THE GREATER CLEVELAND HIV CARE CONTINUUM

FINDINGS FROM THE GREATER CLEVELAND HIV HEALTH INFORMATION PROJECT (CHHIP)

Ann Avery, MD
MetroHealth Medical Center
Objectives

1. Describe the local HIV care continuum
2. Understand trends and factors affecting HIV retention in care and viral suppression
Disclosures

Gilead- Participated in the Steering Committee for PrEP
Test and Treat- and problems with the

FIGURE 3. Number and percentage of HIV-infected persons engaged in selected stages of the continuum of HIV care — United States

- HIV-infected*: 1,178,350
- HIV-diagnosed*: 941,950
- Linked to HIV care*: 725,302
- Retained in HIV care*: 480,395
- On ART*: 426,590
- Suppressed viral load (≤200 copies/mL)**: 328,475

35%
National HIV/AIDS Strategy (NHAS)

Reducing New HIV infections (by 25%)

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

Reducing HIV-Related Health Disparities
Challenges to a local Health Care Continuum (HCC)

- Ohio Department of Health (ODH) does not provide data to care information (though planned)
- Local Health Dept (CDPH) data is different than ODH
- Ryan White data does not cover entire population
- Patients that move in or out of area and not necessarily accounted for by health department
- A single system would limit generalizability
- No one single source for desired information
CHHIP
GREATER CLEVELAND HIV HEALTH INFORMATION PROJECT

LEVERAGING EMRS TO IMPROVE HEALTH OF PATIENTS LIVING WITH HIV/AIDS (PLWHA)
The Goal

Develop & pilot community-wide clinical information system

- Build data system that *integrates quality metrics* (i.e., CD4 count, viral load, treatment adherence) with *patient characteristics & needs* (i.e., demographics, risk factors, co-morbidities, food stamp use)

Optimize individual and population health

- Coordination of intervention activities *for all practices* delivering care to PLWHA
Electronic Medical Records (EMR)

Epic is used in most partner organizations, all have some type of EMR

- Labs
- Ambulatory visits
- Medical co-morbidities
- Utilization (hospital, ED)
Outcome vs Process

Process
-was the appropriate diagnostic or monitoring test completed or captured?

Outcome
-what was the result?
Better Health Greater Cleveland

Independent, grant-funded 501(c)(3)

- Established in 2007
- Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative
- Leverages data to identify opportunities & best practices in improving care & outcomes within a peer network of primary care professionals
  - Diabetes
  - Hypertension
  - Heart failure
Why Cleveland Rocks!

• Comprehensive connection of HIV care providers
  o Current CHHIP partners
    o UH, CCF, Care Alliance, Free Medical
  o Agreed upon HIV care standards & metrics
  o Maximize delivery impact on both individual & community

• Dedicated manpower for population management

• Consistent identifier to track movement
CDPH participation for all reported cases

Bi-directional sharing to determine:

1. people who are HIV+ but not reported to the health department
2. people who have died or moved out of the area
3. people who are HIV+ (tested by health department) but not linked to care
Who is missing from data?

Veteran’s Administration Medical Center (VAMC)
AIDS Health Care Foundation
St Vincent Charity
Some community CCF sites (new in 2016)
Free Medical Clinic (missing only for 2015-16)
Small non-affiliated providers
Ryan White HIV Care Continuum

Cuyahoga County Board of Health Ryan White Part A program- CareWare data
Cuyahoga County HIV HCC 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Total unique # reported in the time period (year)</th>
<th># linked in year</th>
<th># engaged (visit in 1st and 2nd half)</th>
<th># engaged (CD4 or VL in 1st and 2nd half)</th>
<th>Prescribed HIV meds in any quarter</th>
<th># undetectable</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>2777</td>
<td>2532</td>
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<td>3729</td>
<td>3192</td>
<td>2148</td>
<td>2288</td>
<td>2288</td>
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</table>

Note: # engaged (CD4 or VL in 1st and 2nd half) refers to individuals with CD4 or VL levels recorded within the first and second halves of the year. Prescribed HIV meds in any quarter indicates the number of individuals who were prescribed HIV medications during any quarter of the year.
Reported HIV Prevalence in Cuyahoga County by ODH vs CHHIP data

Source: Ohio Department of Health
Persons Living with a Diagnosis of HIV Infection Reported in Ohio
Cuyahoga County undetectable (<200)

Uses CHHJP data 2016 and reported prevalence from ODH for denominator.
Data from MHS, UH, Care Alliance and Cleveland Clinic
Cuyahoga County HCC by gender

Males n=2914, Females n=815

Data from CHHIP 2016
2016 Cuyahoga County HCC AA vs White

Data from CHHIP 2016
HCC 2016 Ethnicity

Data from CHHIP 2016
2016 HCC by age group

Data from CHHIP 2016
### Depression/Psych Status 2

<table>
<thead>
<tr>
<th>Depression/Psych Status 2</th>
<th>Total unique # reported in the time period (year)</th>
<th># linked (1 visit in year)</th>
<th># engaged (visit in 1st and 2nd half)</th>
<th># engaged (CD4 or VL in 1st and 2nd half)</th>
<th># prescribed HIV meds in any quarter</th>
<th># medical visit within period</th>
<th># undetectable</th>
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<tr>
<td>None</td>
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<td>2463</td>
<td>1577</td>
<td>1498</td>
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<td>2463</td>
<td>1973</td>
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<tr>
<td>Yes, &lt; 2 Psych Visits</td>
<td>665</td>
<td>596</td>
<td>452</td>
<td>385</td>
<td>599</td>
<td>596</td>
<td>469</td>
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<tr>
<td>Yes, &gt;= 2 Psych Visits</td>
<td>136</td>
<td>133</td>
<td>119</td>
<td>99</td>
<td>131</td>
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Data from CHHIP 2016
# Cuyahoga County HCC by Insurance Status

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<tr>
<th>Primary Insurance Class</th>
<th>Total unique # reported in the time period (year)</th>
<th>linked (1 visit in year)</th>
<th>engaged (visit in 1st and 2nd half)</th>
<th>engaged (CD4 or VL in 1st and 2nd half)</th>
<th>prescribed HIV meds in any quarter</th>
<th>medical visit within period</th>
<th>undetectable</th>
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<td>Missing or Unavailable</td>
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<td>46</td>
<td>21</td>
<td>9</td>
<td>37</td>
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<td>24</td>
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<tr>
<td>Commercial or Private</td>
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<td>926</td>
<td>604</td>
<td>571</td>
<td>608</td>
<td>926</td>
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<td>Medicaid</td>
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<td>1338</td>
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<td>795</td>
<td>992</td>
<td>1338</td>
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<td>Medicare</td>
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<td>715</td>
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<td>517</td>
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<td>Uninsured or Self-Pay</td>
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<td>56</td>
<td>74</td>
<td>106</td>
<td>69</td>
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<td>Other Class</td>
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<td>64</td>
<td>61</td>
<td>55</td>
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Data from CHHIP 2016
Cuyahoga County 2016 HCC by Neighborhood Income

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<tr>
<th>Neighborhood Income</th>
<th>Total unique # reported in the time period (year)</th>
<th>linked (1 visit in year)</th>
<th>engaged (visit in 1st and 2nd half)</th>
<th>(CD4 or VL in 1st and 2nd half)</th>
<th>prescribed HIV meds in any quarter</th>
<th>medical visit within period</th>
<th>undetectable #</th>
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<td>($0K, $20K]</td>
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<td>($20K, $30K]</td>
<td>850</td>
<td>701</td>
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<td>707</td>
<td>701</td>
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<td>($30K, $40K]</td>
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<td>618</td>
<td>607</td>
<td>483</td>
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<tr>
<td>($40K, $50K]</td>
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<td>367</td>
<td>613</td>
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<td>($50K, ]</td>
<td>585</td>
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<td>329</td>
<td>286</td>
<td>499</td>
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<td>427</td>
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Data from CHHIP 2016
Cuyahoga County 2016 HCC by Immune Status

Data from CHHIP 2016
Highest rate of reported cases 65% viral suppression
2nd highest rate of reported cases 70% viral suppression
Estimated number of new HIV infections per 100 person-years among heterosexual serodiscordant couples by serum viral load of HIV partner:

- 50,000 or more copies/ml: N=26*
- 10,000–49,999 copies/ml: N=15*
- 3,500–9,999 copies/ml: N=13*
- <3,500 copies/ml: N=2*
Conclusion

Viral suppression is excellent among patients who engage in the care system— even if just once in a year.

Efforts should be coordinated and target to address disparities.

Priority groups are youth, poverty and those with advanced disease.
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Discussion and Questions

aavery@metrohealth.org