A. GENERAL QUESTIONS ABOUT THE HIV CARE CONTINUUM AND THE CCD

1. What is the HIV Care Continuum?

   The HIV Care Continuum is defined as a coordinated delivery system, encompassing a comprehensive range of health and social services that meet the needs of people living with HIV at all stages of illness.¹ ²

2. Why were linkage to care, viral load suppression, and viral load below transmission threshold selected as areas of focus for the CCDs?

   Linkage to care, viral load suppression, and viral load transmission threshold are critical components of the HIV Care Continuum. Linkage to care is the entry point within the care continuum. Viral load suppression – when sustained – results in less morbidity and mortality, and reduces transmission to sex or needle-sharing partners. Viral load below transmission threshold reduces the likelihood of HIV transmission to partners and is informative about local progress towards viral suppression. These key indicators can be estimated using comprehensive HIV-related laboratory reporting to the National HIV Surveillance system. These data are being used to track progress towards the goals set forth in the National HIV/AIDS Strategy.³

3. Where can one get more information about the 2010 amended New York State (NYS) Public Health Law that says providers must link all patients diagnosed at their facility to care?

   A change in the NYS Public Health Law that became effective on September 1, 2010 (Chapter 308 of the Laws of 2010) requires the offer of an HIV test to all persons, aged 13 to 64 in most healthcare settings, with limited exceptions. The law simplified consent for HIV testing and requires that HIV test providers arrange, with the consent of the patient, an appointment for medical care for those who test positive. You can learn more by clicking here.

4. What HIV-related information is reported to the New York City (NYC) Department of Health and Mental Hygiene (DOHMH)?

   All previously-unreported diagnoses of HIV and AIDS are reportable to the DOHMH by New York State law. Clinical laboratories must report all positive confirmatory test results, viral load test results (detectable and undetectable), CD4 test results, and viral nucleotide sequence results. All HIV surveillance information reported to the DOHMH is stored in the NYC HIV Surveillance Registry (the Registry). The Registry does not currently include treatment status information (e.g. whether a patient is on antiretroviral therapy or not) or HIV care visit information.

5. Why are the CCDs being shared?

   The DOHMH believes that it is important for facilities providing medical care to HIV-infected NYC residents to know their status relative to national and local goals for treating people living with HIV. This information may be useful to facilities seeking to
understand how progress towards the goals of the National HIV/AIDS Strategy is being monitored. These data may also be useful to facilities wishing to assess the quality of HIV care they deliver.

6. **When did the first CCD release occur?**
   The first release occurred in December 2012.

7. **How often are CCDs released?**
   Individual CCD reports are sent biannually to facilities, once in June and once in December. Annually, starting in December 2015, DOHMH publicly releases viral suppression data from the CCDs on a dedicated [CCD webpage on the DOHMH website](#).

8. **How are facilities selected to receive CCDs?**
   In the initial 2012 release of the CCDs, the 21 facilities selected were either among the highest-volume facilities or a part of the Health and Hospital Corporation (H+H) hospitals. These 21 facilities collectively cared for a large proportion of persons receiving care for HIV in NYC. For the June 2014 release, the criteria expanded to include New York City HIV testing and care providers that either: a) reported >10 newly diagnosed patients and/or b) had >150 patients “in care” based on Registry data in a designated 12 month time period. Once a site qualifies for receiving a CCD based on these criteria, it will thereafter receive a CCD biannually.

9. **To whom is the CCD being sent at each institution?**
   Our goal is to send CCDs semi-annually to persons responsible for leading HIV care and treatment efforts at each facility, such as the Medical Director of the HIV clinic and HIV administrator, as well as other facility leaders, such as the Chief Medical Officer and the Chief Executive Officer. If there are any additional key individuals that should receive your facility’s CCD, please email us at HIVCCD@health.nyc.gov.

10. **How will the CCD be used by the DOHMH? What will happen if a facility does not meet these goals?**
    The CCD is meant to help and encourage facilities to meet national and local goals for HIV treatment. It is up to facilities to decide how they wish to use these data.

11. **Does the DOHMH have any plans to use these facility-specific data as a basis for funding decisions?**
    No.
B. SPECIFIC QUESTIONS ABOUT THE HIV CARE CONTINUUM DASHBOARD

1. **How were the indicators for linkage to care, viral load suppression, and viral load below transmission threshold calculated?**

   The DOHMH uses the following definitions:

   - **Timely linkage to care**: all persons diagnosed with HIV infection at the facility in the given 12 month time period according to the Registry were included in the denominator. Persons who timely linked to care at “your facility” (including affiliated sites) as well as persons who timely linked at any “other facility” in NYC were included in the numerator. Timely linkage to care was considered to have occurred in a newly-diagnosed person if any HIV viral load, CD4, or HIV genotype test within three months (91 days) of HIV diagnosis was reported to the DOHMH, following a seven day lag.\(^4\) Please note that the CCD for timely linkage to care is generated only if your site reported >10 newly diagnosed patients to the Registry in the specified 12 month time period.

   - **Viral load suppression**: all HIV-diagnosed persons meeting the Human Resources Service Administration’s definition of continuous care were included in the denominator.\(^5\) This definition requires at least two HIV lab reports (CD4 or VL) drawn at least 90 days apart within the given 12 month time period. Persons were considered to be in continuous care at a specific facility if the two or more labs that defined this status were ordered by providers at that facility. Viral suppression is the proportion of persons whose most recent quantitative HIV RNA level was ≤200 copies/mL among all persons in continuous care at that facility during the given 12 month time period. Along the same line, viral load below transmission threshold is the proportion of persons whose most recent quantitative HIV RNA level was <1,500 copies/mL among all persons in continuous care at that facility during the given 12-month time period. Sites with >150 patients “in care” per Registry data in the initial 12-month time period were selected to receive a viral suppression CCD. Once a site qualifies for receiving a viral suppression CCD based on this criterion, it will thereafter receive the viral suppression CCD biannually.

   As of 2015, a methodological change has been made in the calculation of viral load suppression. Viral suppression estimates for the prior year have been adjusted based on the new methodology to enable comparisons across years.

2. **What does the seven-day lag\(^4\) refer to in the timely linkage to care measure?**

   HIV-related labs (CD4, VL, and HIV genotype results) reported to the Registry as having been performed within the first seven days after HIV diagnosis are likely to be part of the diagnostic HIV work-up, and are therefore not considered by the DOHMH to be a valid proxy for linkage to care. Newly-diagnosed patients are considered to have linked timely to care only if a lab result is drawn eight to 91 days after HIV diagnosis.\(^4\)

3. **Why are data being used in the time period reported on the graphs?**

   This is the latest time period for which data reporting to the DOHMH are sufficiently complete to be meaningful and useful.
4. **What is the basis for the goals in the CCDs?**

The timely linkage to care goal of 85% matches that of the 2010 *National HIV/AIDS Strategy*.² The viral suppression goal of 90% is based on published literature and local NYC HIV surveillance data.

5. **Why do the numbers of persons diagnosed and in continuous care used for the indicator proportions in the CCDs differ from our clinic estimates?**

CCD indicators are calculated using Registry data, which come from multiple sources, including provider reports, laboratory reporting, and matches to local and national death registries. It is not unusual for clinic estimates and estimates based on surveillance data to differ because of these multiple sources of case information.

- **Timely Linkage to Care**: the denominator was based only on those persons who are newly reported to the Registry in the given 12 month time period. Hence, this graph does not represent all tests that your facility may have conducted.

- **Viral Suppression and Viral Load Below Transmission Threshold among Patients in Care**: the denominator for your facility was calculated based on a person having at least two CD4 or viral load tests that were at least three months apart in the given 12 month time period from your facility (including care affiliates) reported to the Registry. It is not unusual for there to be a difference in the size of the patient census when comparing facility information to Registry data, because care status assessments using Registry data rely upon reportable laboratory events only. Please note that the denominator for the citywide indicator includes patients who have two labs 90 days apart within the given 12 month time period, without regard to changes in the ordering facility that may occur during the year.

6. **Why does the Timely Linkage to Care figure show the patients who linked to care “your facility” and “other facility” for the facility-specific indicator but not for the New York City indicator?**

The NYC indicator provides a population-level view of timely linkage to HIV care in NYC. This indicator presents the proportion with timely linkage to care among all persons newly-diagnosed with HIV in the given time 12 month period, regardless of the NYC facility where they linked to care. Whereas for individual facilities, the DOHMH is able to provide the percentage of all patients who were diagnosed at your facility who linked to care within three months of diagnosis at “your facility” including care affiliates as well as at any “other facility” in NYC. In those circumstances in which patients were not identified as linking at any “other facility” in NYC, this label was not displayed.

7. **Has the use of CD4/VL/HIV genotype reports as a proxy measure been validated?**

CD4, VL, and HIV genotype reports received by public health surveillance registries are widely used by local and national health agencies as proxy measures for the receipt of HIV-related medical care, and estimates of care engagement based on these data are the subject of numerous peer-reviewed publications. They are used by the Centers for Disease Control and Prevention to measure care status and track national progress towards the goals in the *National HIV/AIDS Strategy*.² ³
8. **Why was VL≤200 chosen as the marker of suppression?**

   The Centers for Disease Control and Prevention defines viral suppression as ≤200 copies/mL for in the National ‘Continuum of HIV Care’ ([http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6047a4.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6047a4.htm)) and also in recent guidance on VL-related analyses (“Using Viral Load Data to Monitor HIV Burden and Treatment Outcomes in the United States”, February 2012).

9. **Why was VL<1,500 chosen as the marker of transmission threshold?**

   Several studies showed that an HIV viral load below 1,500 copies/mL lowers the risk of transmitting HIV to sex and needle-sharing partners.6,7

C. **RESOURCES**

1. **For more assistance or information regarding the CCD:**

   - If you would like to contact us with questions or concerns about the HIV CCDs, please, email us at HIVCCD@health.nyc.gov.
   
   - To see citywide data on care and clinical status of persons living with HIV in NYC based on HIV surveillance data, please visit: [http://www1.nyc.gov/site/doh/data/data-sets/aids-hiv-epidemiology-and-field-services.page](http://www1.nyc.gov/site/doh/data/data-sets/aids-hiv-epidemiology-and-field-services.page)
   
   - Our surveillance unit is also happy to work with you to determine if assistance with reporting at your facility is needed:
     - Email us at HIVCCD@health.nyc.gov, or
     - Call 212-442-3388
   
   - For information on the many programs which may be of benefit to you including HIV testing, partner services, free condom distribution, syringe services and many additional resources, please visit: [http://www1.nyc.gov/site/doh/health/health-topics/aids-hiv.page](http://www1.nyc.gov/site/doh/health/health-topics/aids-hiv.page).

2. **Additional websites:**

   - **NYC DOHMH’s HIV Care Status Reports web application:** limited patient-specific data regarding patients who are out of care can now be shared with NYC HIV care providers. For more information: [https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page](https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page)

     - ARV initiation is addressed on page E-1
• Department of Health and Human Service (DHHS) *Guidelines for the Use of Antiretroviral Therapy in Adults and Adolescents* can be found here: [http://aidsinfo.nih.gov/guidelines/](http://aidsinfo.nih.gov/guidelines/)


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