District of Columbia
Department of Health
HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

Annual Epidemiology & Surveillance Report

Supplemental Report: Clinical and Care Dynamics

Surveillance Data Through **December 2012**

Vincent C Gray, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Acknowledgements

This report was compiled by the combined efforts of many individuals in the District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration, with major contribution from The George Washington University School of Public Health and Health Services, Department of Epidemiology and Biostatistics. This report would not have been possible without the hard work, dedication, and contribution of health care providers, community groups, researchers, and members of the community.

Vincent C. Gray, Mayor
Allen Lew, Office of the City Administrator
Joxel Garcia, MD, Interim Department of Health Director
Michael Kharfen, Interim Senior Deputy Director

With special thanks to:
- Strategic Information Division
- STD & TB Control Division
- Care, Housing, and Support Services Division
- Hepatitis Coordinator
- The George Washington School of Public Health and Health Services

The Annual Epidemiology & Surveillance Report is compiled annually by the Strategic Information Division. To request additional data or aid in interpreting the data herein, contact:

Strategic Information Division
HIV/AIDS, Hepatitis, STDs and TB Administration (HAHSTA)
Government of the District of Columbia
Department of Health
899 North Capitol St NE
Fourth Floor
Washington DC, 20002

Phone: (202) 671-4900

This report is available online at: www.doh.dc.gov

Contents

Section 1: HIV Care Dynamics & Surveillance Data 4

- Understanding HIV Care Surveillance
- Limitations of Surveillance Data

Section 2: Initial Care Dynamics for Newly Diagnosed HIV Cases 2007-2011 5

Section 3: 2012 Care Dynamics for Currently Living HIV Cases Diagnosed 2007-2011 7

Section 4: 2012 Care Dynamics for Ryan White Clients 9

Section 1: HIV Care Dynamics & Surveillance Data

Given that HIV is a chronic condition, effective clinical management is imperative for infected persons to maintain long-term health. The National HIV/AIDS Strategy emphasizes the need for organizations to collaborate in striving to meet three main goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and improving health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The District of Columbia Department of Health (DC DOH) is committed to identifying all residents diagnosed with HIV and ensuring that those diagnosed access the appropriate care and treatment needed to achieve and maintain viral suppression. Sustained viral suppression is not only important for improving health outcomes among individuals living with HIV, but is also an important strategy for reducing the risk for new transmissions. Assessing HIV care dynamics is an essential step in understanding the strengths of HIV related policies and programs in the District, as well as an opportunity to identify and resolve gaps in the care continuum.

Understanding HIV Care Surveillance

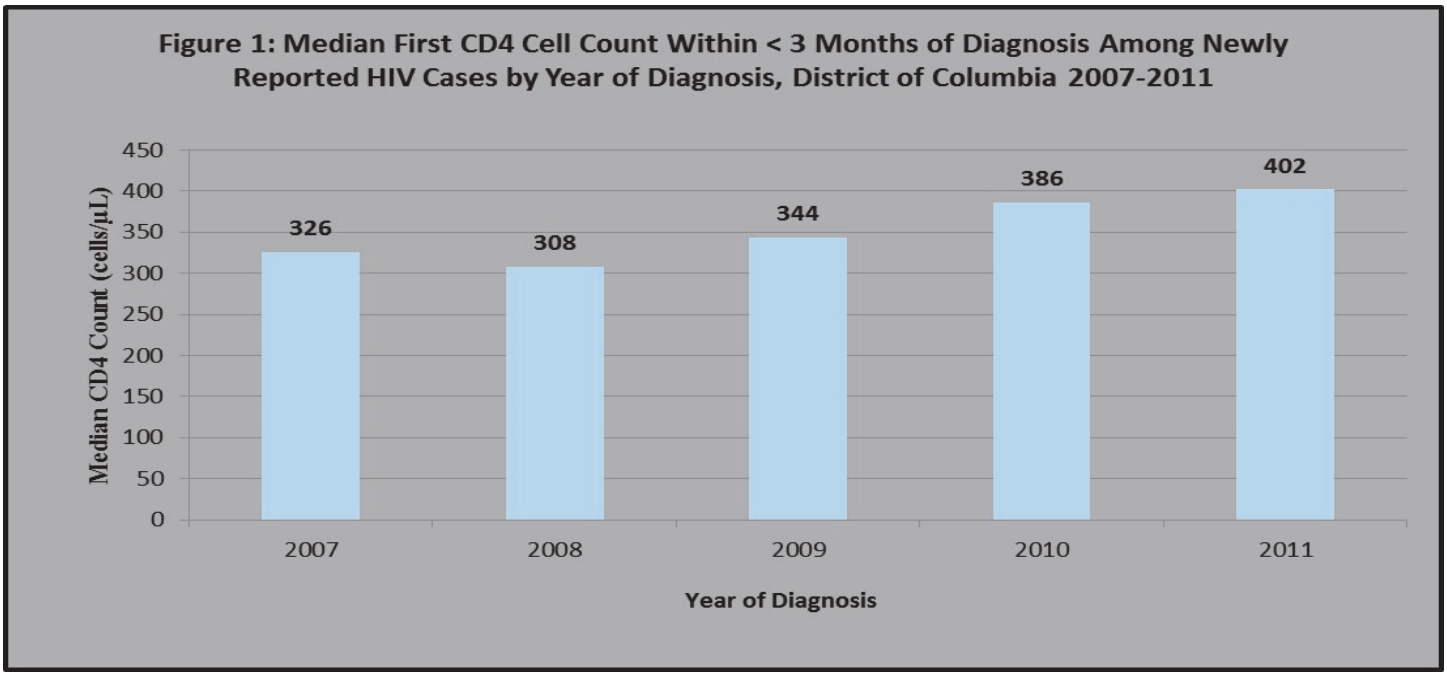
District of Columbia Municipal Code mandates that clinical providers and laboratories report the results of HIV-related medical tests such as CD4+ T-cell counts and HIV RNA viral loads to the District of Columbia Department of Health. These laboratory reports provide approximate measures for monitoring the HIV-related clinical health status of the population, as well as approximate measures for evaluating access to care. Based on these reports, the HIV/AIDS, Hepatitis, STD, & TB Administration (HAHSTA) is able to produce a snapshot of HIV care utilization and outcomes among persons living with HIV in the District.

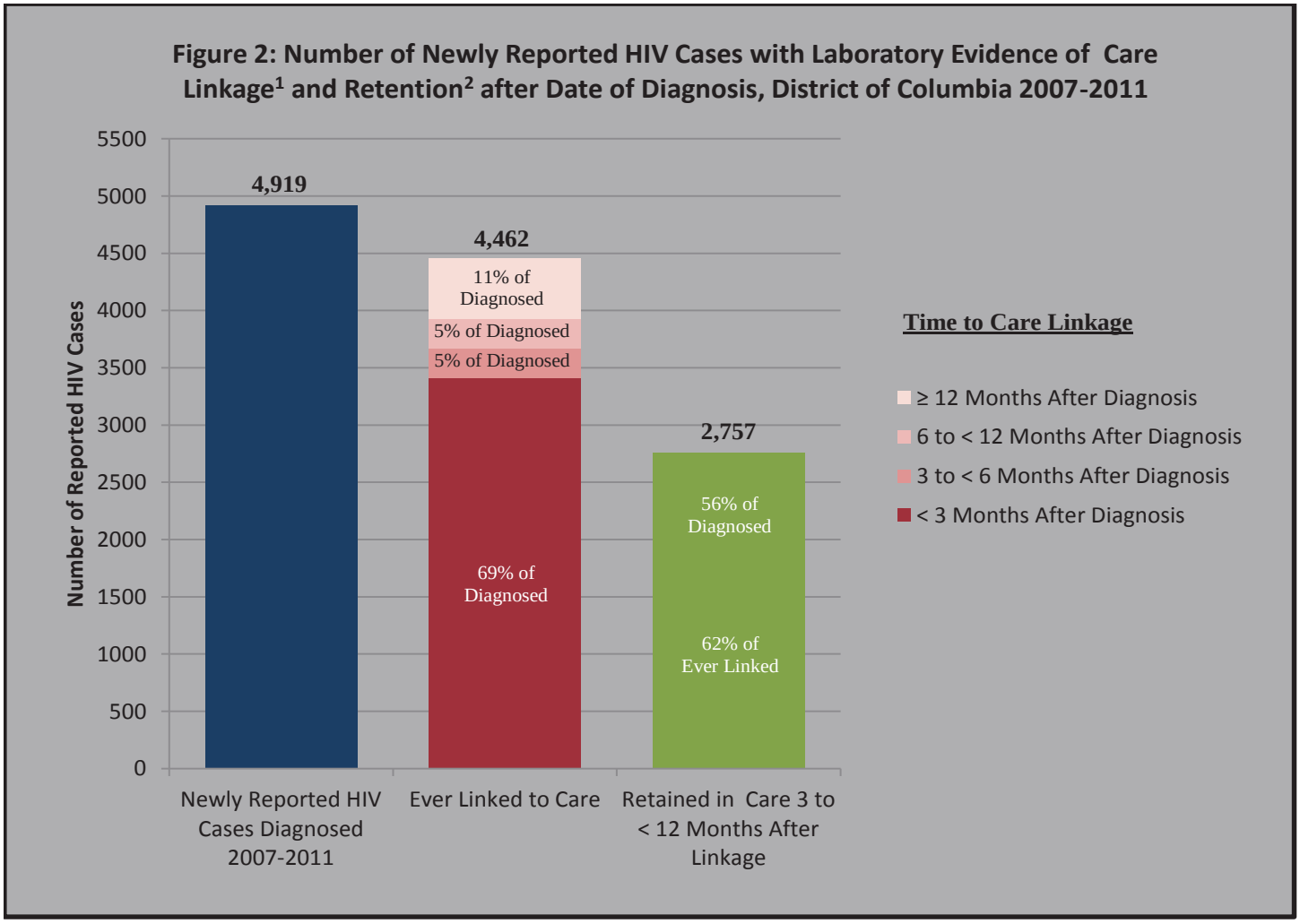
Limitations of Surveillance Data

Federal agencies such as the Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), and the Department of Health and Human Services (DHHS) have each released guidelines for measuring and monitoring the stages of HIV care, including diagnosis, linkage to care, retention in care, and viral suppression. While such guidelines informed the assessment outlined in this report, federal care continuum definitions were adjusted to reflect local variation in surveillance data collection, quality, and completeness. Limitations inherent in the use of surveillance data to evaluate HIV care dynamics include:

- **Delayed Reporting**
  Metrics are subject to variation by year since they are based on reported surveillance data; fluctuations in the timing of data reported to the DC DOH may affect data availability.
- **Changes in surveillance procedures over time**
  Although instituted in 2007, systematic collection of laboratory data began in 2009; thus, data collected prior to 2009 are not as complete or reliable as data collected since 2009.
- **Missing data**
  The accuracy of the information presented concerning care dynamics is highly dependent on the completeness of laboratory and provider reporting. To the extent that the reporting of HIV-related medical tests results is incomplete, surveillance data may provide an underestimate of the proportion of individuals living with HIV that are receiving appropriate clinical care.
- **Limited extra-jurisdiction data**
  While healthcare facilities in the District serve residents in the greater metropolitan area, DC DOH surveillance data are currently limited to HIV patients who were established as residents of the District at the time of HIV or AIDS diagnosis.
- **The receipt of care services outside of the city and population migration**
  This report uses as a denominator the number of HIV positive people who were first diagnosed while residents of the District over the past five years. DC DOH expects that some of these persons are receiving care in other jurisdictions or they have moved out of the District.
- **Variation in individual care and treatment needs**
  HIV positive persons in good health may be less likely to receive routine medical tests as compared to those who are in poorer health and require more care. Thus, there may be a trend towards persons with suppressed viral loads and higher CD4 counts to have long time intervals between the receipt of recommended medical tests. If this is the case, it would result in an underestimate of retention in care.
- **Limited population focus**
  Data used in the continuum of care are for the past five years. As such, it provides only a portion of the picture of linkage to care, retention, and viral suppression in the District. With the exception of the section concerning Ryan White clients, persons diagnosed HIV positive more than five years ago are not included in this report and patterns and trends concerning their care cannot be assumed from these data.
- **No comparison to other data**
  These data should not be compared to other continuum of care presentations. Lack of uniformity of data systems and definitions of care metrics prevent accurate between-jurisdictional assessments. This supplement is designed to examine patterns and trends in the District only.

Section 2: Initial Care Dynamics for Newly Diagnosed Cases 2007-2011





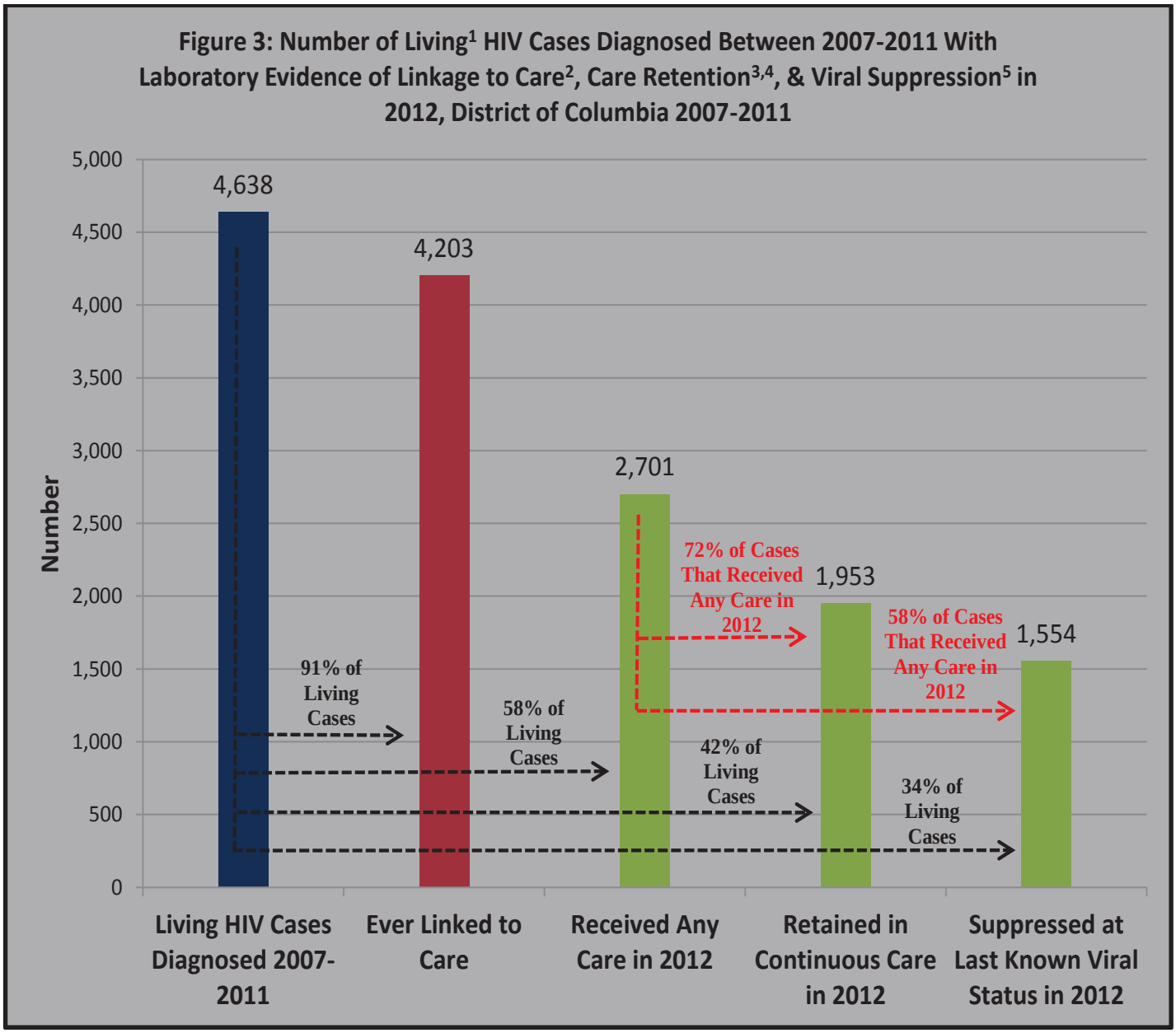
[1] ≥ 1 CD4 or viral load test result reported after date of diagnosis
[2] ≥ 1 CD4 or viral load test result reported 3 to < 12 months after date of care linkage

Table 2. Initial Care Dynamics for Newly Diagnosed HIV Cases by Selected Characteristics
District of Columbia, 2007-2011

	Newly Reported HIV Cases Diagnosed 2007-2011	Ever Linked to Care[1]		Linkage to Care < 3 Months After Diagnosis[2]		Retained in Care 3 to <12 Months After Linkage[3]	
	N	N	%	N	%	N	%
Sex							
Male	3,503	3,165	90%	2,406	69%	1,922	55%
Female	1,416	1,297	92%	1,006	71%	835	59%
Race/Ethnicity							
Black	3,808	3,432	90%	2,598	68%	2,126	56%
White	660	624	95%	494	75%	397	60%
Hispanic	308	282	92%	221	72%	166	54%
Other	143	124	87%	99	69%	68	48%
Mode of Transmission[4]							
MSM	1,846	1,705	92%	1,287	70%	1,081	59%
IDU	394	347	88%	269	68%	206	52%
MSM/IDU	108	88	81%	54	50%	57	53%
Heterosexual	1,543	1,407	91%	1,076	70%	906	59%
RNI/Other	1,028	915	89%	726	71%	507	49%
Age at Diagnosis							
0 to 19	186	171	92%	129	69%	116	62%
20 to 29	1,189	1,043	88%	751	63%	647	54%
30 to 39	1,159	1,062	92%	829	72%	664	57%
40 to 49	1,336	1,217	91%	929	70%	754	56%
50 to 59	786	729	93%	575	73%	449	57%
60 and older	263	240	91%	158	60%	128	49%
Year of Diagnosis[5]							
2007	1,333	1,220	92%	912	68%	669	50%
2008	1,159	1,041	90%	664	57%	609	53%
2009	861	782	91%	592	69%	534	62%
2010	848	778	92%	670	79%	531	63%
2011	718	641	89%	574	80%	414	58%
Grand Total	4,919	4,462	91%	3,412	69%	2,757	56%

[1] ≥ 1 CD4 or viral load test result reported after date of diagnosis
[2] ≥ 1 CD4 or viral load test result reported < 3 Months after date of diagnosis
[3] ≥ 1 CD4 or viral load test result reported 3 to < 12 months after date of care linkage
[4] MSM: Men who have sex with men; IDU: Injecting drug users; RNI: Reason not indicated
[5] Improvements in data quality and completeness may account for some of the differences in proportions observed across years of diagnosis

Section 3: 2012 Care Dynamics for Currently Living HIV Cases Diagnosed 2007-2011



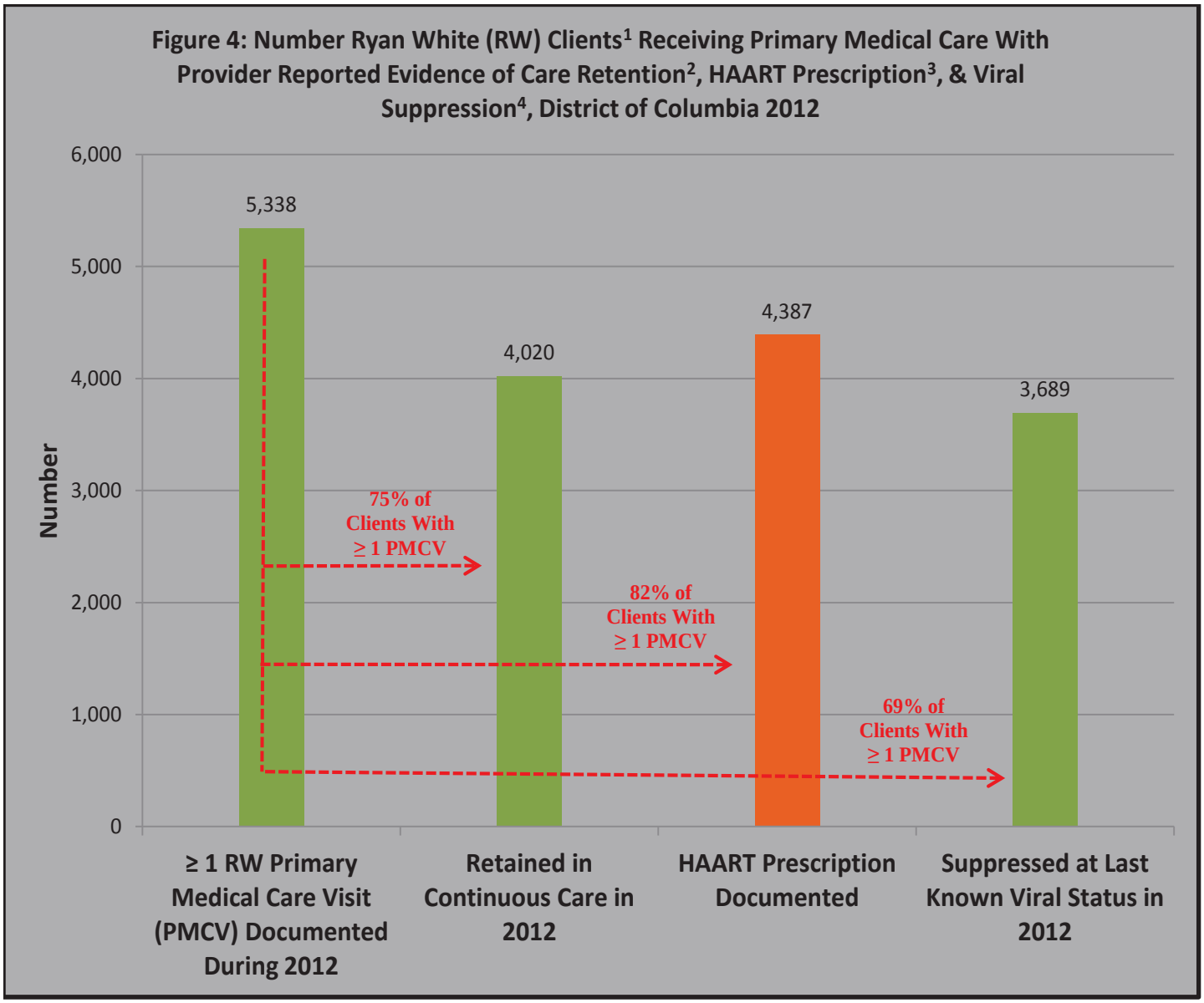
[1] Living as of 01/01/2012
[2] Ever linked to care defined as ≥ 1 CD4 or viral load test result reported after date of diagnosis
[3] Ever received care in 2012 defined as ≥ 1 CD4 or viral load test result reported during 2012
[4] Retained in continuous care in 2012 defined as ≥ 2 CD4 or viral load test results reported during 2012 at least 90 days apart
[5] Viral suppression assessed based on the last viral load result reported in 2012; Viral suppression defined as viral load test result ≤200 copies/mL

Table 3. 2012 Care Dynamics for Currently Living HIV Cases Diagnosed 2007-2011 by Selected Characteristics
District of Columbia, 2007-2011

	Number of Currently Living HIV Cases Diagnosed 2007-2011[1]	Received Any Care in 2012[2]		Retained in Continuous Care in 2012[3]		Suppressed at Last Known Viral Status in 2012[4]	
	N	N	%	N	%	N	%
Sex							
Male	3,309	1,862	56%	1,317	40%	1,087	33%
Female	1,330	839	63%	636	48%	467	35%
Race/Ethnicity							
Black	3,561	2,117	59%	1,518	43%	1,183	33%
White	643	358	56%	259	40%	231	36%
Hispanic	295	160	54%	126	43%	99	36%
Other	140	66	47%	50	36%	41	29%
Mode of Transmission[5]							
MSM	1,793	1,047	58%	751	42%	611	34%
IDU	357	195	55%	139	39%	108	30%
MSM/IDU	103	56	54%	43	42%	29	28%
Heterosexual	1,479	912	62%	683	43%	537	36%
RNI/Other	907	491	54%	337	37%	269	30%
Age at Diagnosis							
0-19	184	129	70%	91	49%	55	30%
20-29	1,170	625	53%	440	38%	330	28%
30-39	1,116	633	57%	454	41%	372	33%
40-49	1,272	769	60%	571	45%	456	36%
50-59	699	442	63%	327	47%	276	39%
60 and older	198	103	52%	70	35%	65	33%
Year of Diagnosis							
2007	1,218	665	55%	489	40%	401	33%
2008	1,072	612	57%	352	41%	292	31%
2009	819	502	61%	359	43%	302	37%
2010	824	482	58%	351	43%	282	34%
2011	706	440	62%	317	45%	246	35%
Grand Total	4,639	2,701	58%	1,953	42%	1,554	34%

[1] Living as of 01/01/2012
[2] Ever received care in 2012 defined as ≥ 1 CD4 or viral load test result reported during 2012
[3] Retained in continuous care in 2012 defined as ≥ 2 CD4 or viral load test results reported during 2012 at least 90 days apart
[4] Viral suppression assessed based on the last viral load result reported in 2012; Viral suppression defined as viral load test result ≤200 copies/mL
[5] MSM: Men who have sex with men; IDU: Injecting drug users; RNI: Reason not indicated

Section 4: 2012 Care Dynamics for Ryan White Clients



[1] HIV clients reported by facilities receiving Ryan White funding
[2] Retained in continuous care in 2012 defined as ≥ 2 primary medical care visits reported during 2012 at least 90 days apart
[3] Provider reported HAART prescription
[4] Viral suppression assessed based on the last provider reported viral load result in 2012; Viral suppression defined as viral load test result ≤200 copies/mL

Table 4. 2012 Care Dynamics for Ryan White Provider Clients by Selected Characteristics
District of Columbia, 2012

	≥ 1 Ryan White Primary Medical Care Visit Reported During 2012[1]	Retained in Continuous Care in 2012[2]		HAART Prescription Reported[3]		Suppressed at Last Known Viral Status in 2012[4]	
	N	N	%	N	%	N	%
Gender[5]							
Male	3,464	2,507	72%	2,921	84%	2,400	69%
Female	1,713	1,404	82%	1,332	78%	1,175	69%
Transgender	158	109	69%	132	84%	113	72%
Age at Diagnosis							
0-19	88	44	50%	9	10%	9	10%
20-29	679	444	65%	480	71%	364	54%
30-39	933	635	68%	769	82%	612	66%
40-49	1,616	1,238	77%	1,380	85%	1,174	73%
50-59	1,528	1,246	82%	1,317	87%	1,133	74%
60 and older	494	413	84%	432	87%	397	80%
Grand Total	5,338	4,020	75%	4,387	82%	3,689	69%

[1] HIV clients reported by facilities receiving Ryan White funding
[2] Retained in continuous care in 2012 defined as ≥ 2 primary medical care visits reported during 2012 at least 90 days apart
[3] Provider reported HAART prescription
[4] Viral suppression assessed based on the last provider reported viral load result in 2012; Viral suppression defined as viral load test result ≤200 copies/mL
[5] Missing 3