MONITORING AND IMPROVEMENT

2017-2021

Office of Infectious Disease
Washington State Department of Health

HIV Planning Steering Group

SEATTLE TGA·HIV PLANNING COUNCIL

Washington State Department of Health

Public Health Seattle & King County

Contents

Inclusion of Stakeholders and Planning Bodies

The Washington HIV Planning Steering Group and Seattle TGA HIV Planning Council will be regularly updated on plan progress. The Plan is a living document that serves as a roadmap and will be updated as needed. The Integrated HIV Prevention and Care Plan reflects Washington State's vision and values regarding how best to deliver the most appropriate, effective HIV services.

Washington State Planning System

The Washington State Planning System has multiple mechanisms for input inclusive of the formal planning bodies. Cross representation occurs within both bodies. PLWH and PAHR are encouraged to participate in all components of the planning system, which includes the HIV Planning Steering Group, HIV Stakeholder Village, and HIV Special Emphasis Workgroups.

Washington State HIV Planning System
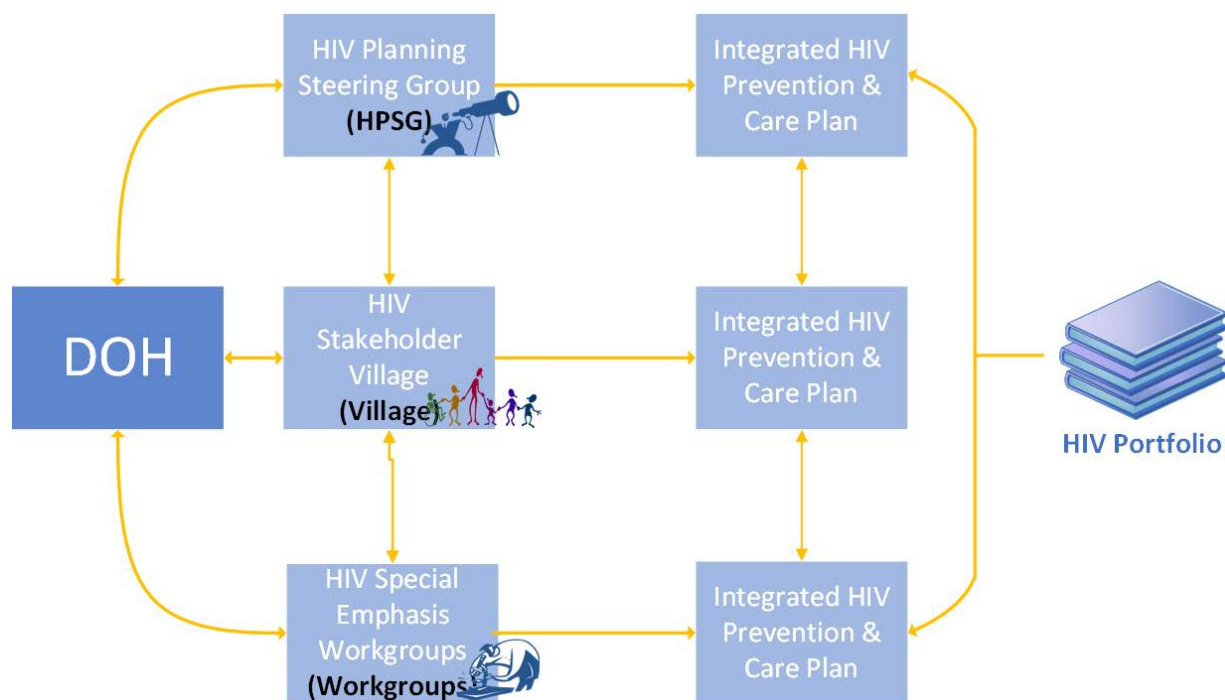
HIV Planning Steering Group HPSG

The HIV Planning Steering Group (HPSG) is a 21-member, formal, standing, advisory committee. It works with the Department of Health to develop a statewide HIV plan.

The Stakeholder Village

The Stakeholder Village is open to everyone. It does not have formal members. Its purpose is to both give and receive information. The Department of Health will educate the community on current and proposed HIV interventions and strategies. The community will provide input to the Department of Health.

HIV Special Emphasis Workgroups
Subject matter experts convened on an ad-hoc basis to advise on strategy implementation.

Seattle TGA HIV Planning Council

The Seattle TGA HIV Planning Council is the formal planning body invested with the authority to assess need, prioritize services, allocate funds and set directives for the Ryan White Part A dollars allocated to the Seattle Transitional Grant Area of King, Snohomish and Island Counties. The Council includes *unaligned* consumers of Part A services (always more than 33%, currently 44%), service providers, representatives of other Ryan White parts, community leaders, and others. Additionally, all Council and Committee meetings are open to the public and advertised. The Council has committees which carry out much of its work:

Services and Needs Assessment (SNAC)

The SNAC Committee reviews available data, identifies data gaps and develops assessments to address those gaps. They also define service units, and, in some cases, set additional directives to the grantee. In collaboration with the grantee, they also develop the service standards. Some of the activities undertaken by this group in assessing need are similar to the State's Special Emphasis Workgroups.

Priority Setting and Resource Allocation (PSRA)

PSRA is the committee responsible for reviewing all of the available data and using it to set a list of service priorities that are not wholly met by other funders, prioritizing those services, allocating dollars to them, and setting directives on how the services should be carried out. Both committees set long-range plans, as well as making periodic adjustments to funding. Council members have participated in the State's first Special Emphasis Workgroup on Disparities, and, will participate in future workgroups.

Monitoring and Evaluation Plan

This section outlines the methods with which DOH plans to measure progress to towards achieving the Integrated HIV Prevention and Care Plan. In all cases, measurement will be based on people diagnosed with HIV in Washington State. Unless otherwise stated, data from the calendar year 2014 will be used to establish baselines for trend evaluation, while target values will apply to the year 2020. Due to reporting delays, DOH anticipates that an additional 12 months (year-end 2021) will be required in order to complete a final performance evaluation.

It is important to keep in mind that measures based on HIV surveillance data are dynamic in nature; depending on the date of report, small changes will occur over time as newer and better data become available. HIV surveillance information is based on data reported through December 31, 2015.

Goal 1: Reduce by 50% the rate of new HIV diagnoses

2014 baseline: 6.3 new HIV diagnoses per 100,000
2020 target: ≤ 3.2 new HIV diagnoses per 100,000
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)

Office of Financial Management (OFM)

Crude rate calculation requires dividing the reported, annual number of newly diagnosed cases of HIV infection by the estimated number of people residing in Washington State within the same year. To improve ease of interpretation, diagnosis rates are described as the average number of diagnoses per 100,000 residents. Although new HIV diagnoses are often used a proxy measure for HIV incidence (new infections), it is not uncommon for people to remain infected but undiagnosed for long periods of time.

Goal 2: Increase to 80% the percentage of people living with HIV who have a suppressed viral load

2014 baseline: 68% suppressed
2020 target: ≥ 80% suppressed
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)

This proportion is based on the most recent viral load reported within a given calendar year, among all people reported to be living in Washington as of the end of the same calendar year. This can include individuals who were initially diagnosed with HIV while living outside Washington.

Goal 3: Reduce by 25% the age-adjusted mortality rates among people living with HIV

2014 baseline: 2.2 deaths per 100,000
2020 target: ≤ 1.7 deaths per 100,000
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)
                        Washington Center for Vital Statistics
                        Social Security Death Master File
                        National Death Index
                        Office of Financial Management (OFM)

Age-adjusted mortality rates are calculated by first dividing the reported, annual number of deaths among people living with HIV by the estimated number of people residing in Washington State within the same year. Because HIV mortality is age-dependent, DOH uses a direct method for age adjustment: age-specific rates are adjusted to reflect the relative contribution made by each of 18 separate age groups, based on the U.S. Standard Population 2000. To improve ease of interpretation, mortality rates are described as the average number of deaths per 100,000 residents.

Goal 4: Reduce HIV-related health disparities among people living with HIV

HIV-related health disparities can be measured in a variety of different ways. In 2015, DOH convened a Special Emphasis Workgroup (SEW) to examine health disparities experienced by people living with HIV across Washington State. The SEW published a report identifying and prioritizing 10 specific health disparities which the group felt needed the most attention. Nine of these disparities have been adopted as part of this End AIDS goal. However, one disparity identified by the SEW - engagement in care among young adults ages 18-34 - was omitted based on newer data which suggest this gap has decreased to the point that it does not merit further action. Nevertheless, DOH will continue to monitor engagement in care among young adults over time to ensure this disparity does not re-emerge.

In addition, at the request of the HIV Prevention Steering Group, we have added a disparity indicator based on viral load suppression among HIV-positive persons who inject drugs (PWID).

1) Reduce by 50% the absolute difference between the HIV diagnosis rate among U.S. born Black residents and the statewide HIV diagnosis rate

2014 Baseline: Rate difference of 14.6 cases per 100,000
2020 Target: Rate difference of ≤ 7.3 cases per 100,000
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)
                 Office of Financial Management (OFM)

Crude rate calculation requires dividing the reported, annual number of newly diagnosed cases of HIV infection by the estimated number of people residing in Washington State within the same year. The absolute rate difference can be calculated by subtracting the HIV diagnosis rate among U.S.-born Black residents and the statewide HIV diagnosis rate.

2) Reduce by 50% the absolute difference between the HIV diagnosis rate among foreign-born Hispanic residents and the statewide HIV diagnosis rate

2014 Baseline: Rate difference of 8.9 cases per 100,000
2020 Target: Rate difference of ≤ 4.5 cases per 100,000
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)
                 Office of Financial Management (OFM)

See description of absolute rate difference above.

3) Reduce by 50% the absolute difference between the percentage diagnosed late among foreign-born Black residents and the late HIV percentage among all new HIV diagnoses

2012-2014 Baseline: Difference in late HIV percentage of 4%
2018-2020 Target: Difference in late HIV percentage of ≤ 2%
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)

Late HIV diagnosis describes an event in which a new case is diagnosed with AIDS within 12 months of HIV diagnosis. Late HIV diagnosis can be an indication that a person at risk for HIV was not getting routinely tested prior to diagnosis. However, interpretation of late HIV diagnosis can be limited by the accuracy and completeness of diagnostic date information reported to the health department. Also, the speed with which different people progress from HIV infection to AIDS can vary greatly.

4) Reduce by 50% the absolute difference between the percentage diagnosed late among foreign-born Hispanic residents and the late HIV percentage among all new HIV diagnoses

2012-2014 Baseline: Difference in late HIV percentage of 10%
2018-2020 Target: Difference in late HIV percentage of ≤ 5%
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)

See explanation of late HIV diagnosis above.

5) Reduce by 50% the absolute difference between the percentage diagnosed late among people ages 45 and older and the late HIV percentage among all new HIV diagnoses

2012-2014 Baseline: Difference in late HIV percentage of 10%
2018-2020 Target: Difference in late HIV percentage of ≤ 5%
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)

See explanation of late HIV diagnosis above.

6) Reduce by 50% the absolute difference between the percentage who are linked to HIV medical care within 30 days of diagnosis among newly diagnosed U.S.- born Black residents and the percentage linked among all new HIV diagnoses

2012-14 Baseline: Difference in late HIV percentage of 4.1%
2018-2020 Target: Difference in late HIV percentage of ≤ 2.0%
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)

Linkage to care refers to the percentage of new HIV diagnoses for whom we have laboratory evidence of an HIV medical care visit (either CD4 or viral load) within 30 days of the initial date of HIV diagnosis (based on the date of the confirmatory test result). This indicator is recommended by the National HIV/AIDS Strategy. However, the indicator is limited by the completeness of HIV laboratory reporting, and by the potential for misclassification bias based on whether the first reported CD4 or viral were used for diagnostic purposes vs. the delivery of HIV medical care.

7) Reduce by 50% the absolute difference between the percentage engaged in HIV medical care among foreign-born Hispanic people living with HIV and the percentage engaged among all people living with HIV

2014 Baseline: Difference in percentage engaged in care of 14.5%
2020 Target: Difference in percentage engaged in care of ≤ 7.3%
Data source(s): Washington State HIV/AIDS Reporting System (eHARS)

Engagement in care refers to the percentage of individuals for whom we have laboratory evidence of at least one HIV medical care visit (either CD4 or viral load) within the past 12 months (or calendar year). The denominator includes those who have been both diagnosed with HIV and are currently living with HIV in Washington State, as of the end of the calendar year of interest. This includes people initially diagnosed within the same year and people who were originally diagnosed while residing outside Washington.

8) Reduce by 50% the absolute difference between the percentage virologically-suppressed among U.S.-born Black people living HIV and the percentage suppressed among all people living with HIV

2014 baseline: Difference in percentage suppressed of 8.1%
2020 target: Difference in percentage suppressed ≤ 4.0%
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)

See explanation of the viral load suppression above. This indicator requires subtracting the suppressed percentage of U.S.-born Black people living with HIV from the same percentage among all people living with HIV within the same calendar year.

9) Reduce by 50% the absolute difference between the percentage virologically-suppressed among foreign-born Hispanic people living HIV and the percentage suppressed among all people living with HIV

2014 baseline: Difference in percentage suppressed of 10.5%
2020 target: Difference in percentage suppressed ≤ 5.2%
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)

See explanation of the viral load suppression above. This indicator requires subtracting the suppressed percentage of foreign-born Hispanic people living with HIV from the same percentage among all people living with HIV within the same calendar year.

10) Reduce by 50% the absolute difference between the percentage virologically-suppressed among persons living with HIV who inject drugs and the percentage suppressed among all people living with HIV

2014 baseline: Difference in percentage suppressed of 20%
2020 target: Difference in percentage suppressed ≤ 10%
Date source(s): Washington State HIV/AIDS Reporting System (eHARS)

See explanation of the viral load suppression above. This indicator requires subtracting the suppressed percentage of HIV-positive PWID from the same percentage among all people living with HIV within the same calendar year.

Goal 5: Improve quality of life among people living with HIV

Quality of life (QOL) is defined by CDC as "perceived physical or mental health over time." This is a broad concept involving subjective evaluations of both positive and negative aspects of life with respect to personal expectations. Many techniques for measuring QOL exist. For End AIDS, DOH has chosen to measure quality of life using the Healthy Days core module. This 4-question module has been part of the state's Behavioral Risk Factor Surveillance System since 1993, and provides data in support of Healthy People 2020 goals. The module was also asked as part of a statewide pilot survey which recruited a representative sample of people living with HIV in Washington between 2012 and 2014. In 2017, the module will be incorporated into the annual, statewide Medical Monitoring Project survey. All surveys are weighted in order to accurately reflect outcomes within underlying populations.

1) General health indicator: Increased to 82% the percentage of people living with HIV who rate their overall health as good, very good, or excellent

2014 Baseline: 81.1%
2020 Target: ≥ 82.0%
Data source(s): Case Surveillance-Based Sample (CSBS) Pilot Survey
                 Medical Monitoring Project (MMP) Survey

This indicator is based the first question in the Healthy Days core module: "Would you say that in general your health is…?" Answer options include a) excellent, b) very good, c) good, d) fair, or e) poor. General health includes both physical and mental health. The indicator will be expressed as a proportion.

2) Health-related disability days: Decrease to 3.0 the mean number of days in which poor physical or mental health prevented normal activities among people living with HIV

2014 Baseline: 3.6 days
2020 Target: ≤ 3.0 days
Data source(s): Case Surveillance-Based Sample (CSBS) Pilot Survey
                 Medical Monitoring Project (MMP) Survey
                 Behavioral Risk Factor Surveillance System Survey

This indicator is based on the fourth question of Healthy Days core module: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?" The answer is expressed as a number of days which cannot be greater than thirty. The indicator will be expressed as the average (or mean) number of days.

3) Summary index of healthy days: Increase to 22.0 the mean number of healthy days reported over past 30 day period

2014 Baseline: 19.8 days
2020 Target: ≥ 22.0 days
Data source(s): Case Surveillance-Based Sample (CSBS) Pilot Survey
                 Medical Monitoring Project (MMP) Survey
                 Behavioral Risk Factor Surveillance System Survey

The summary index is based on the combined responses to the second and third questions of the Health Days module:
1. "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
2. "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Answers to both questions are expressed as a number of days which cannot be greater than thirty. These two numbers are then added together (maximum limited to 30) and then averaged to calculate the summary index of <u>unhealthy</u> days. The summary index of <u>healthy</u> days is simply the positive complement of the unhealthy days index, and can be calculated by subtracting the latter value from the number 30.

Strategy to Utilize Surveillance and Program Data

Surveillance and Program Data are presented regularly to HPSG and Seattle TGA HIV Planning Council. Plan progress as defined in the monitoring section will be evaluated. Adjustments to strategies and activities will take place as necessary.

Monitoring & Evaluation

Better Outcomes for PAHR & PLWH

Data Informed Decisions