Meeting Notes

Participants: Clifford Batson, Sara Burns, Christian Castro, Daniel Davidson, Christina Del Vecchio, Juan Hernandez, Clunie Jean-Baptiste, Dionne Kotey, Susan Major, Mitchell Namias, Peta-Gaye Nembhard, Maribel Nieves, Luje Pierre Louis, Shaquille Pigatt, Ramón Rodriguez-Santana, Robert Sideleau, Sue Speers, Idiana Velez, Danielle Warren-Dias

Facilitator: Nilda Fernandez **Recorder:** Dave Bechtel

Meeting Accomplishments

The team accomplished the following tasks:

- Sue Speers presented data on Connecticut's Progress Indicators and Hepatitis C. Connecticut is meetings its 2021 goals on 10 of its indicators, and needs to improve on 5 of its indicators to reach 2021 goals.
- The team discussed developing a new indicator for Hepatitis C, and requested more data on Hepatitis C and late testers.

Identified Tasks

- QPM staff will review and share existing data on late testers (see Page 4 for details).
- Sue Speers will send additional data on late testers by county and for 2019.
- Sue Major will check with Luis Diaz on the availability of PnR (PrEP-to-Need Ratio) data by race and gender. (This data is not available on AIDSVu.)

Next Meeting

- September 16, 2020 at 11:15 a.m. virtual meeting

Welcome

DAC co-chair Nilda Fernandez welcomed everyone to the online meeting of the Quality and Performance Measures (QPM) Team at 11:18 am. QPM reviews and discusses data, develops indicators to track progress in HIV prevention and care, and seeks to improve the quality of HIV prevention and care.

Ms. Fernandez reminded the team about the approach for our online meetings:

- We are using Zoom so we can see people's faces (if you're willing to turn your camera on).
- Please mute your audio during the presentation.

- Participants can use the Chat box and unmute themselves to have our discussion today. Please raise your hand if you want to ask a question or share a comment. We'll try to make sure everyone who wants has a chance to speak.

Participants introduced themselves and provided feedback on the July QPM meeting notes. Participants approved the notes by consensus.

Update from July Meeting

Danielle Warren-Dias asked for an update on the July meeting request for demographic data on overdose (OD) reversals:

- Ramón Rodriguez-Santana reported that he is in the process of contacting the EMS (Emergency Medical Services) manager to request this data, although he noted that the only data available may be gender as reported by the EMS worker (vs. self-reported data).

Connecticut Progress Indicators Presentation

Sue Speers presented the latest data on Connecticut's Progress Indicators. The QPM Team has developed and revised these indicators over the past 5 years. The full presentation is attached and Page 6 shows a list of all the indicators.

Highlights from the presentation included:

- **Preliminary 2019 Data**. Ms. Speers included 2019 data, but noted that these figures are preliminary.
- **New HIV Diagnoses**. New HIV diagnoses decreased by 23% from 2015 through 2019. Connecticut is on track to meet its 2021 goal in reducing new infections.
- **Seropositivity Rate**. This indicator examines the effectiveness of state-funded HIV testing programs in identifying new HIV infections. In 2019, Connecticut met its goal for its targeted testing program (called OTL).
- **Viral Load Suppression**. This indicator examines viral load suppression for people in care. While Connecticut met its goal with 91% of people in care virally suppressed, Ms. Speers noted that only 71% of all people living with HIV (PLWH) were virally suppressed.
- **Linkage to Care**. Last year, QPM changed the definition of this indicator to linkage to care within one month of diagnosis. While the team has not set a goal for the revised indicator yet, Connecticut has exceeded the national goal of 85% in recent years.
- **Retention in Care**. This indicator uses the "retention in care" definition of HRSA (Health Resources and Services Administration), which is quite complicated. Connecticut has been well below its goal of 70% in recent years. Ms. Speers suggested checking if retention in care was higher for Ryan White programs.

- **Late Testers**. Connecticut has consistently lagged the U.S. in the percent of people diagnosed with AIDS within three months of their initial HIV diagnosis. After a decrease in late testers in recent years, the percent increased to 29% in 2019 (representing approximately 62 of the 216 people diagnosed with HIV in 2019).
- **Partner Services**. Ms. Speers presented data on the percent of newly diagnosed PLWH referred to Partner Services who were interviewed, which has consistently been above 90%. QPM is planning to revise this indicator based on new data being collected by Partner Services.
- **Housing Stability**. This indicator is for Ryan White clients. Connecticut has been consistently below its goal of 85%, with 81% of Ryan White clients stably housed in 2019.
- **Syringe Services Program (SSP)**. As highlighted in last month's SSP presentation, Connecticut has exceeded its goal of serving 4,000 clients and distributing 500,000 syringes – with 4,428 clients and over 1 million syringes distributed in 2019.
- **Reduce Disparities in New Diagnoses**. Connecticut is exceeding its goal of reducing new diagnoses by 15% among MSM (men who have sex with men), Hispanic/Latino men, Black/African American women, and Hispanic/Latino women. However, new diagnoses among Black/African American men increased from 2015 through 2019.
- **PrEP-to-Need Ratio (PnR)**. The PnR measures how well Connecticut is doing in expanding PrEP (Pre-Exposure Prophylaxis), comparing the number of people taking PrEP with new diagnoses. Connecticut has exceeded its goal of 5.1 in 2019 with a PnR of 9.1, and may want to consider setting a more ambitious goal.
- **Hepatitis C (HCV) Data**. Ms. Speers noted that HCV is more prevalent than HIV in the United States, and shared data on trends in chronic and acute HCV diagnoses. The number of new chronic HCV diagnoses decreased to 1,328 in 2019, while the number of new acute HCV cases was very low (and likely underreported) at 8 diagnoses. Like HIV, people with chronic HCV tend to be young (ages 20-39) and male. Unlike HIV, many people with chronic HCV are from rural areas and the primary risk is via IDU (injection drug use).
- **Overall**. Connecticut is exceeding its 2021 goals for 10 indicators, needs to improve on 5 indicators, and QPM needs to set goals for 2 indicators.

Ms. Fernandez facilitated a discussion of on the presentation, primarily using **questions and comments** submitted via the Chat box.

Peta-Gaye Nembhard. Can you explain how "street drugs" differ from Injection Drug Use for HCV? (Both are risk factors.)

- Ms. Major replied that injection does not need to be the modality for HCV transmission; drugs can be snorted, etc.

Nilda Fernandez. Do you relate the higher Hep C numbers in rural areas because they have less access to Hep C testing?

- Ms. Speers replied that it most likely shows that testing was available since the towns highlighted have a high number of positives. At DPH (Department of Public Health), surveillance

for hepatitis C has been underfunded in recent years. DPH just hired a dedicated epidemiologist for HCV, Dustin Pawlow, so will have better (and more detailed) data in the future.

Nilda Fernandez. Do you attribute the opioid epidemic to the higher numbers of Hep C among 20-29?

- Ms. Speers stated possibly, we have seen the opioid epidemic as the cause of hepatitis C outbreaks in other states (MA, KY) and could be contributing to the numbers in CT. People who inject drugs or share works are at high risk of HCV infection.
- Bob Sideleau noted that the location of SSPs could be a factor. If Torrington has an SSP, more people may be getting tested there, and the number of diagnoses could then lead to more education and outreach in these areas. SSPs may also target young people.
- Ms. Speers noted that the goal is to test everyone. The CDC (Centers for Disease Control) is promoting routine HCV testing.

Mitchell Namias. HIV late testers is concerning...do we know if this increase is isolated to one part of the state? Or was it throughout the state?

- Ms. Speers stated DPH has looked at this in the past and has sliced and diced the data without seeing high levels in a particular area. She can look at late tester data by county because past experience has shown that the numbers at the town or zip code level are too small to show differences and also depend on how you define location (e.g., residence, location of provider).

Ramón Rodriguez-Santana asked whether different groups were more likely to be late testers?

- Ms. Speers stated that there is data on the DPH website, and she can compile 2019 data as well. Per the website, in 2018, the following groups were more likely to be late testers:
    - Black and Hispanic women via heterosexual contact (37%)
    - People ages 50 or older (41%)
    - Males via heterosexual contact (54%)
- Mr. Sideleau cautioned the group that this could be a challenging indicator to improve, given the small number of people in each group. If late testers are not concentrated in one part of the state, it will be difficult to reach them. Ms. Speers agreed the expansion of routine testing may be the best way to address this challenge. Like HCV, many people will not get tested until they feel sick.

Ms. Warren-Dias. When will we set indicators to address the lack in PrEP uptake for black folk and women? The data shows we're failing Black folks.

- Sue Major noted that this data is not available on AIDSVu. Ms. Major will check with Luis Diaz on the availability of PnR data by race and gender from other sources.

Ms. Warren-Dias suggested that we implement an indicator for HEP C for the QPM committee.

- Ms. Speers noted in the past, treatment was less than 50% successful and was taxing on individuals, but currently there are several treatment options with successful outcomes in less than 12 weeks. Now that there are interventions that are considered a "cure", QPM members

might want to explore creating an indicator as long as the DPH and/or its partners are able to implement an intervention that can be measured.

- Ms. Warren-Dias suggested setting an indicator based on Ryan White data. Programs are required to report on HCV.
- Ms. Major asked if we could track the percent cured? Ms. Speers said this might be a possibility in the future or in a limited capacity currently. Hepatitis C continuums of care similar to the HIV continuum of care are being encouraged by the CDC as a means to track hepatitis C elimination. We might be able to estimate the percent "cured" by using negative RNA tests as proxies for SVR (sustained virologic response). This indicator could possibly be defined in a similar way as viral load suppression with HIV. Ms. Major and Ms. Warren-Dias agreed that this would be a great measure.

Meeting Feedback

Ms. Fernandez thanked everyone for their participation, and asked participants to share feedback on the meeting. Comments and suggestions included:

- Participants appreciated the presentation of HCV data, and the overall data presentation.
- Participants were interested in seeing more HCV and PrEP data (per the group discussion).

Feedback via Chat

- Nilda Fernandez: Wow that is new and good data on Hep C.
- Clifford Batson: Sue, that was awesome.
- Robert Sideleau: Very helpful data and discussions
- Peta-Gaye Nembhard: The data presentation was great
- Juan Hernandez: I would like to see additional HCV and PrEP data.
- Dionne Kotey: I like that we were able to maintain ongoing discussions during the session just as well as our in-person session. I second seeing more HCV data.
- Clunie Jean-Baptiste: The data presentation was great
- Juan Hernandez: I am looking forward to meeting in person again.

Adjourn

The meeting adjourned at 12:14 pm.

##End QPM Notes##

Connecticut Progress Indicators

Indicator 1	HIV Positivity (Biological): Number of newly diagnosed (dx) in the 12-month calendar year. **2021 Goal: 218 newly diagnosed** (Baseline: 351 in 2011, 277 in 2015) Source: HIV Surveillance (eHARS)
Indicator 2	Seropositivity Rate (Service/Access): Percent of OTL and ETI HIV positive tests in the 12-month calendar year. **2021 Goal: 0.2% ETI; 0.3% OTL** (Baseline: ETI: 0.15% in 2015, 0.17% in 2016. OTL: 0.20% in 2015, 0.23% in 2016) Sources: HIV Surveillance (eHARS) and HIV Prevention (EvaluationWeb)
Indicator 3	Viral Load Suppression Among Persons in HIV Medical Care: Percent of persons with an HIV diagnosis with a viral load <200 copies/ml at last test in the 12-month calendar year. **2021 Goal: 90%** (Baseline: 85% in 2015) Source: HIV Surveillance (eHARS)
Indicator 4	Linkage to HIV Care (Biological): Percent of persons who attended a routine HIV medical care visit within 1 month of HIV diagnosis. **2021 Goal: TBD** (Baseline: 87% in 2015) Source: HIV Surveillance (eHARS)
Indicator 5	Retention in HIV Medical Care (Service/Access): Percent of patients who had at least 1 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 subsequent 6-month period. **2021 Goal: 70%** (Baseline: 68% in 2014-15) Source: HIV Surveillance (eHARS)
Indicator 6	Late HIV Diagnoses (Late Testers) (Biological): Percent of people who had their first HIV positive test less than 3 months before receiving AIDS diagnosis. **2021 Goal: 25%** (Baseline: 28% in 2015) Source: HIV Surveillance (eHARS)
Indicator 7	Partner Services (Service/Access): TBD based on review of latest data. Source: STD Control Program (STD * MIS)
Indicator 8	Housing Status (Service/Access): Percent of Ryan White clients who were stably housed in the 12-month calendar year. **2021 Goal: 85%** (Baseline: 83% in 2015) Source: Ryan White Programs (CAREWare)
Indicator 9	Syringe Services Program (SSP) (Service/Access): *10a:* Number of SSP clients served: **2021 Goal: 4,000** (Baseline: 3,642 in 2015) *10b:* Number of syringes collected: **2021 Goal: 450,000** (Baseline: 356,112 in 2015) *10c:* Number of syringes distributed: **2021 Goal: 500,000** (Baseline: 369,665 in 2015) Source: HIV Prevention (XeringaX DB)
Indicator 10	Disparities in New HIV Diagnoses: Number of newly diagnosed (dx) 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. **2021 Goal: Reduce new HIV diagnoses by 15% for each priority population.** Source: HIV Surveillance (eHARS)
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. **2021 Goal: 5.1** (Baseline: 4.3 in 2017) Source: AIDSVu
Indicator 12	Sexually Transmitted Diseases (STDs): TBD after September 2020 presentation