

HIV Health Improvement Affinity Group

Increasing Rates of Virologic Suppression:
Promising Practices from HIV Health
Improvement Affinity Group States

December 6, 2017

2:30- 4:00 PM ET



Agenda

- **Welcome**
- **Overview of Findings from HIV Affinity Group**
 - Dr. Richard Wolitski, HHS
 - Dr. Ellen-Marie Whelan, CMS
 - Heather Hauck, HRSA
 - Dr. Janet Heitgerd, CDC
- **State Best Practices and Lessons Learned**
 - Susan Jones, Alaska
 - Brad Wheeler, North Carolina
- **Question & Answer**
- **Forthcoming Resources**

Logistics

- Lines will be on mute for the duration of today's webinar
- Use the chat box in the lower left hand corner of your screen to ask a question or leave a comment
 - Note: chat box will not be seen if you are in "full screen" mode
- We will hold all questions/comments from the chat box until the Q&A period at the end of the webinar, but please send them in throughout
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience



Richard Wolitski, PhD

Director, Office of HIV/AIDS and Infectious Disease
Policy, Department of Health and Human Services



Dr. Ellen-Marie Whelan

Chief Population Health Officer, Centers for
Medicare & Medicaid Services



Heather Hauck

Deputy Associate Administrator, HIV/AIDS Bureau,
Health Resources and Services Administration



Dr. Janet Heitgerd

Behavioral Scientist, National Center for HIV, Viral
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ALASKA'S HIV HEALTH IMPROVEMENT AFFINITY GROUP

Susan A. Jones RN, MN

Margaret Brodie

December 2017



Alaska is very large

ALASKA vs. THE LOWER 48

IF ALASKA WERE PLACED ON TOP OF THE CONTINENTAL U.S., IT WOULD STRETCH FROM NORTHERN MINNESOTA DOWN THROUGH TEXAS, FROM THE PACIFIC OCEAN OFF THE CENTRAL CALIFORNIA COAST TO SAVANNAH, GEORGIA.



ALASKA'S AREA WOULD COVER 21% OF THE LOWER 48 STATES.

Characteristics of Alaska

- Covered with Boreal Forest
- Infertile Soil and Permafrost
- 656,424 Square Miles/ third smallest population
- Highest point- Denali 20,320 feet
- Largest mammal- Blue whale (12th in mammalian diversity)
- Temperature range +100 to -80
- Daylight to Darkness
- High Cost of living
- Few roads- travel by air
- Anchorage has one of the most diverse neighborhoods in the country

Background

- Alaska is a low HIV incidence state
- 2012 -Alaska received funds for Linkage to Care under CDC HIV Prevention Grant 12-1201
- 2015- September Alaska accepted federal Medicaid expansion
- 2016 & 2017- Alaska received funds for Early Intervention Services under Ryan White Part B Supplemental Funds to continue Linkage to Care

Goal for Affinity Project

By November 2017 individuals with HIV infection who are enrolled in Medicaid will have a reduced viral load and be less likely to transmit virus, by being maintained in HIV care

Steps in August 2016



Margaret Brodie, Director
Division Health Care Services



Susan Jones
HIV/STD Program Manager

1. Meet Medicaid Director
2. Agree on goal/s
3. Establish a way to share data

Combined goals (Oct 2016)

Focus

Improve the health of Alaskans with HIV
Prevention transmission of HIV

Outcome

Alaskans with HIV enrolled in Medicaid are actively enrolled in HIV medical care

Milestones/Activities

Medical providers serving patients with HIV infection

Know about Alaska's Linkage to Care Program (L2C)

Know how to access L2C

HIV program identify any Medicaid enrollees who have HIV and unknown in surveillance database

Collaboration

Share data between Medicaid and HIV Care services

PROVIDER ENGAGEMENT QUALITY IMPROVEMENT COMMUNITY

Alaska, Connecticut,
Michigan, Mississippi, Nevada,
New Hampshire, Virginia

Data Confidentiality Agreement- Nov 2016

Advantages:

Medicaid had other data agreements with other Divisions

The state attorney for Medicaid and Public Health (HIV/STD Program) is the same person

Viewed agreement from other states (LA)

Components

- **Protect privacy of information**
- **Data only used for Project: care coordination, L2C, disease control, QI, and improve performance**
- **Agreed that DHCS owns data**
 - **Not release, transmit, or publish personal data to those not involved in Project without approval**
- **DPH acknowledged civil and criminal penalties under federal law**
- **One clarification, DPH can contact persons who are in Medicaid database (L2C)**

First Steps

- Preliminary search by Medicaid staff = 295 individuals with a medical claim associated with HIV Care
 - All but one was in our eHARS database
- PH desired to have access to Medicaid claims data



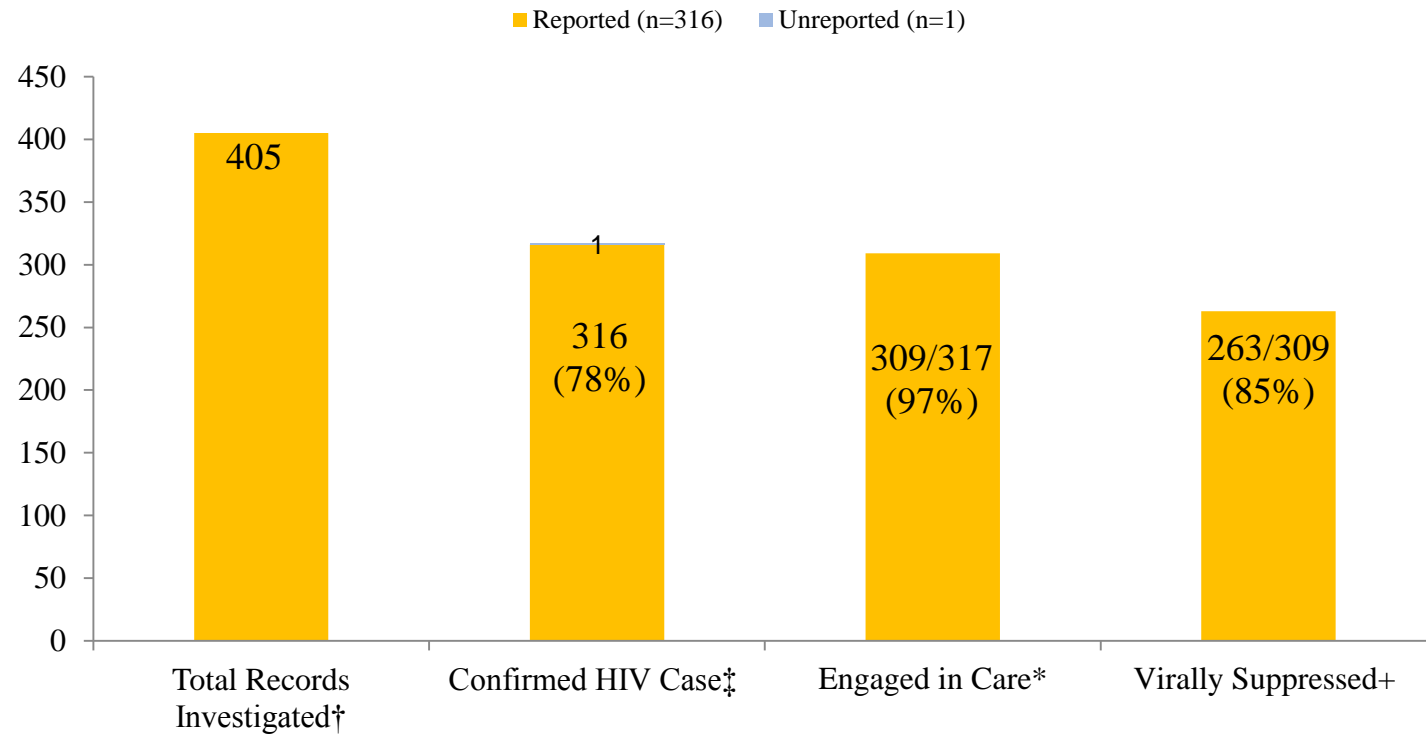
PH Gains Access to Medicaid Claims Data

Data extracted

- ICD 10 Claim for medical care visit
- Pharmacy claim for antiretroviral medications
 - Medical Claim only
 - Antiretroviral Claim only
 - Both claims



Engagement in HIV Medical Care and Viral Suppression as of June 30, 2017 among Alaska HIV Cases with a Medicaid Claim from April 1, 2016 –March 31, 2017 (N=405)



†Includes Medicaid clients with at least one medical or pharmacy claim with an HIV-related ICD10 code from April 1, 2016 to March 31, 2017 (n=405)

‡ Includes confirmed HIV Cases on Medicaid with at least one medical or pharmacy claim from April 1, 2016 to March 31, 2017 (n=317).

* Received at least one CD4 or Viral Load between April 1, 2016 and June 30, 2017.

+ Most recent viral load prior to June 30, 2017 ≤ 200 copies/mL

Findings

Manual review of
Medicaid data against
eHARS data

- Person in eHARS
- Person with unknown HIV status
- Person with negative HIV status or assumed negative
- Erroneous data record



R&C Buchanan

IF A PERSON DID NOT HAVE A CLAIM...

We may have missed them!

Challenges, Supports, and Ah Ha's

- Challenges

- Small staff
- Complicated Medicaid database

- Supports

- Integrated HIV Program
- Strong Linkage to Care
- Medicaid goals consistent with HIV/STD

- Ah Ha's

- Looking at antiretrovirals
 - PrEP
 - PEP
- Hospital
 - could report B20 Codes to prompt Linkage to Care
 - ER actions when a person self-reports positive HIV status
- Errors in billing

Next Steps

- Electronic review of data match
- Search Medicaid database by name
- eHARS provide a list of those with viral loads
- Repeat review annually



Returning the hauls to the sea

Susan Jones

Questions?





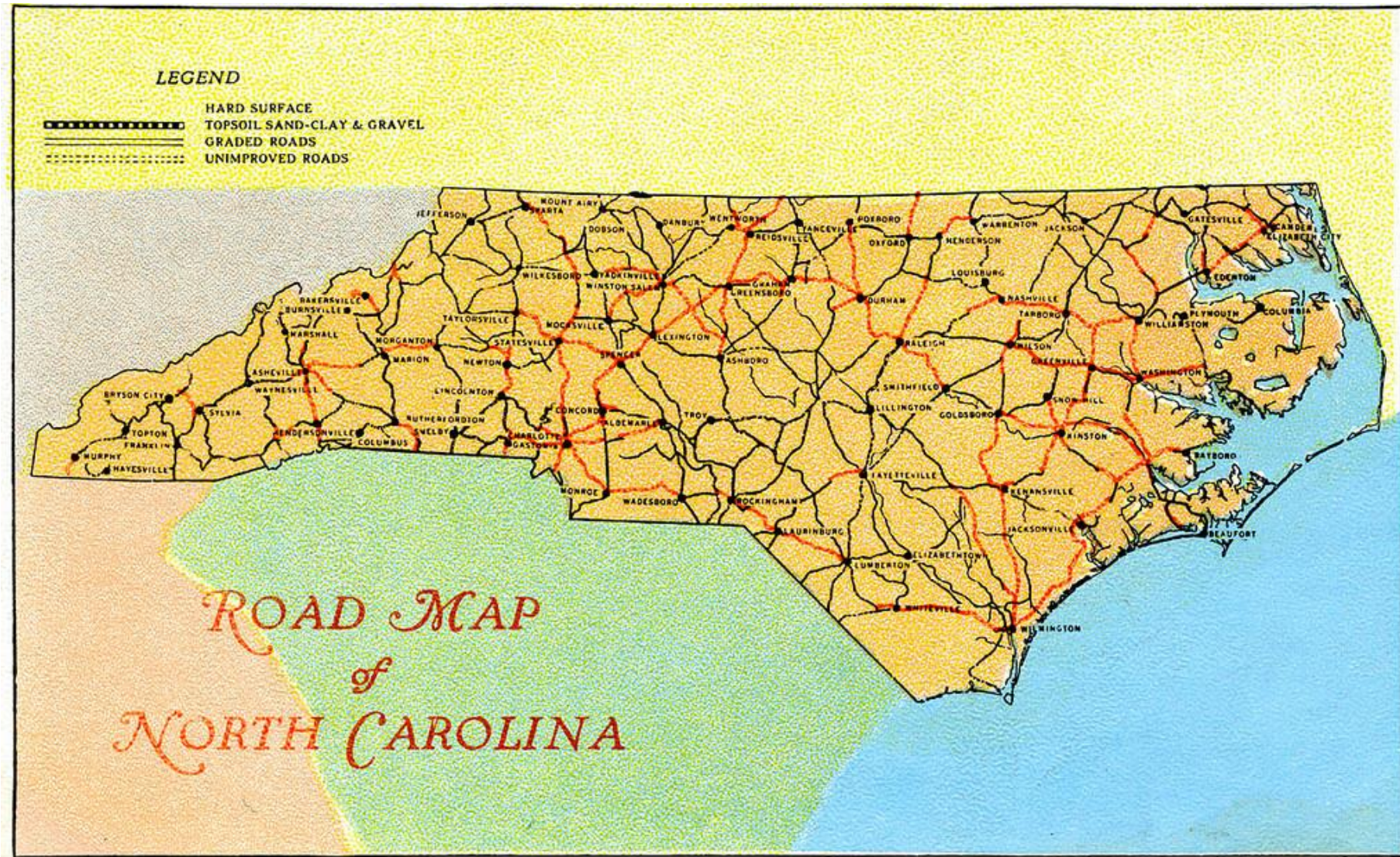
North Carolina's HIV Health Improvement Affinity Group

Brad Wheeler, MPH

Epidemiology Section, NC Division of Public Health



December 6, 2017



circa 1915 www.lib.unc.edu/ncc/pcoll/52postc.html

Background on North Carolina

The 9th largest state, by population

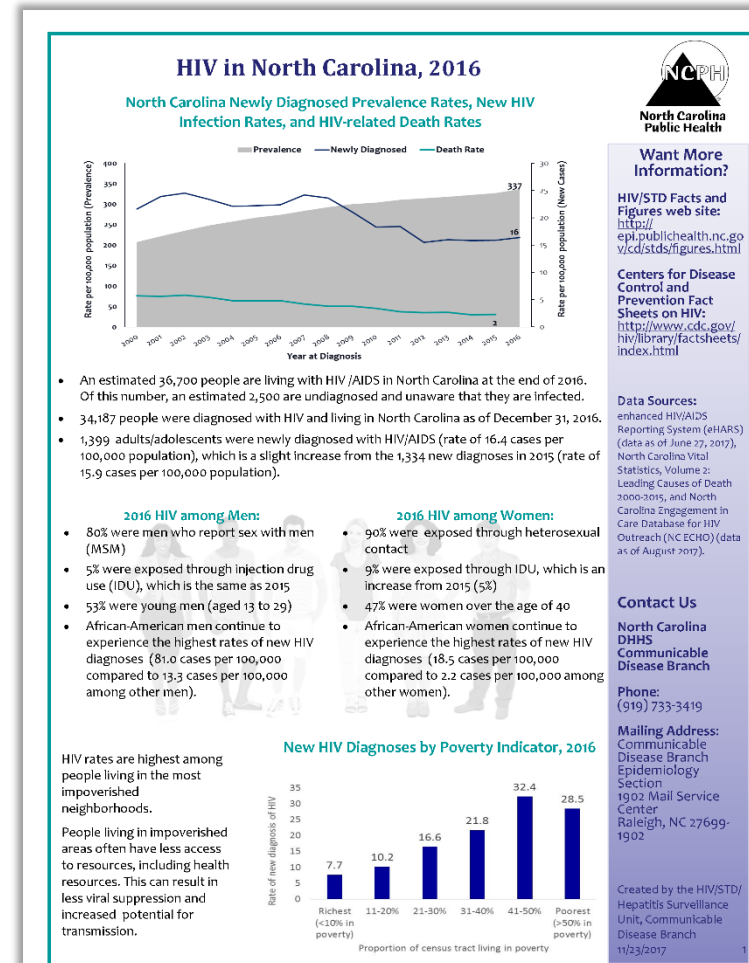
- High growth (ranked 13th) in the US

Mountains to the coast

- 5 of top 100 most populous cities
- Substantial rurality
- 2 Different Barbecue Styles

HIV in North Carolina

- High Incidence State (16.4 cases/100,000)
- Approx. 1400 new diagnoses in 2016
- Approx. 34k reported HIV clients currently living in North Carolina



North Carolina's New HIV Care Outcomes Platform

- Funded through HRSA SPNS Grant
- NC ECHO enables NC to sync the care “state” of clients from 5 data systems
- Includes HIV Surveillance, RW Programs, and NC Medicaid
- Linking to External Data is straightforward (via probabilistic linkage)
- Construction of standardized HIV care outcomes measurements greatly facilitated for various subpopulations
- HHIAG interest letter circulated the same month NC ECHO “went live” ... we were interested!



Used to Measure HIV Outcomes For

NC HMAP



HOPWA

Housing Opportunities
for Persons With AIDS

RYAN WHITE
HIV/AIDS
PROGRAM
PART B



HIV Health Improvement Affinity Group

Goals of our work in the Data Linkage/Outcomes Evaluation Learning Community:

- Develop a claims / utilization-based definition of HIV care
- Develop a 3-way relationship to execute a data use agreement
- Match Combined HIV Surveillance/HIV Care data with Medicaid data to identify common cohort
- Generate a “Medicaid HIV Continuum of Care” to better understand Care in this population (situational awareness!)



Data Use Agreement Between CCNC/DMA/DPH

- Borrowed heavily (template, language, terms) from previous request between DPH and DMA
- Look back **1 year** for clients with indicators of HIV
 - Annual renewal specified in DUA
- Person-Level Line list format:
 - Identifiers
 - HIV Care Utilization type
 - Utilization count
 - Managed Care Status



Sensitive Claims Algorithm

Casting a “wide net” to detect PLWH in Medicaid Data

- HIV Diagnosis Codes
 - B20, Z21, B9735, O987
- HIV Lab Markers (proxy for medical visit)
 - CD4 CPT codes
 - HIV RNA CPT codes
- Antiretroviral Drug Dispenses
 - Array of 169 NDC codes
 - DUA listed each code *individually* (e.g. 61958190101 Genvoya)

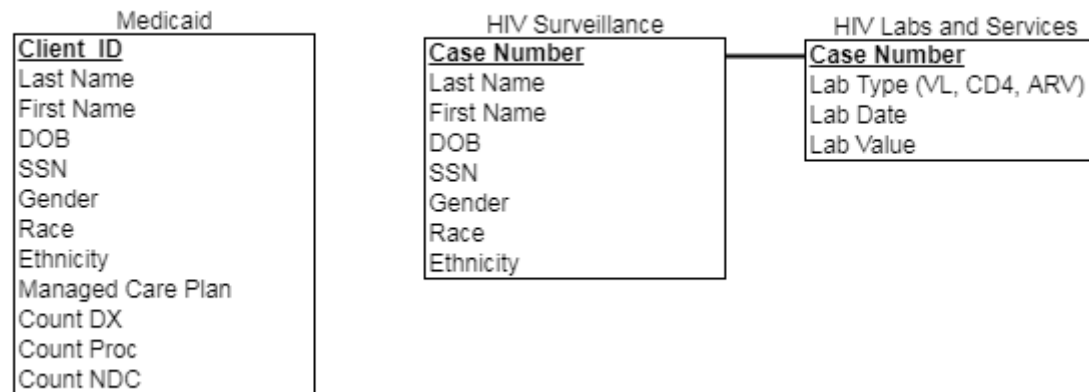


Method

- Clients that matched any criterion were included, with separate counts of Diagnoses, Procedures, and NDCs during 12 month period

Probabilistic Linkage

- Used Link Plus to compare:
 - Line List from CCNC
 - HIV Surveillance Extract of all reported NC HIV Cases
(From NC EDSS – this is our pre-eHARS system)
- Common fields include: SSN, Birthdate, Last name, First name, Sex, Race, Ethnicity



Results of Match

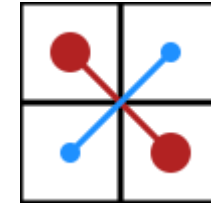
- 83% Linked to HIV Surveillance Case
 - No major demographic differences (age, race/ethnicity) between 2016 NC PLWH with care
- 17% Not Linked to HIV Surveillance Case
 - This group had a different demographic distribution than matched population and those from HIV Surveillance in Care in 2016

More on this later...

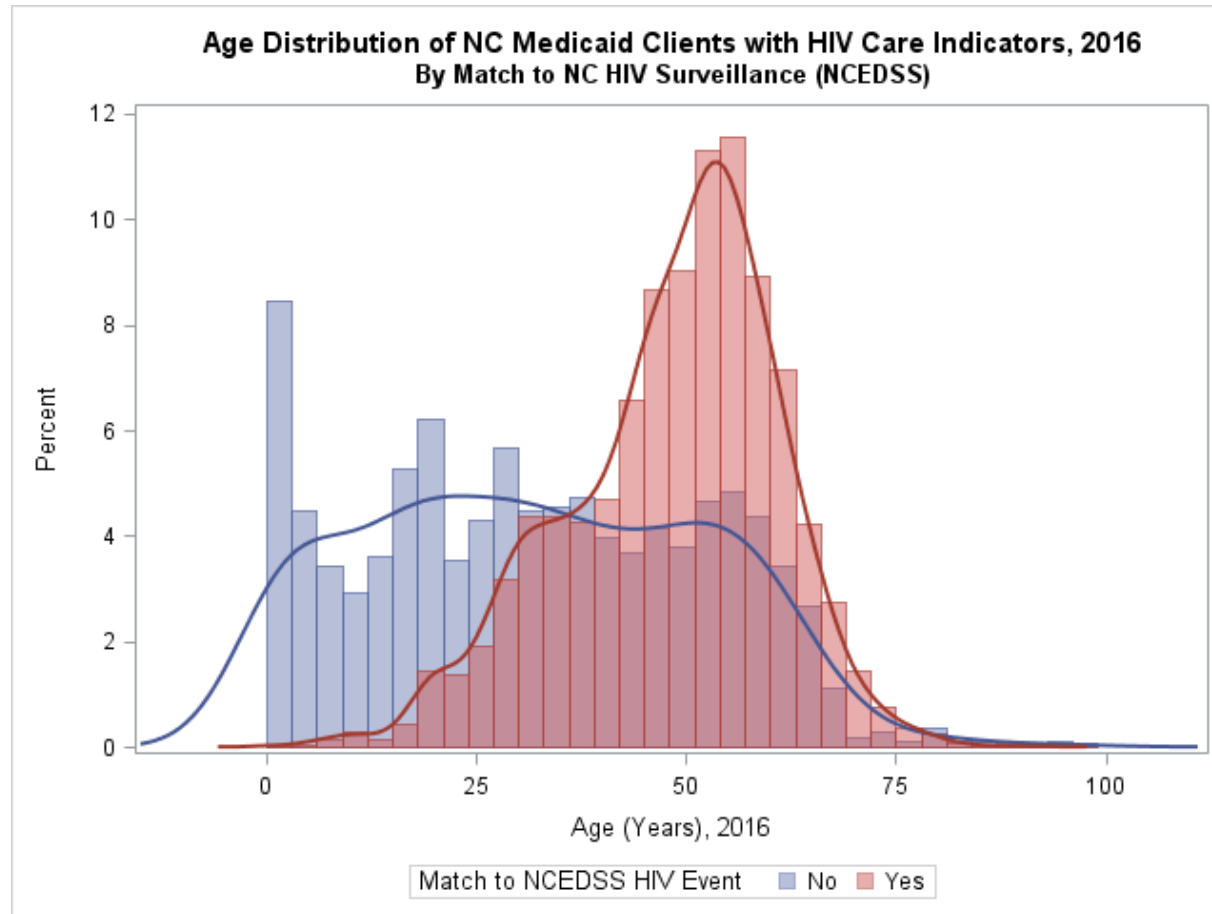


Results of Claims Analysis by Match Status

- HIV Diagnosis Codes were the most predictive factor of clients matching to HIV surveillance
 - Clients with 1+ HIV ICD Dx code were **74 times** more likely to match to HIV surveillance than those with 0 diagnosis codes (sensitivity of 98%)
 - However 46% of clients not matching had 1+ ICD (specificity of 54%)
- Upon further inspection, we identified
 - Antiretroviral Drugs: Good specificity of **82%**
 - Lower than expected sensitivity of **52%** (did we miss key drugs?)
 - Could improve sensitivity and specificity by reclassifying Truvada (HIV PrEP), Epivir (HBV). Also observed cases that looked like post-exposure prophylaxis (PEP)
- CD4 + Viral Loads alone have poor sensitivity and specificity
 - Could improve by separating CD4 and RNA, focusing on viral load tests



Notable Demographic Differences



Medicaid Clients with HIV indicators that **did not** match to HIV Surveillance were *younger*

Could this be

- “Rule Out” HIV
- Missed HIV Cases
- Something else?

Approx 70% of infants/children/youth **only** had CD4 /RNA lab procedures

We should be able to further refine future matches

Surveillance Systems Unit

Reporting Viral Load Suppression

- HIV Care Continuum's Viral Load Suppression (Tracked by CDC)
 - *Numerator*: Virally Suppressed in Measurement Year
(Last Test, <200 copies/mL)
 - *Denominator*: People **living** with diagnosed/reported HIV who **reside** in the jurisdiction
 - Exclusion period for clients diagnosed in the calendar year
 - Exclusion for clients who died in the calendar year

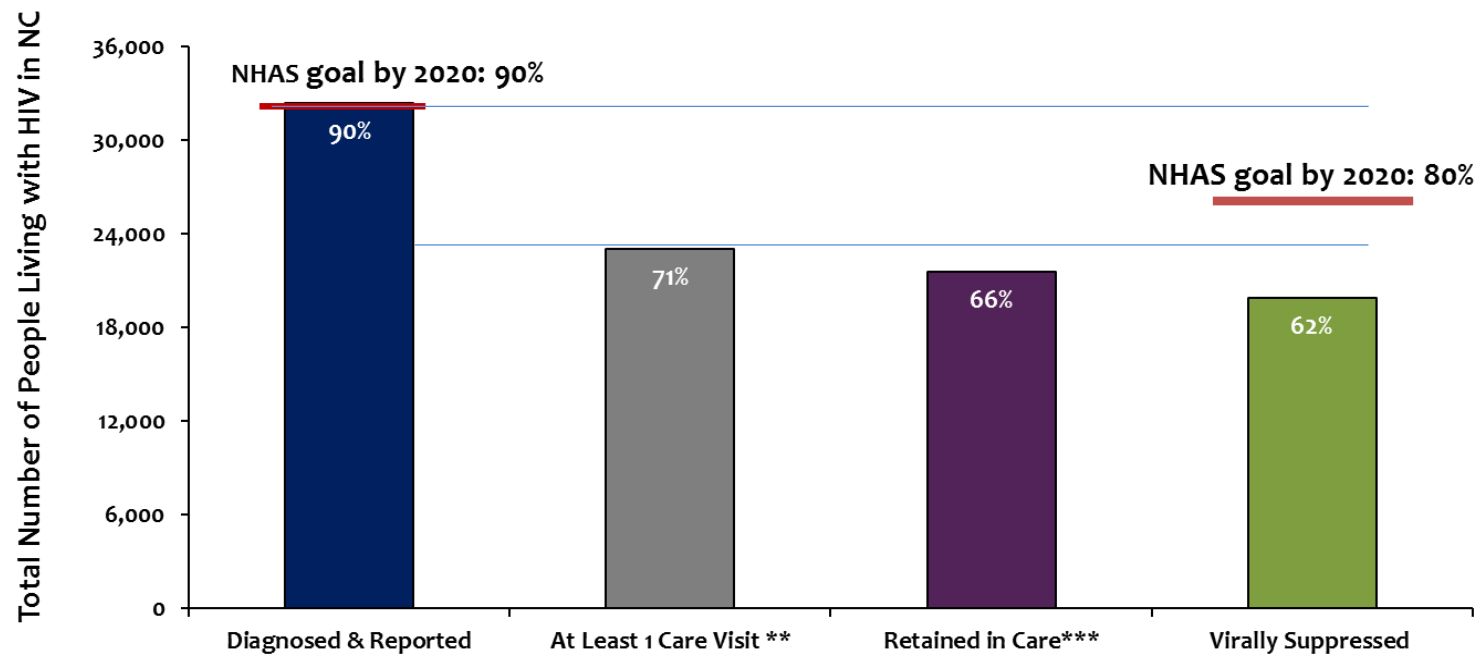
Adjustments

- NQF 2082 Quality Measure (Developed by HRSA)
 - *Numerator*: Virally suppressed in Measurement Year
(Last Test, <200 copies/mL)
 - *Denominator*: Diagnosed HIV, 1+ Medical visits in the measurement year

No Adjustments

...the denominators are quite different!

North Carolina's HIV Continuum, 2016

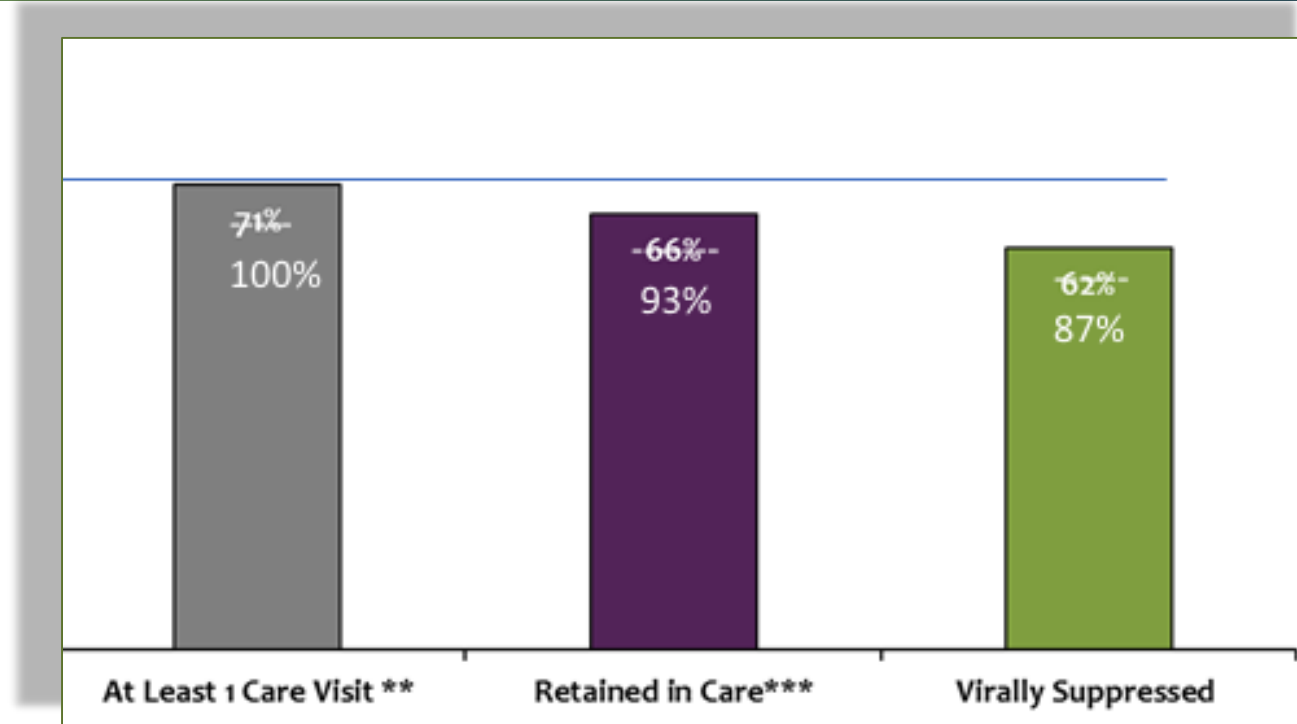


**At least 1 care marker in 2016.

***Retained in care is defined as having 2 or more care visit (VL or CD4 test) at least 90 days apart in a given year.

In 2016, this definition also includes if they were virally suppressed during the given year.

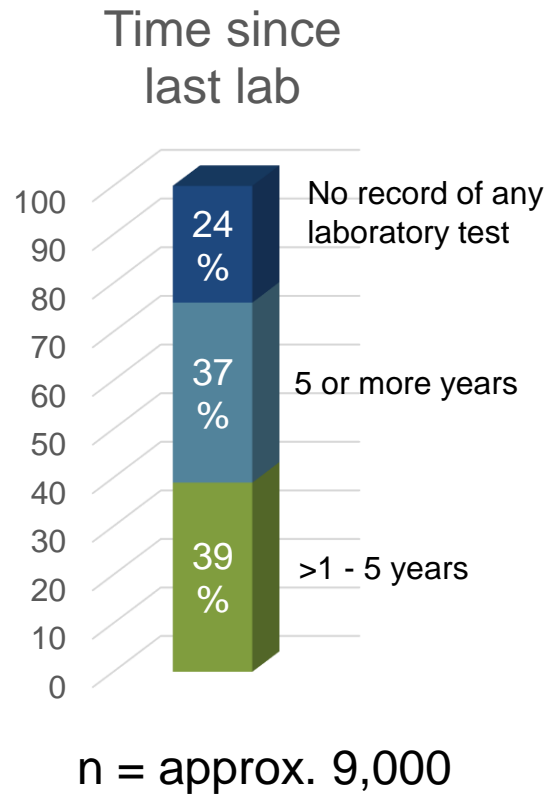
Translated into NQF2082



These Continuum denominators are “rebased” to PLWH with care in the last year

Ryan White performance measures incorporated NQF2082 circa 2013

What's the Difference?



People LWH with no HIV care markers in one year are classified as “out of care” and are subject to further field investigation

A “long tail” of older HIV cases fall into this category

- Some have HIV care intervals > 1 year
- Some have moved out of state
- Some are deceased (misclassified)

North Carolina has a Data to Care program focusing on this group

Won't include these people in VL comparisons

Next Steps

- Continue the work
 - Exchange Data Once Again (per DUA)
 - Increase Frequency of Sharing
 - Refine Methodology
 - HIV Care Algorithm Definitions
 - Check our code set
 - Build valid comparisons
- Design “Dashboard measures” that are meaningful
 - Look closer at other topics (ARV utilization, retention)
 - Identify opportunities for Data-Driven Managed Care Interventions



Questions



Questions and Answers



Forthcoming Resources

- Blog, “States Use Data to Improve the Health of People Living with HIV”
- Issue briefs
 - *Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV*
 - *Utilizing Medicaid and State Health Department Data to Improve Health Outcomes of People Living with HIV*
- Interactive “toolkit” of HIV-related Medicaid and state health department resources

These resources will be published to <https://nashp.org/> throughout December 2017!



HIV Health Improvement Affinity Group

Thank you for participating in today's webinar!

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