Colin Flynn - HIV in the Baltimore-Towson Metropolitan Area

1) From talking to newly infected patients, I realize quite a few suspected they were infected once they got to know their partners were positive. Is this something that the Gay Men's Surveillance Study found?

- From the Behavioral Surveillance (BESURE) Study, we do know that the most common reason given by MSM for not getting an HIV test during the previous 12 months was that they were afraid of finding out that they were positive (between 27 and 36 percent of responses). Some of these men may have suspected that they were positive because they found that their partners were positive.

2) In your Gardner's Cascade for Baltimore City, what was your definition for suppression?

- For the 2011 continuum of care cascade presented for the Baltimore-Towson metropolitan area, viral suppression was defined as <400 copies per milliliter. Twenty-two percent of the estimated total number of persons living with HIV infection (with includes the undiagnosed) were found to be virally suppressed.

3) I thought the suppressed viral load in Gardner's Cascade was 200 cells/ml? You mentioned 400.

- The original article by Gardner (Clin Inf Dis 52(6):793, 2011) used undetectable levels of virus as their measure of viral suppression. In our 2010 continuum of care cascades we used undetectable but revised it to 400 copies per milliliter for two reasons: One, different viral load tests have different cut-off levels for undetectable, and these typically range from <20 to <400 copies per milliliter. And two, low levels of virus indicate that a person is in care and responding well to care, even though there may be small blips where their viral load rises slightly above undetectable.

4) Do you think the ACA – with more people in primary care will help to find those unknown HIV positive people?

- The Affordable Care Act will expand health insurance coverage to more people. If more people do then start utilizing health care for routine and preventative care, then more of the undiagnosed will be identified. However, to identify more of the undiagnosed, more physicians and clinics will need to adopt the CDC and USPSTF (U.S. Preventive Services Task Force) recommendations to perform routine screening for HIV.

5) For the retention in care data, were people who moved considered?

- At this time, the retention in care data, and all the rest of the surveillance data, are based on residence at time of diagnosis. We have been collecting recent address data and future analyses will begin reporting cases by recent address.

6) How do you target resources? Through AIDS diagnosis and service utilization studies?

- Different programs use different methods for targeting and allocating resources. The Baltimore Ryan White Part A Planning Council reviews the data presented to them and votes on priority service categories, and then resources are allocated through a competitive bidding process. For Ryan White Part B, the Maryland Department of Health and Mental Hygiene has Regional Advisory Committees (RACs) that review the epidemiological and services data and vote on priority service categories. Resources are then allocated to jurisdictions following a formula that uses new diagnoses of HIV and living cases of HIV and AIDS. Jurisdictions then use the priorities to guide their spending.

7) Do you think socio-economic status causes infections?

- HIV infection is caused by the passing of infected bodily fluids (such as blood, semen, or breast milk) from one person to another. Low socio-economic status is often, but not always, associated with high levels of HIV infection. In Maryland, the highest rate of HIV infection is in Baltimore City, which also has the highest rate of poverty in the state. However, the second highest rate of poverty is in Somerset County, which has the second lowest rate of HIV infection. There are many social and economic factors that influence the behaviors that put people individually at risk for acquiring HIV infection. These same factors may also create social and geographic environments where people are collectively at higher risk for infection, irrespective of their individual risk behavior.

8) Why do you think there is an AIDS diagnosis within one year for some patients?

- Late diagnosis of their HIV infection. In an untreated individual, the average time from HIV infection to AIDS diagnosis is eight years. During 2011, in the Baltimore-Towson metropolitan area, 28% of new HIV diagnoses developed AIDS within 12 months, and the median CD4 count after HIV diagnosis was only 353 cells per microliter. And, 43% of new AIDS diagnoses had just been diagnosed with HIV in the preceding 12 months. These statistics indicate that

many HIV infections are going undiagnosed for years and these individuals are progressing towards AIDS during this time instead of receiving treatment.

9) Medicaid does not guarantee that an individual stays in care, what is being done about that?

- No health insurance program guarantees that an individual stays in care. Medical case management and adherence programs have been found to be effective in helping individuals to stay engaged in care. As the Affordable Care Act transitions the medical costs of HIV infected persons to health insurance programs, the Ryan White programs will need to transition from providing medical services to providing the supportive services needed to help maintain individuals in care. In addition, the Maryland Department of Health and Mental Hygiene is expanding its ability to identify individuals who drop out of care and will work with local health departments, Ryan White providers, and the Medicaid program to re-engage these individuals in care.