Implementation of the National HIV/AIDS Strategy
Progress and Challenges

Grant Colfax, MD
Office of National AIDS Policy
HIV Prevention Trials Network
June 27, 2012
Outline

• Review resource allocations in relation to national epidemiology
• Describe implementation challenges and research needs
• Discuss ongoing implementation efforts
The National HIV/AIDS Strategy
Overview

Goals
1. Reduce the number of people who become infected with HIV
2. Increase access to care and optimize health outcomes for people living with HIV
3. Reduce HIV-related health disparities
4. Achieving a more coordinated national response to the HIV epidemic

Facets of the Strategy
• Small number of action steps
• 5-year targets
• Emphasis on evidence-based approaches and populations at greatest risk
• Multiple Federal agencies charged with Strategy implementation: HHS, HUD, VA, DOJ, DOL, SSA; HHS lead coordinating agency.
• Roadmap for all public and private stakeholders responding to the domestic epidemic
• Focus on improving coordination and efficiency across and within Federal, state, local and tribal governments
• Catalyst for all levels of government and stakeholders to develop their own implementation plans for achieving their goals
New HIV Infections in the U.S.

- Estimated 50,000 new HIV infections annually in U.S.
- MSM 64% of new infections; 48% increase young black MSM
- Black women most impacted among all women
- Latinos disproportionately impacted compared to whites

Figure 1: Estimated New HIV Infections in the U.S., 2009, for the Most-Affected Subpopulations

(Prejean et al., 20011)
Ongoing Challenges to Implementing the National HIV/AIDS Strategy

• Fiscal
  – Cost for biomedical interventions
  – Funding for HIV prevention

• Coordination among agencies
  – Metrics
  – FOAs
  – Traditional siloed approach

• Coordination across Federal, State, and local levels
  – Higher you go, less understanding of issues on the ground
  – Inadequate funding or staffing at each level

• Ability of organizations to adapt to a changing environment

• Political will to place funds where the epidemic is

• Educating providers about HIV prevention and care
  – # of HIV care providers decreasing
  – Reluctance to care for HIV+ patients
  – Reimbursement
President Obama’s 2013 Budget for HIV

• $22.3 billion for domestic HIV prevention, care and treatment
• $766 million increase for HIV/AIDS care and prevention
• $1 billion for ADAP
Aligning Prevention Resources with the Epidemic

Matching Prevention Funds to the Epidemic

When CDC’s new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.

Proportion of Americans Living with an HIV Diagnosis (2008)

Proportion of CDC Core HIV Prevention Funding—FY2016

Greater emphasis on: testing, linkage to care
Realigning housing support resources with the epidemic...
Aligning Our Research Investments with the Epidemic

- Are research dollars aligned with populations where HIV is most concentrated?
- Is participation in research trials reflective of these populations?

Figure NIH FY 2010 HIV/AIDS Funding by risk group
Let’s Get the Basic Things Right

• Effective, Evidence-based Approaches We Know Prevent HIV
  – Condom availability
  – Comprehensive drug treatment
  – HIV testing (awareness of status)
  – Circumcision (limited effectiveness in US)
  – Antiretroviral therapy for diagnosed positives
  – Antiretroviral therapy for high risk negatives
  – Serosorting (among positives)
  – Testing pregnant women

*Best combination of HIV prevention approaches that will have a population-level impact for specific populations is unknown*
We Must Do Better

HIV Treatment Cascade

<table>
<thead>
<tr>
<th>Stage</th>
<th>Percentage</th>
<th>Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infected</td>
<td>1,178,350</td>
<td>79%</td>
</tr>
<tr>
<td>HIV diagnosed</td>
<td>941,950</td>
<td>62%</td>
</tr>
<tr>
<td>Linked to HIV care</td>
<td>725,302</td>
<td>41%</td>
</tr>
<tr>
<td>Retained in HIV care</td>
<td>480,395</td>
<td>36%</td>
</tr>
<tr>
<td>On ART</td>
<td>426,590</td>
<td>28%</td>
</tr>
<tr>
<td>Suppressed viral load (≤200 copies/mL)</td>
<td>328,475</td>
<td></td>
</tr>
</tbody>
</table>
A Higher Bar: Inclusive Treatment Recommendations

• Spring 2010: SFDPH recommends offering treatment to all

• December 2011: NYC DOHMH recommends offering treatment to all

• March 2012: DHHS panel recommends therapy for all HIV-infected patients

• July 2012: D.C. recommends treatment for all
Modeling Test and Treat: Annual Number of New HIV Infections
Adherence to Care
13 U.S. Areas

- 5,137 persons dx with HIV in 2008
- 63% had 2 or more visits 3 months apart within 12 months of dx
- Blacks and Latinos less likely to be in established care than whites (54.3%, 69.4% vs 74.7%)
- Females exposed through heterosexual contact more likely to be in care than MSM, heterosexual men, IDU (male or female)

Hall et. al, JAIDS, 2012
Supporting Demonstration Projects to Maximize the Treatment Cascade: Secretary’s Minority AIDS Initiative

- $44 million over 3 years
- Eligible jurisdictions have large HIV-related health disparities among blacks, Latinos
- Emphasis on increasing testing, linkage, engagement in care
- Interventions to address social, economic, clinical, and structural factors influencing health outcomes
- Requires coordination, collaboration, evaluation
Questions for the future of HIV prevention research

• What is the next generation of biomedical interventions that will help achieve NHAS goals?

• As focus turns from interventions based on self-reported sexual risk, what behavioral intervention research is most salient?

• What is the role of structural interventions, and how do we measure their effects?

• Are populations representative of the domestic HIV epidemic fully represented in all phases of research?
Implementation Research Questions

• What is the acceptable level of evidence needed to move interventions forward?

• What combination of interventions is optimal for achieving the greatest effect?

• What are the core structural and operational components of a sustainable program?

• How do we maintain the flexibility needed on the ground to implement and scale-up programs, while also maintaining the core principles of an evidence-based approach?

• How do we measure the effectiveness of interventions in an ever-changing environment?

• How do we adapt interventions for different populations and/or environments?

• How long do we give a program to succeed?
Collaborative Model: Research and Program Implementation

- NHAS encourages collaboration between Federal agencies and “the medical and scientific community”
- CDC supports Comprehensive HIV Prevention Planning (ECHPP) for 12 MSAs most affected by HIV/AIDS
  - Required use of a core set of interventions to maximize reduction of HIV incidence
- NIH encouraged CFARs in ECHPP cities to provide TA to local DOHs based on CFAR expertise and DOH priorities
- DC CFAR coordinating initiative

8 of 14 required ECHPP interventions addressed
- Routine opt-out screening
- HIV testing in non-clinical settings
- PEP and PrEP
- Linkage to care
- Retention and re-engagement in care
- ARV adherence
- Behavioral screening and risk reduction
- Linkages to other medical and social services

Slide courtesy of Alan Greenberg
Coordinating Federal Research Efforts to Address the Treatment Cascade

- Convene interagency consultation to discuss and identify all cascade research being conducted within each Federal agency, e.g. NIH, CDC, HRSA, SAMHSA

- Create and maintain an inventory of all Federal “linkage-to-care” research, organized by the population targeted & timelines for scaled-up implementation

- Create an online database of Federal, evidence-based, population-specific “linkage-to-care” strategies to help local communities
HIV and Health Coverage: Room for Improvement

- Of PLWHA in the U.S.
  - 13% have private coverage
  - 24% of have no coverage
  - 47% receive Medicaid
  - Approximately 500,000 receive some form of Ryan White services

Sources: HRSA; [http://www.healthcare.gov](http://www.healthcare.gov); Kaiser Family Foundation
AIDS Mortality by Race

AIDS deaths have declined least in the ART era

• Among black and Latino MSM relative to white MSM (Blair et al., 2002; Hall et al., 2007)

• Among black women compared to white men (44% vs. 79%, respectively; CDC 2009)

• Among Latinos compared to blacks or whites (Cunningham et al., 2010)

(Levine, 2010)
HIV Infection Among Heterosexuals in Urban Areas, by Socio-Economic Indicators

Social, Economic and Clinical Differences among KP Cohort of PWAs

• KP Northern California cohort study of PWAs

• Black and Latino patients more likely to live in census tracts characterized by lower education and SES

• Latinos had less access to public health insurance

• ART adherence over 2 year period highest among whites compared with blacks or Latinos

• Mean CD4 highest among whites compared to blacks or Latinos

• How did this translate into AIDS-related events or death?

Slide courtesy of G. Millett
Time to AIDS-Related Events or Death

Toward Health Equity: The Affordable Care Act

• Expands coverage to 32 million Americans
  – 5.4 million Latinos
  – 3.8 million African-Americans

Source: Office of the Assistant Secretary for Planning and Evaluation, 2012
The Affordable Care Act: Meaningful Change Now

- 54 million additional Americans receiving preventive services
- 3.1 million young adults insured by remaining on parent’s private insurance
- Hundreds of persons living with HIV now covered under Pre-existing Condition Insurance Plans
- ADAP benefits considered contribution toward true out-of-pocket expenses, helping fill “donut hole”
- Insurers cannot rescind coverage except in cases of fraud or intentional misrepresentation
- Expanded National Health Service Corps
  - 3600 providers (2008) to 10,000 (2011)
  - Increased patients served from 3.7 to 10.5 million
Affordable Care Act: 2014

- No denial of coverage for pre-existing conditions
- Expands Medicaid eligibility to 133% of Federal poverty level
- People without access to employer-sponsored insurance or Medicaid will be able to buy private coverage from Affordable Insurance Exchanges
- Increased resources to community health centers ($11 billion over next 5 years)
- Shift to electronic health records
Measuring HIV-related Outcomes: Towards a National Consensus

- Parsimony
- Harmony
- Achievable
- Sustainable
- Usable
- Shareable
Secretary’s Memo to Identify Core Variables and Reduce Reporting Burden

Calls upon HHS offices to:

• Finalize a set of common core HIV/AIDS indicators consistent with IOM’s recommendations
• Reduce reporting burden by at least 20-25%
• Streamline data collection
## Measuring outcomes: VA System

### Table 2. National and Facility Rates for 10 National Quality Forum Measures for HIV/AIDS Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Eligible, No.</th>
<th>National Rate, %</th>
<th>Minimum Facility Rate, %</th>
<th>Maximum Facility Rate, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Visit</td>
<td>21564</td>
<td>83</td>
<td>73</td>
<td>96</td>
</tr>
<tr>
<td>HBV Screening</td>
<td>17904</td>
<td>97</td>
<td>88</td>
<td>100</td>
</tr>
<tr>
<td>HCV Screening</td>
<td>17904</td>
<td>98</td>
<td>92</td>
<td>100</td>
</tr>
<tr>
<td>HBV vaccination</td>
<td>16606</td>
<td>81</td>
<td>53</td>
<td>98</td>
</tr>
<tr>
<td>TB screening</td>
<td>16526</td>
<td>65</td>
<td>30</td>
<td>94</td>
</tr>
<tr>
<td>Syphilis screening</td>
<td>17904</td>
<td>54</td>
<td>8</td>
<td>97</td>
</tr>
<tr>
<td>CD4 lymphocyte count</td>
<td>17904</td>
<td>93</td>
<td>81</td>
<td>100</td>
</tr>
<tr>
<td>Potent ART</td>
<td>14508</td>
<td>91</td>
<td>75</td>
<td>99</td>
</tr>
<tr>
<td>HIV RNA control</td>
<td>15537</td>
<td>73</td>
<td>28</td>
<td>91</td>
</tr>
<tr>
<td>PCP prophylaxis</td>
<td>2709</td>
<td>72</td>
<td>20</td>
<td>93</td>
</tr>
</tbody>
</table>

73 Facilities With ≥ 100 HIV Caseload

Abbreviations: ART, antiretroviral therapy; HBV, hepatitis B virus; HCV, hepatitis C virus; HIV, human immunodeficiency virus; PCP, *Pneumocystis* pneumonia; TB, tuberculosis

Ongoing Implementation Needs

• Continued collaboration among Federal, State, local government and private partners
• Flexibility at local level regarding implementation while maintaining alignment with NHAS principles
• Technical assistance to prepare HIV workforce for ongoing changes in environment
• Support for shift from process-oriented to outcome-oriented metrics
• Research to determine best ways to move forward among multiple options
Implementation Takes Time:
SF HIV Prevention Shift

- 2010 - February – Prevention Plan published
- 2010 - February- November - extensive community dialogue and planning
- 2010 - November - RFP released
- 2011 - February - applications due
- 2011 - May - awards issued
- 2011 - June - August - program negotiations; planning for client transitions
- 2011 - September 1 - new contracts start
- 2012 – Start reduction in CDC contract
NHAS Implementation Dialogues

• *Incorporating Prevention and Care Research Into HIV Programs*
  – Birmingham, AL

• *Building Capacity within the HIV Workforce so that it Delivers What We Need Today and Tomorrow*
  – Seattle, Washington

• *Sustaining the Community-Based Response to HIV*
  – Philadelphia, PA

• *Fostering Collaboration Between all Public and Private Stakeholders at the State and Local Level*
  – Baton Rouge, Louisiana

• *Maximizing Impact in Low-Prevalence Jurisdictions*
  – De Moines, Iowa
• In U.S. for first time in 22 years - - made possible by Administration’s lift of HIV entry ban
• Focus on science and policy
• Bidirectional learning for U.S. and International partners
• Reflect on tremendous progress in 22 years since last U.S. conference
• Highlight successes and ongoing challenges in domestic epidemic
  – ONAP Implementation Update
  – HHS Implementation Progress
Vision for the National HIV/AIDS Strategy

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”
Acknowledgements

• HHS: Ron Valdiserri, Howard Koh, Greg Millet
• ONAP team: James Albino, Aaron Lopata, Helen Pajcic