INLAND EMPIRE HIV PLANNING COUNCIL

351 N. Mt. View Avenue • San Bernardino, CA 92415-0475
(909) 693-0750
Website: www.iehpc.org

Riverside/San Bernardino California Transitional Grant Area

Maxwell Ohikhuare, MD
County Health Officer Co-Chair

Gregory French
Community Co-Chair

Continuum of Care Committee

Thursday, January 16, 2014
9:00am-10:30am

Meeting Location
Department of Public Health
351 North Mt. View Ave., Basement
San Bernardino, CA 92415
(909) 693-0750

Teleconferencing Location***
Desert AIDS Project
1695 North Sunrise Way
Palm Springs, CA 92262
(760) 323-2118

Agenda

9:00am	**1. Call to Order** ▪ Roll Call* ▪ Introductions	B. Contreras
	2. Public Comments[1]	Members of the Public
	3. Members Privilege	PC Members
	4. Approval of Agenda[2]	B. Contreras
	5. Approval of Minutes[2] 5.1 Minutes of November 11, 2013	B. Contreras
	6. Old Business[2] 6.1 Affordable Care Act Discussion/Updates (A-1)	Committee Members
	7. New Business[2] 7.1 Transition Process for Ryan White Clients to ACA 7.2 Discuss impact of Standards revisions (Substance Abuse and Mental Health)	B. Contreras

	8. Public Comments[1]	Members of the Public
	9. Members Privilege	PC Members
	10. Review of Action Items	PC Staff
	11. Agenda Setting for Next Meeting March 13, 2014 HIV Planning Council Conference Room	PC Members/ B. Contreras
	12. Roll Call*	PC Staff
10:30am	**13. Adjournment**	B. Contreras

[1] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.

[2] The agenda item may consist of a discussion and a vote. Public comments can be made prior to each Planning Council vote.

* Members must be present at both roll calls to receive credit for meeting attendance.

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California Addresses the National HIV/AIDS Strategy Goals and Objectives

In July 2010, the White House released the *National HIV/AIDS Strategy (NHAS) for the United States*, which outlined four goals for a national response to HIV in the United States. These goals are to: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV; 3) reduce HIV-related health disparities; and 4) achieve a more coordinated national response to the HIV epidemic.

California's Integrated HIV Surveillance, Prevention, and Care Plan Goals are in alignment with NHAS. Because the objectives associated with the first three NHAS goals are measurable using current California data sources, this report focuses on these first three goals and shows the baseline status of these objectives and specifies 2015 targets for California. Data sources and methods are described on page 4.

Goal 1: Reduce the Number of New HIV Infections

NHAS Objectives for 2015	California	
	Baseline (2010)	Target (2015)
Objective 1-1: Reduce the number of new HIV infections by 25 percent.	5,598[1]	4,199
Objective 1-2: Reduce the HIV transmission rate[2] by 30 percent	4.3	3.0
Objective 1-3: Increase the percentage of people living with HIV who know their serostatus[3] to 90 percent.	N/A[4]	90%

[1] 95 percent confidence interval: 4,576 – 6,621 cases.
[2] HIV transmission rate is defined as the number of new HIV infections per 100 people living with HIV.
[3] Serostatus is an individual's status with respect to being positive or negative for HIV antibodies.
[4] California-specific data for this objective is not currently available. The nationwide estimate for this objective is 82 percent.

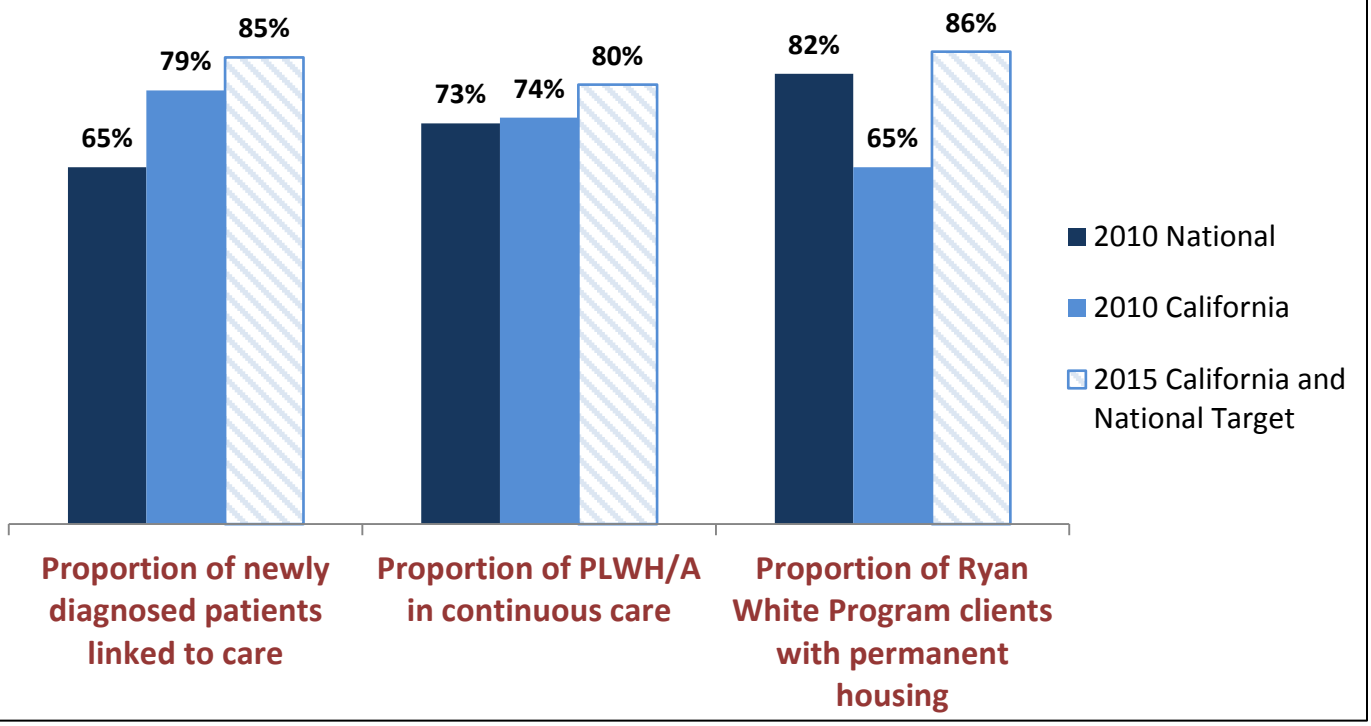
Goal 2: Increase Access to Care and Optimize Health Outcomes for People Living with HIV/AIDS (PLWH/A)

NHAS Objective for 2015	California	
	Baseline (2010)	Target (2015)
Objective 2-1: Increase the proportion of newly diagnosed patients linked to clinical care within three months of HIV diagnosis from 65 to 85 percent.	79%	85%
Objective 2-2: Increase the proportion of PLWH/A who are in continuous care to 80 percent.[1]	74%	80%
Objective 2-3: Increase the proportion of Ryan White Program[2] clients with permanent housing to 86 percent.	65%	86%

[1] California is applying the objective to all Californians living with HIV/AIDS who are in care, regardless of payer source. The national objective is based on Ryan White Program clients.

[2] The Ryan White Program is a federally funded program that supports primary medical care and essential support services for PLWH/A who have no other payer source for these services.

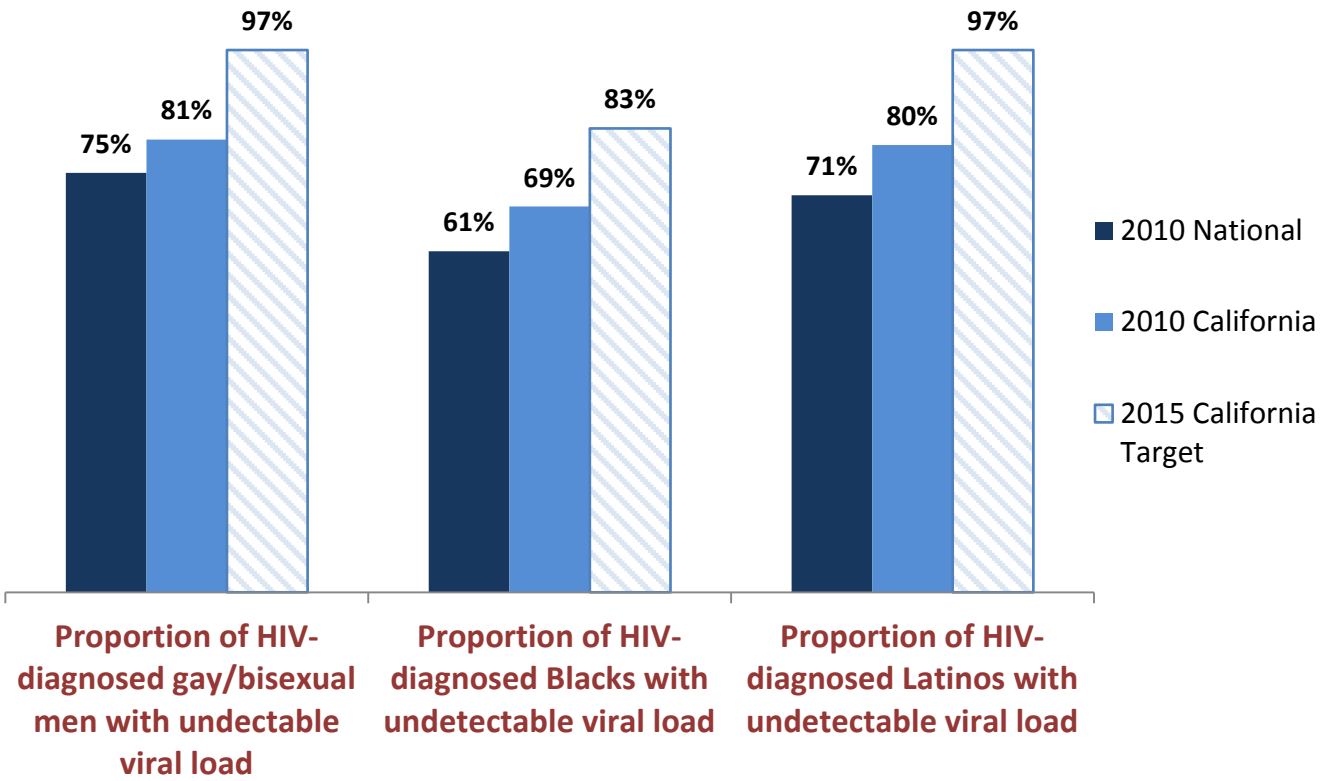
How California Compares to National Baseline Measures for Goal 2 of the National HIV/AIDS Strategy



Goal 3: Reduce HIV-Related Health Disparities

NHAS Objectives for 2015	California	
	Baseline (2010)	Target (2015)
Objective 3-1: Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20 percent.	81%	97%
Objective 3-2: Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.	69%	83%
Objective 3-3: Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.	80%	97%

How California Compares to National Baseline Measures for Goal 3 of the National HIV/AIDS Strategy



Data Sources and Methods

Except for Objective 2-3, all California-specific analyses presented in this document were based on 2010 California HIV case and incidence surveillance data, including data from all 61 local health jurisdictions (LHJs) in California, as reported to the California Department of Public Health (CDPH) through December 27, 2012. All analyses were restricted to persons aged 13 years and older.

1) **Goal 1: Reduce the number of new HIV infections**
   a. **Objectives 1-1 and 1-2**
      - HIV incidence estimates are based on algorithms developed by the Centers for Disease Control and Prevention (CDC).
      - Baseline calculation: 5,598 cases (estimated incidence)/128,731 estimated prevalence (diagnosed + undiagnosed)*100 = 4.3 new HIV transmissions per 100 people living with HIV.
      - More information about California HIV incidence surveillance is available at: http://www.cdph.ca.gov/programs/aids/Pages/OAHISHome.aspx)

   b. **Objective 1- 3**
      - CDC estimates of the proportion of HIV-infected individuals nationwide who know their serostatus:
        Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and six U.S. dependent areas—2010. *HIV Surveillance Supplemental Report* 2012;17 (No. 3, part A). http://www.cdc.gov/hiv/library/reports/surveillance/2010/surveillance_Report_vol_17_no_3.html. Published June 2012. [Accessed November 18, 2013.]

2) **Goal 2: Increase access to care and optimize health outcomes for people living with HIV**
   a. **Objectives 2-1 and 2-2**
      - Calculated using CDC's NHAS indicator computer programs [SAS® Version 9.2 (SAS Institute Inc., Cary, NC, USA)].
      - Laboratory data were used as a proxy for care visits; a care visit was defined as a CD4 and/or viral load laboratory result reported to CDPH.
      - Newly diagnosed persons linked to care were defined as persons diagnosed with HIV infection during January 1, 2010–December 31, 2010 and received care within three months of their diagnosis.
      - In continuous case was defined as having had more than two care visits, as represented by a CD4 and/or viral load laboratory result, during January 01, 2010-December 31, 2010, where the visits were at least three months apart.
        - Denominator included California residents diagnosed with HIV infection on or before December 31, 2009 and ≥13 years old on December 31, 2009 who received HIV care during January 1, 2010–December 31, 2010 and were still alive on December 31, 2010.

b. **Objective 2-3:**

- Defined as HIV Care Program Ryan White Part B clients in California (excluding those in the counties of Alameda and Los Angeles, although clients in the city of Long Beach are included) who received at least one service during 2010 and reported "stable/permanent" housing as their living situation as of the end of calendar year 2010.
- Data are from California's HIV Care Program client management system, the AIDS Regional Information and Evaluation System (ARIES).
- Unknown/missing data (13.6 percent) were excluded from denominator.
- For additional information about the Ryan White Program, please see: http://hab.hrsa.gov/abouthab/index.html.

3) **Goal 3: Reduce HIV-related health disparities**

a. **Objectives 3-1; 3-2; and 3-3**

- Denominator included California residents diagnosed with HIV infection on or before December 31, 2009 and over 13 years old on December 31, 2009 who had had at least one viral load result in during January 01, 2010–December 31, 2010, and were still alive on December 31, 2010.
- Persons whose most recent viral load test result was less than 200 copies/ml during January 1, 2010–December 31, 2010 were considered virally suppressed and included in the numerator of those with an "undetectable viral load."

4) **2010 National data for comparison for Goals 2 and 3**

a. **Objectives 2-1; 3-1; 3-2; and 3-3**

- Source: Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data-United States and six U.S. dependent areas—2010. *HIV Surveillance Supplemental Report* 2013;18(No. 2, part B). http://www.cdc.gov/hiv/library/reports/surveillance/2010/surveillance_Report_vol_18_no_2.html. Published January 2013. [Accessed November 18, 2013].

b. **Objectives 2-2 and 2-3**

- Source: National Office of AIDS Policy. NHAS for the United States. http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas.pdf. Published July 2010.

5) Additional resources:

- NHAS: http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf.
- CDPH's Office of AIDS Integrated HIV Surveillance, Prevention, and Care Plan: http://www.cdph.ca.gov/programs/aids/Documents/IntegratedPlan.pdf.

Acknowledgements

CDPH's Office of AIDS would like to thank all California providers, laboratories, LHJs surveillance staff, and ARIES users whose work made this report possible.

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Continuum of Care Committee

Thursday, November 21, 2013
2:00pm-3:00pm

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(909) 693-0750

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Minutes

Members: L. Ford-Watson, P. Hagan, B. Orr, T. Evans, S. Cromwell
Staff: A. Fox
Guests: N. Prelesnick, J. Williams

2:10pm	**1. Call to Order** ▪ Roll Call* ▪ Introductions	B. Contreras
	2. Public Comments[1]	Members of the Public
	3. Members Privilege	PC Members
	4. Approval of Agenda[2] **Motion to approve the November 21, 3013 Agenda with revision.** **M/S/C D. Wahl, P. Hagan**	B. Contreras
	5. Approval of Minutes[2] 5.1 Minutes of April 11, 2013 **Motion to approve April 11, 2013 Minutes.** **M/S/C: D. Wahl, B. Orr**	B. Contreras
	6. Old Business[2] 6.1 Review Expenditure and Utilization Report (A-1) 6.2 Affordable Care Act Discussion/Updates (A-2) Committee reviewed California Office of AIDS	Committee Members

	November report to the Council.	
	7. New Business[2] 7.1 Transition Process for Ryan White Clients to ACA 7.2 Care Alternative Hospice – Overview Presented by Jenny Williams from Care Alternatives Hospice	B. Contreras
	8. Public Comments[1]	Members of the Public
	9. Members Privilege L. Ford Watson thanked everyone for their time and to keep in mind the care that's available.	PC Members
	10. Review of Action Items Staff will: 1. Include detailed continuum of care report in packet for January. 2. Agendize the Continuum of Care transition process from Ryan White to ACA. 3. Request the chair of the Standards committee notify the Chair of CCC if a Standards is changed and agendize change on the CCC agenda.	PC Staff
	11. Agenda Setting for Next Meeting January16, 2014 HIV Planning Council Conference Room	PC Members/ B. Contreras
	12. Roll Call*	PC Staff
3:30pm	**13. Adjournment**	B. Contreras

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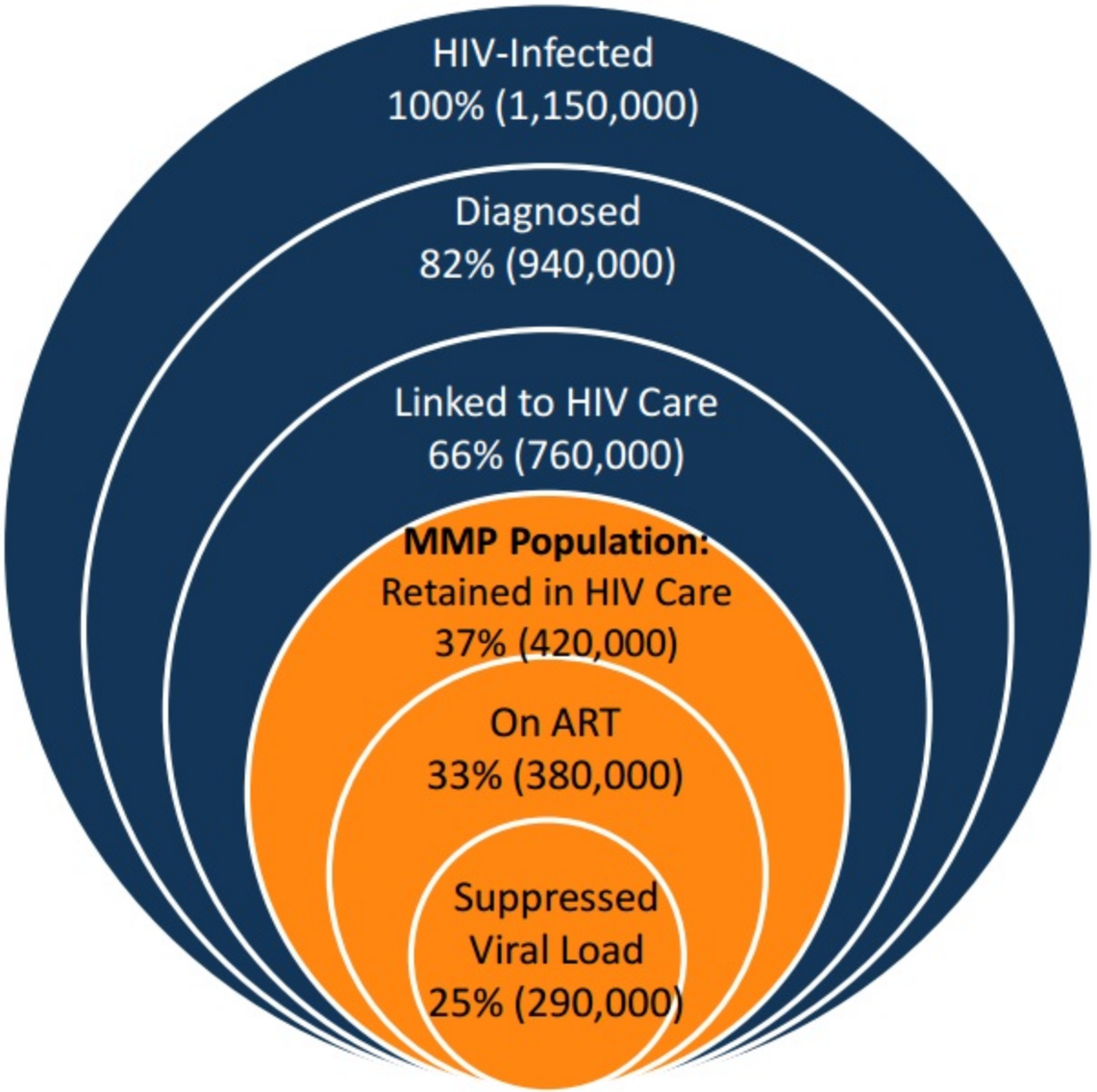
The HIV Care Continuum, 2009



NOTE: Population figures rounded to nearest 10,000.
SOURCE: Adapted from Hall H, Frazier EL, Rhodes P, et al. (2013). "Differences in Human Immunodeficiency Virus Care and Treatment Among Subpopulations in the United States." *JAMA Intern Med*. 173(14):1337-1344.