

# Houston HIV Care Continuum

Creating a Seamless System, Improving Personal and Public Health Outcomes

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## Development of the HIV Care Continuum

- In 2011, Gardner and his colleagues published an article in *Clinical Infectious Diseases* titled “The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Gardner and his colleagues state in the article’s abstract:



Edward M. Gardner, MD

*“For individuals with human immunodeficiency virus (HIV) infection to fully benefit from potent combination antiretroviral therapy, they need to know that they are HIV infected, be engaged in regular HIV care, and receive and adhere to effective antiretroviral therapy. Test-and-treat strategies for HIV prevention posit that expanded testing and earlier treatment of HIV infection could markedly decrease ongoing HIV transmission, stemming the HIV epidemic. However, poor engagement in care for HIV-infected individuals will substantially limit the effectiveness of test-and-treat strategies.”*



## Development of the HIV Care Continuum

- In other words...
  - People living with HIV do not get the full benefit of treatment unless they are diagnosed, linked to care, retained in care, and taking HIV medications as prescribed
  - While expanded testing and earlier treatment of could slow the HIV epidemic, little progress will be made unless people living with HIV are fully engaged in care.
- Treatment as Prevention



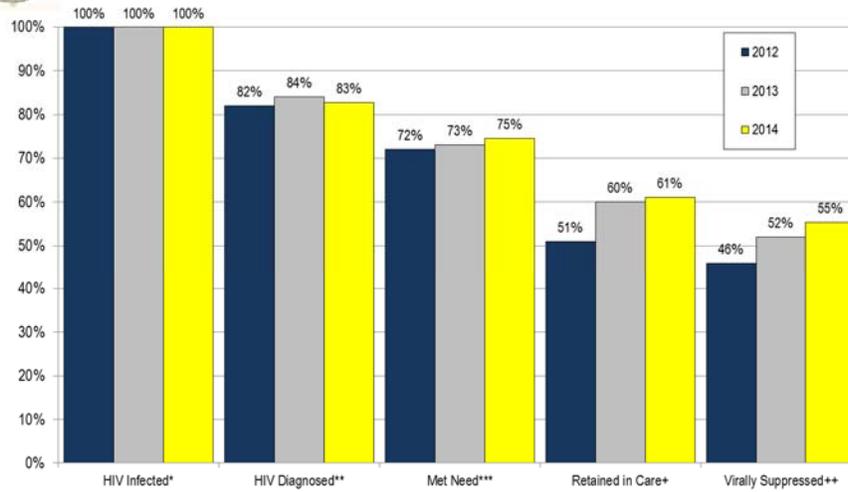
## HIV Care Continuum

*Describes engagement in care in the Houston Area from diagnosis to viral suppression*

- Also called the Treatment Cascade, Spectrum of Engagement, or the Gardner Cascade
- Provides “big picture” view of engagement in HIV care at all stages within a given timespan (usually a year)
  - All individuals **infected with HIV**
    - Those aware of their status
    - Those who are unaware of the status (greater risk of transmitting HIV)
  - All individuals who have **received a positive diagnosis**
  - All individuals **linked** to HIV medical care
  - All individuals **retained** in HIV care in a HIV medical care
  - ~~All individuals **prescribed** (and, presumably taking) HIV medications~~
  - All individuals with **viral load suppression** (greatly reduced risk of transmitting HIV)
- Helpful for identifying system-wide gaps in service linkage and retention in care “at a glance”



## Houston EMA HIV Care Continuum, 2012-2014



\*No. person who are HIV positive in 2012, 2013, and 2014 in the Houston EMA (diagnosed + undiagnosed estimate).

\*\*No. persons who are HIV positive in 2012, 2013, and 2014 in the Houston EMA.

\*\*\*No. persons with met need in 2012, 2013, and 2014 in the Houston EMA.

+No. persons with retained in care (PLWHA with at least 2 visits, labs, or ARVs in 12 months, at least 3 months apart) in 2012, 2013, and 2014 in the Houston EMA.

\*\*No. persons whose last viral load test of 2012, 2013, 2014 <=200 (among persons with >=1 VL test) in the Houston EMA.



## Using the HIV Care Continuum to Identify Communities in Need and Create Change

Reaching goals: performance vs. community and parity

**85%** PLWH retained in HIV care & treatment

**81%** of those retained are virally suppressed

Close the gaps for the community & close the disparity gaps

Ensure that at least 85% of **newly** diagnosed PLWH are linked to clinical care within 3 months, and that at least 85% of **all** diagnosed PLWH are retained in care.

Ensure that at least 81% of clients receiving HIV care achieve and maintain viral suppression

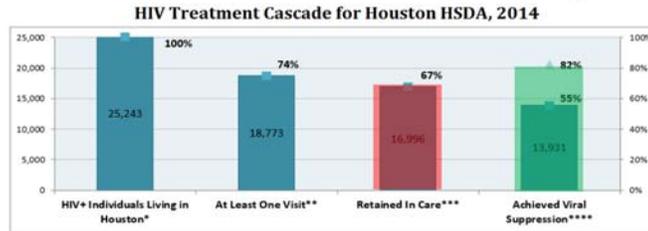
Ensure that all goals listed in the care section...are achieved for all genders, racial/ethnic groups, sexual minorities, and heightened risk groups.

Source: Texas Department of State Health Services

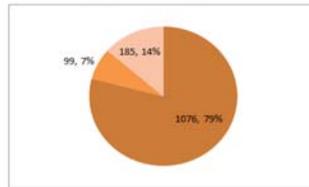


## Using the HIV Care Continuum to Identify Communities in Need and Create Change

### Houston HSDA HIV Treatment Cascade, 2014



### Linkage to Care, 2014

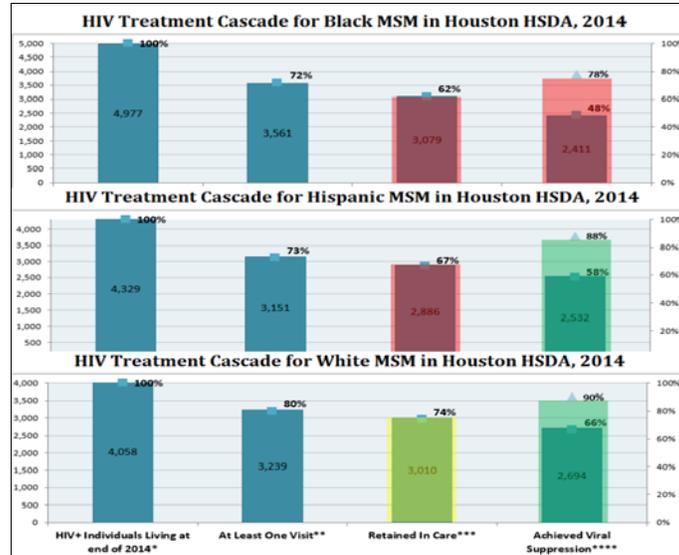


Linked in 3 months\*\* 1076 79%  
 Linked in 4-12 months 99 7%  
 Not Linked 185 14%  
 \*\* No. of newly diagnosed PLWH who were linked to medical care within 3 months of their HIV Dx.

Source: Texas Department of State Health Services



## Using the HIV Care Continuum to Identify Communities in Need and Create Change



Source: Texas Department of State Health Services



## Using the HIV Care Continuum to Identify Communities in Need and Create Change

Close the gaps for the community & close the disparity gaps

	PLWH		Retained in Care		85% retained goal	Gap	Suppressed	81% suppressed goal	Gap
	#	%	#	%	#	#	#	#	#
All PLWH	25,243	100%	16,996	67%	21,457	4,461	13,931	17,380	3,449
Female	6,404	25%	4,456	70%	5,443	987	3,475	4,409	934
Male	18,839	75%	12,540	67%	16,013	3,473	10,456	12,971	2,515
White	5,377	21%	3,912	73%	4,570	658	3,440	3,702	262
Black	12,236	48%	7,945	65%	10,401	2,456	6,116	8,424	2,308
Hispanic	6,704	27%	4,450	66%	5,698	1,248	3,821	4,616	795
<=24	1,459	6%	893	61%	1,240	347	632	1,005	373
25 - 44	11,190	44%	7,222	65%	9,512	2,290	5,689	7,704	2,015
>= 45	12,594	50%	8,881	71%	10,705	1,824	7,610	8,671	1,061
MSM	13,873	55%	9,350	67%	11,792	2,442	7,944	9,552	1,607
IDU	3,459	14%	2,294	66%	2,940	647	1,744	2,382	637
Heterosexual	7,565	30%	5,107	68%	6,430	1,323	4,063	5,208	1,145

Source: Texas Department of State Health Services



## Thank You!

For more information about the HIV Care Continuum, the Houston Ryan White Planning Council, or how you can participate in HIV planning in the Houston area, visit us online at [www.rwpchouston.org](http://www.rwpchouston.org)!

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