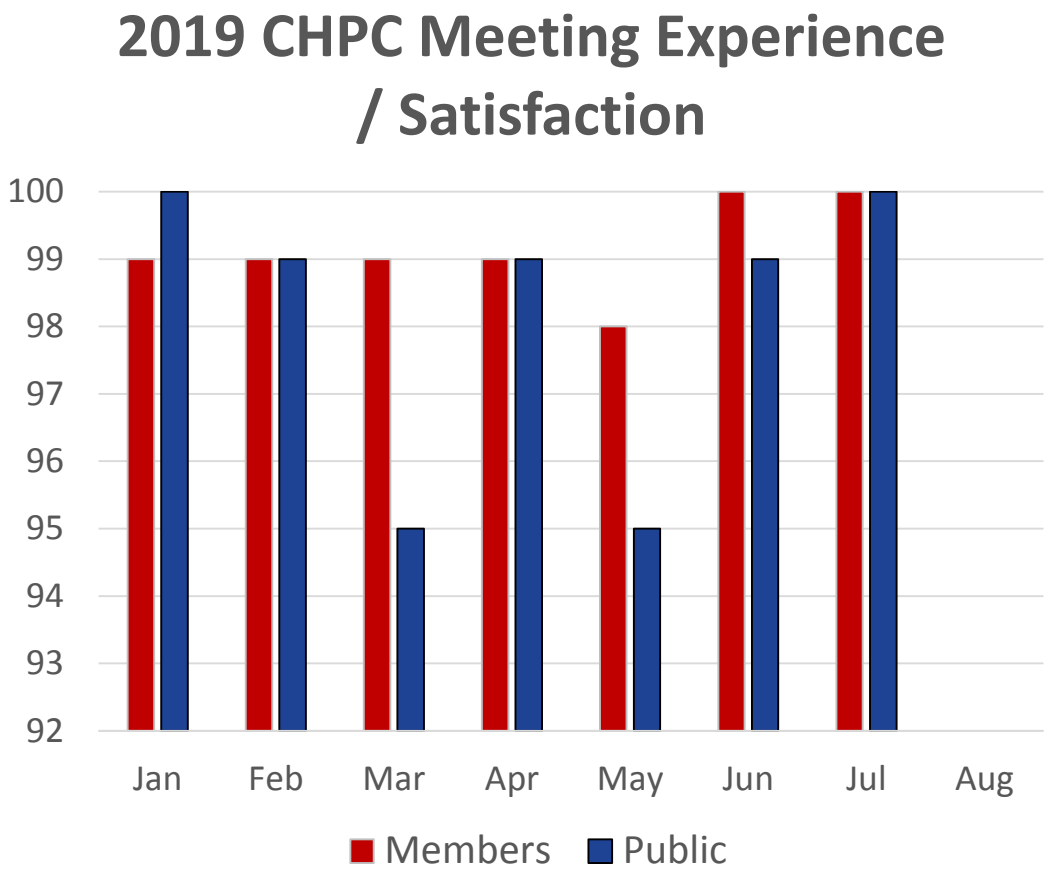
- 8 CHPC meetings
- 8 Executive Committee meetings
- 8 CHPC Co-Chair meetings
- 6 HIV Funders Group meetings

Documents

- Reviewed 500+ documents

Productive, Collaborative Work Space





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Relevant, Forward Thinking Presentations

2019 Topics

- Getting to Zero
- 2018 PLWH Needs Assessment Survey Findings
- Changing Landscape of AIDS Service Organizations
- Housing
- Community Health Workers
- Voice of the People

Encouraging Critical Thinking

- How does CHPC support G2Z recommendations?
  - Ad hoc prevention committee
  - G2Z standing committee
  - Add CHPC prevention indicators
- How does CHPC create more impact in health equity?
  - Peer support models / CHWs
  - Capacity building / training
  - Efforts to change discussion about stable housing for PLWH

Other Points of Emphasis

- Taking a leadership role in conducting the PLWH Needs Assessment focus groups
  - Priority population: young (18 to 28), newly or recently infected
  - Geographic area: Waterbury, Bridgeport, New Haven
- Changing the conversation about the role of social marketing and media
  - Sharing access points and content
  - Training or technical assistance for content development
  - G2Z committee help coordinate consistent messaging and distribution
- Taking the lead in coordinating Getting to Zero efforts statewide to ensure CT is leveraging its human and financial resources to moving the needle in the right direction

2019 “AHA” Moment(s)

- “Many hands make light work”
  - Each of us can contribute … sometimes in ways we never could have imagined
    - Like the hug from Carl Ferris after he and two other CHPC members shared their lived experience for the first time
    - Or, being a champion in your work, family or community
- Passion runs deep, issues are complicated and personal …those voices and perspectives illustrate the meaning of this work
- Reminders of the importance of empowering people living with HIV to let their voices be heard

What's Ahead for 2020?

- **G2Z**
  - Committee
  - Integration of prevention across all committees
- **Results**
  - Workforce survey
  - Focus groups
  - Financial resources inventory
  - Gap analysis
- **Using CHPC presentation time for capacity building workshops**

Sharing Diverse Perspectives

- Let's use the remaining time to hear from you.
  - What CHPC accomplishment stands our for you in 2019?
  - What is an accomplishment for you in 2019?
  - Other comments?

Gratitude for All 2019 Contributions

On behalf of the CHPC, we thank each and every person and partner that contributes to Getting to Zero in Connecticut and to building a culture of inclusion, respect, caring relationships, and good health.

-Barry, Blaise & Gina

CHPC Co-Chairs