



BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

HIV MONITORING QUARTERLY REPORT **FOR INTERIOR HEALTH**

FOURTH QUARTER 2015



BC Centre for Disease Control
An agency of the Provincial Health Services Authority



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Foreword

As part of the BC Centre for Excellence (BC-CFE) in HIV/AIDS's mandate to evaluate the outcomes of STOP HIV/AIDS programming in BC, we have developed quarterly HIV/AIDS monitoring reports. These reports provide up-to-date data on a variety of key HIV-related surveillance and treatment indicators. Selection of these indicators was achieved through a collaborative process with various Health Authority (HA) representatives. There are six reports in total, one for each HA and one for the province of BC as a whole. In addition, there is a technical report which explains how each HIV indicator is calculated. Data used in these reports come from the British Columbia Centre for Disease Control (BCCDC), MSP billings, hospitalization data from the Discharge Abstract Database, the Sunquest Laboratory database at the Provincial Public Health Microbiology and Reference Laboratory, Providence Health Care laboratory and the BC-CFE Drug Treatment Program (DTP) Database.

The objectives of these reports are to:

1. Provide timely HA-specific information on key HIV indicators which will guide and inform HIV leaders and innovators in the development of future HIV interventions and programs which will ultimately lead to decreasing the burden of HIV in BC. The indicators will reflect ongoing or past successful public health interventions and highlight areas in the HIV care spectrum which require further attention and support.
2. Highlight limitations in our current data due to incomplete or time lagged data and to develop future strategies to improve complete and timely data capture.

These reports are produced for the benefit of individual HA's. As such, we are enthusiastic about your involvement and cooperation regarding the development of these monitoring reports. Please forward your comments and queries to Irene Day, Director of Operations at the BC-CFE at iday@cfenet.ubc.ca.

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Acknowledgements and Contributions



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British Columbia Centre for Excellence in HIV/AIDS (BC-CFE): The BC-CFE is responsible for the conception, preparation and ongoing review of this quarterly report. The BC-CFE provides the data and outputs for Indicators 5 (Hiv Cascade of Care), 6 (Programmatic Compliance Score), 7 (New Antiretroviral Starts), 8 (CD4 Cell Count at ART Initiation), 9 (Active and Inactive Drug Treatment Program Participants), 10 (Antiretroviral Adherence Level), 11 (Resistance Testing Results by Resistance Category), 12 (AIDS-Defining Illness), and 13 (HIV-Related Mortality). The BC-CFE database provides PVL and CD4 cell count testing data, as well as ART use. All PVL measurements in BC are performed at the St Paul's Hospital virology laboratory, thus PVL data capture is 100%. An estimated 80% of all CD4 count measurements performed in the province are captured in the BC-CFE data holdings. The STOP HIV/AIDS Technical Monitoring Committee-BC-CFE is responsible for oversight of the monitoring report. Ana Prado writes and compiles the monitoring report. Guillaume Colley, Dr. Viviane Lima and Nada Gataric perform analysis of Indicators 5–13. James Nakagawa is responsible for publishing and editing. This report was conceived and guided by Dr. Julio Montaner.



BC Centre for Disease Control
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British Columbia Centre for Disease Control (BCCDC): The BCCDC provides the data and outputs for Indicator 1 (Hiv Testing Episodes), Indicator 2 (Hiv Testing Rate), Indicator 3 (New Hiv Diagnoses), Indicator 4 (Stage of Hiv at Diagnosis) and Indicator 12 (AIDS-Defining Illness). The BCCDC is the single provincial agency that centralizes all HIV surveillance through the Public Health Microbiology and Reference Laboratory, which does more than 90% of all HIV screening tests in BC and all confirmatory testing. Theodora Consolacion and Dr. Jason Wong are responsible for outputs for Indicators 1–4.

Other Data Sources:

The above databases were supplemented with:

- (I) The BC Vital Statistics database which was used to calculate Indicator 5. The Hiv Cascade of Care and Indicator 13. Hiv-Related Mortality.
- (II) Linkage and preparation of the de-identified individual-level database used for calculating Indicator 5. The Hiv Cascade of Care was facilitated by the British Columbia Ministry of Health.
- (III) The Statistics Canada database: BC and HIV-positive population counts were acquired through the statistics Canada website to calculate HIV-specific mortality rates for Indicator 13. Hiv-Related Mortality.

Membership of the STOP HIV/AIDS Technical Monitoring Committee–BC-CfE

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The Seek and Treat for Optimal Prevention (STOP) HIV/AIDS BC Provincial Program: A Note on Monitoring and Interpreting HIV Indicators

The Seek and Treat for Optimal Prevention (STOP) of HIV/AIDS programme is a provincial initiative to improve HIV diagnosis and care delivery in BC through increased HIV-specific funding to all Health Service Delivery Areas (HSDA's) across BC. The STOP provincial programme is an expansion of a four-year STOP pilot project which was implemented in two Health Service Delivery Areas in March 2010; the Vancouver HSDA which bears the largest burden of the HIV epidemic in the province and the Northern Interior HSDA which bears a high burden of HIV-related mortality. The STOP pilot project demonstrated the urgent need for improved efforts in early diagnosis of HIV and timely initiation of antiretroviral therapy (ART) initiation.

The expansion to a province-wide programme was announced on November 30th 2013 by the BC Ministry of Health with roll out of funding beginning on April 1st, 2013. This funding is intended to be used in the implementation and evaluation of HIV-related diagnosis and care initiatives within individual HA's. Goals of the project include: 1. A reduction in the number of new HIV infections in BC; 2. Improvements in the quality, effectiveness, and reach of HIV prevention services; 3. An increase in early diagnosis of HIV; 4. A reduction in AIDS cases and HIV-related mortality.

The goals of HA-led STOP-funded initiatives are to work toward achieving these goals. To these ends some outcome measures or indicators of progress have been drafted that should be considered in the design and implementation phases of these initiatives.

HIV Testing Episodes and Rates

In this section, the number of HIV test episodes and point of care (POC) HIV tests conducted each quarter in BC is shown. In general terms the goal is to increase the number of tests performed and to maximize testing efficiency. Test episodes are allocated by region according to where the test is performed.

Indicator 1. HIV Testing Episodes

Figure 1.1 HIV Test Episodes for Interior Health

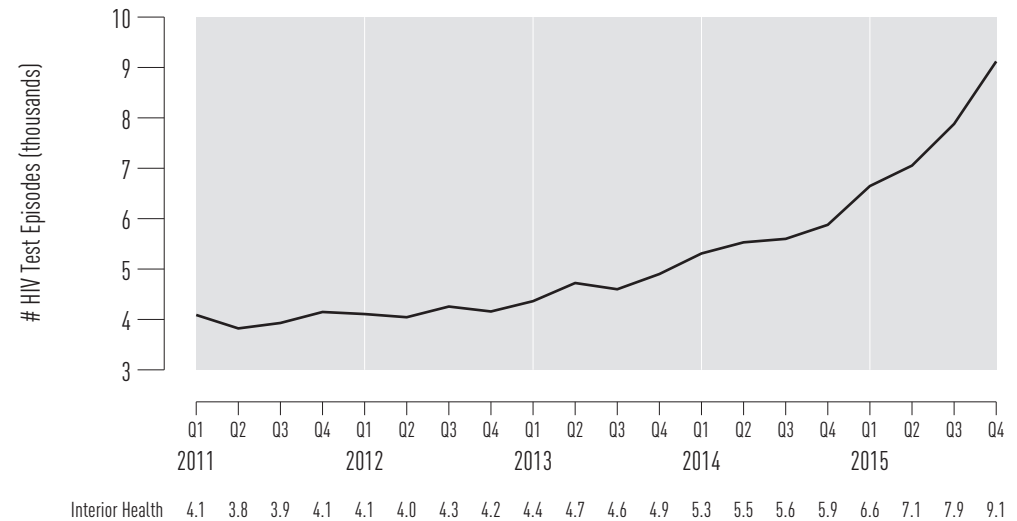


Figure 1.2 HIV Test Episodes by Gender for Interior Health ^{1,2}

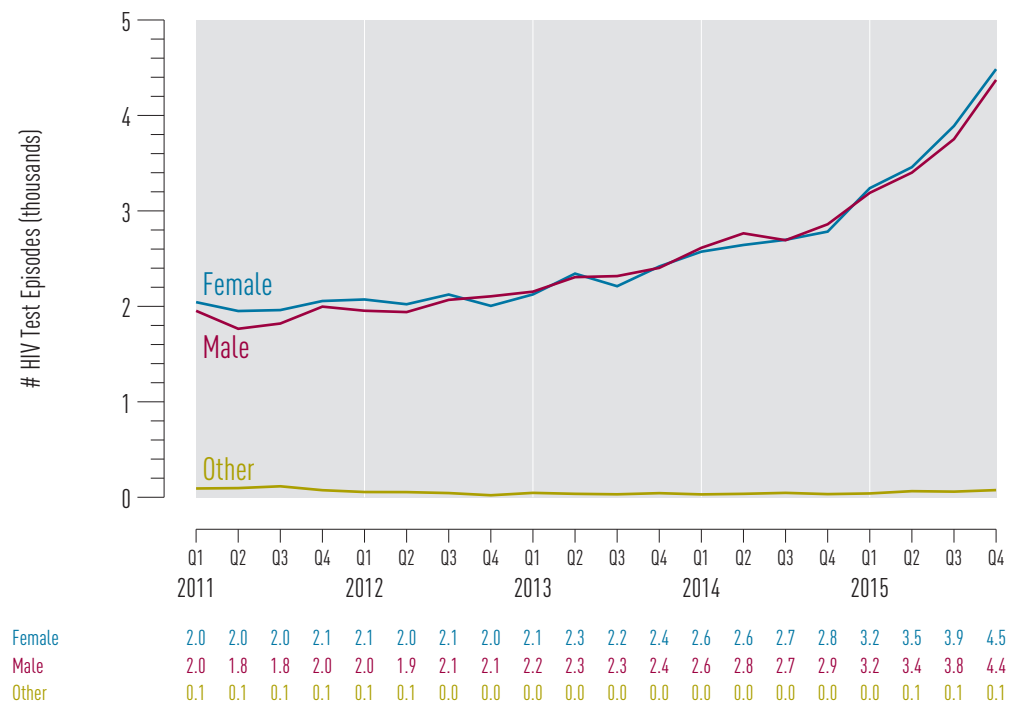


Figure 1.3 HIV Test Episodes by Age Category for Interior Health ^{1,2}

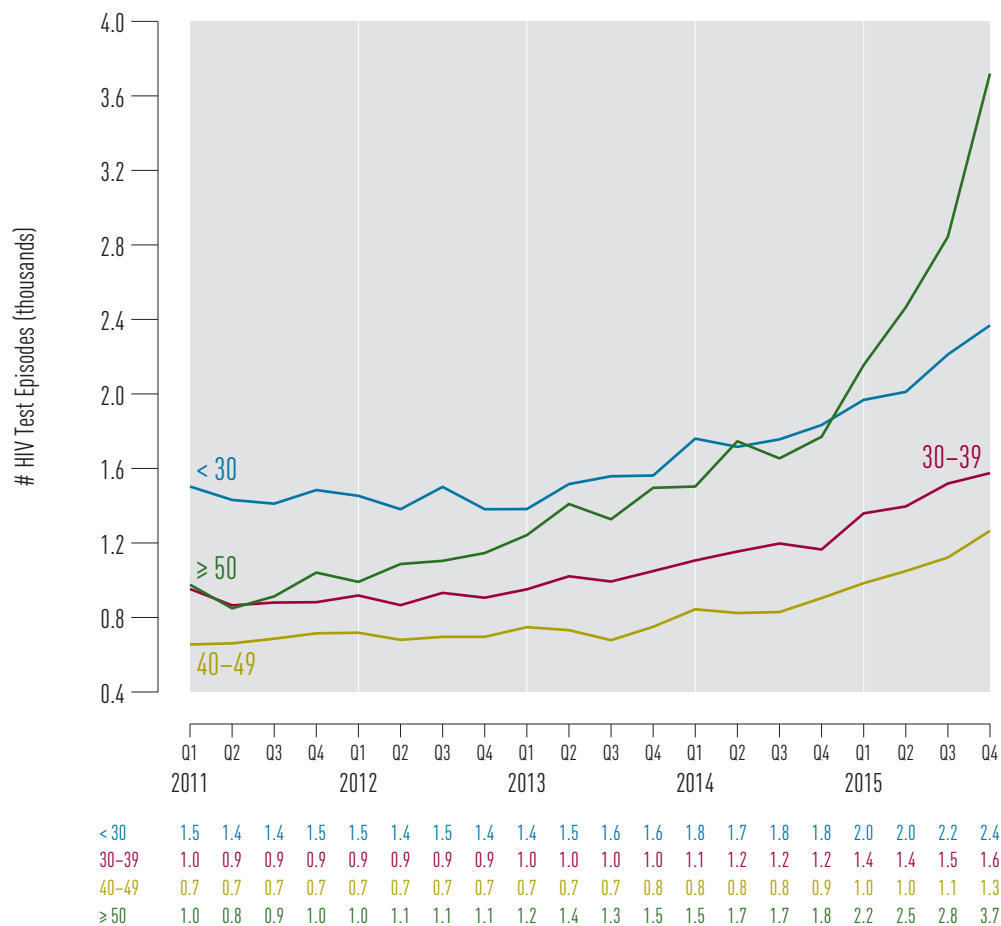
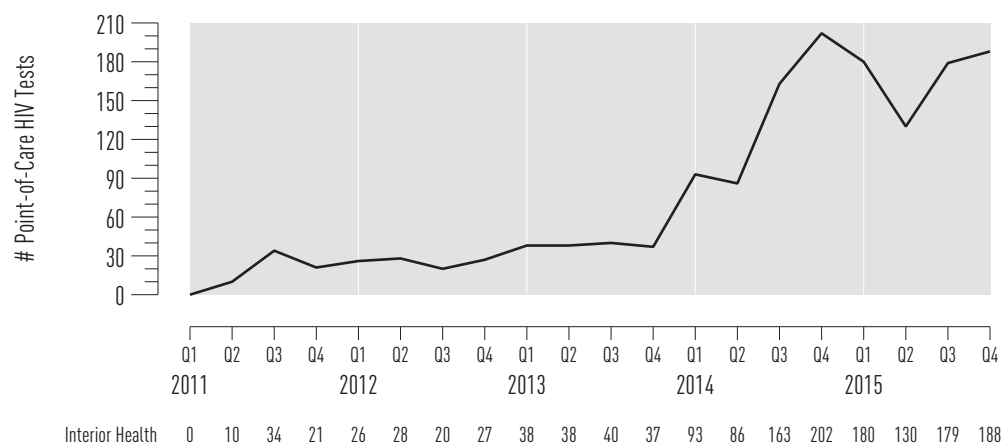


Figure 1.4 Point-of-Care HIV Tests for Interior Health



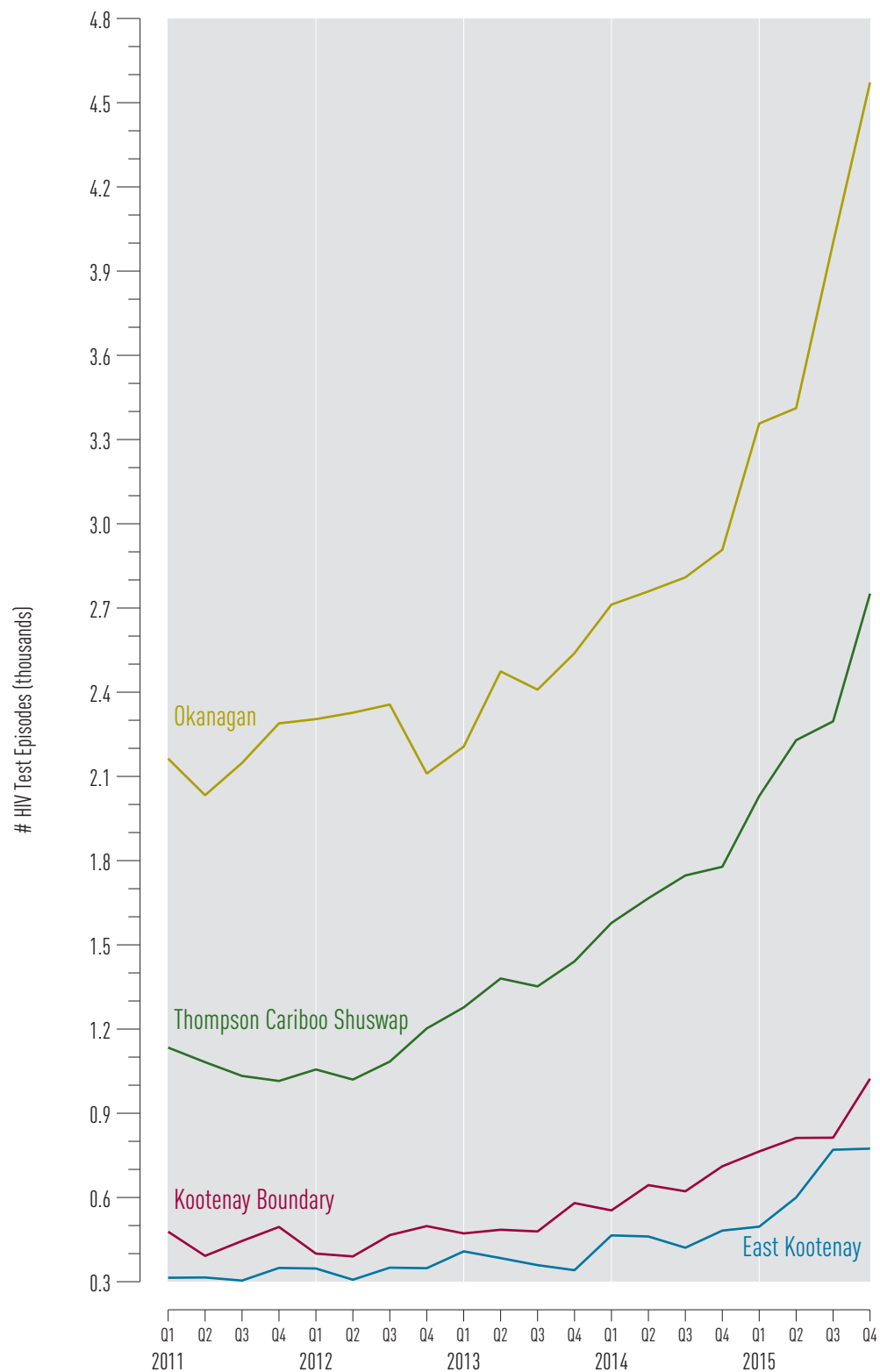
1 Data Source: The BC Public Health Microbiology and Reference Laboratory (BCPHMRL) courtesy of the BC Centre for Disease Control (BCCDC).

Limitations:

- i Repeat tests in individuals who test using various identifiers may not be identified and these individuals may be counted more than once.
- ii In Interior Health, POC testing data are available for May 2011 forward.

2 Testing does not include point of care tests.

Figure 1.5 HIV Test Episodes for Interior Health by HSDA ¹



East Kootenay	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.5	0.5	0.4	0.5	0.5	0.6	0.8	0.8
Kootenay Boundary	0.5	0.4	0.4	0.5	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.8	0.8	0.8	1.0
Okanagan	2.2	2.0	2.1	2.3	2.3	2.3	2.4	2.1	2.2	2.5	2.4	2.5	2.7	2.8	2.8	2.9	3.4	3.4	4.0	4.6
Thompson Cariboo Shuswap	1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.2	1.3	1.4	1.4	1.4	1.6	1.7	1.7	1.8	2.0	2.2	2.3	2.8

Figure 1.6 HIV Test Episodes for Non-prenatal Females in Interior Health by HSDA ^{1,2}

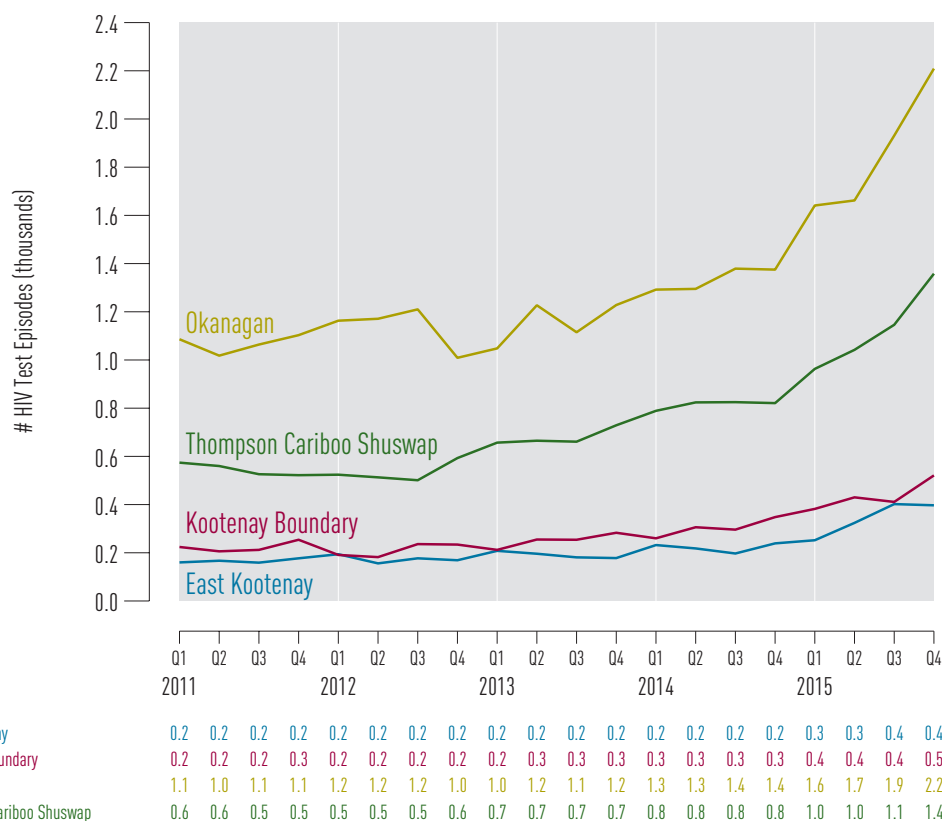
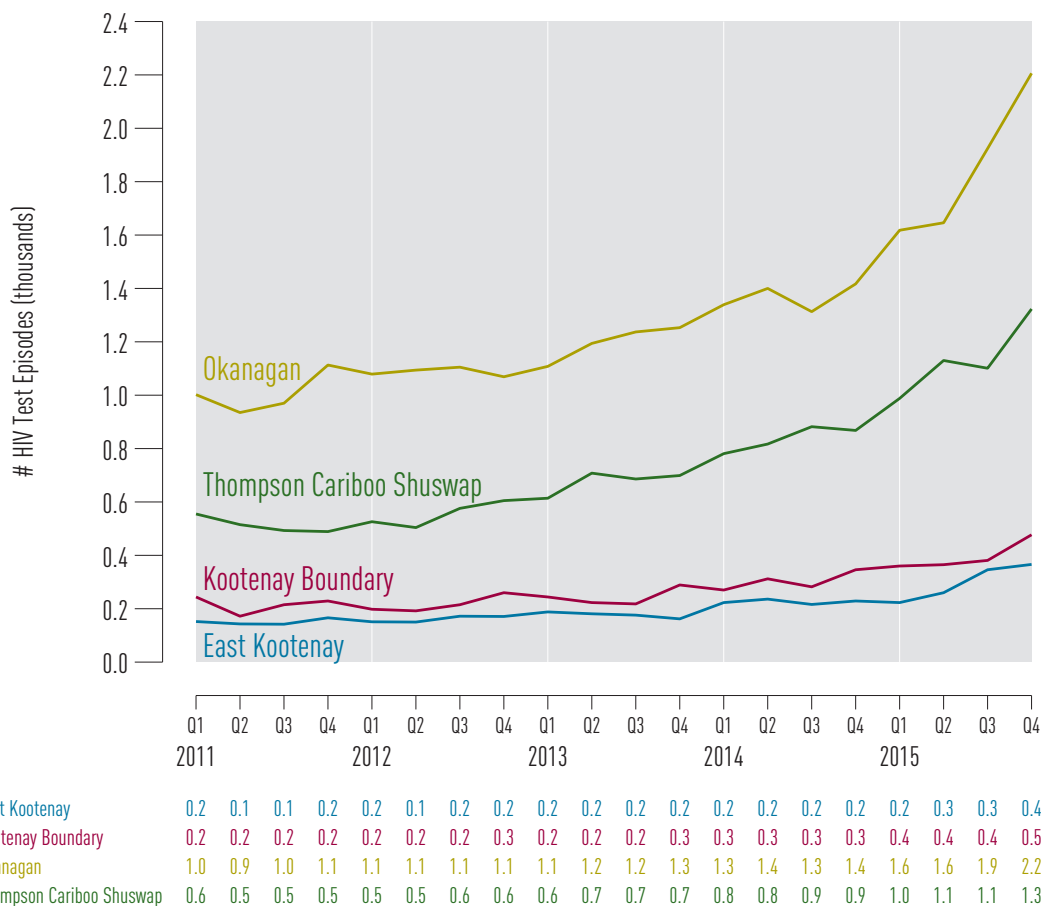


Figure 1.7 HIV Test Episodes for Males in Interior Health by HSDA ^{1,2}



Indicator 2. HIV Testing Rates

Figure 2.1 Rate of HIV Testing for Interior Health and HSDAs ²

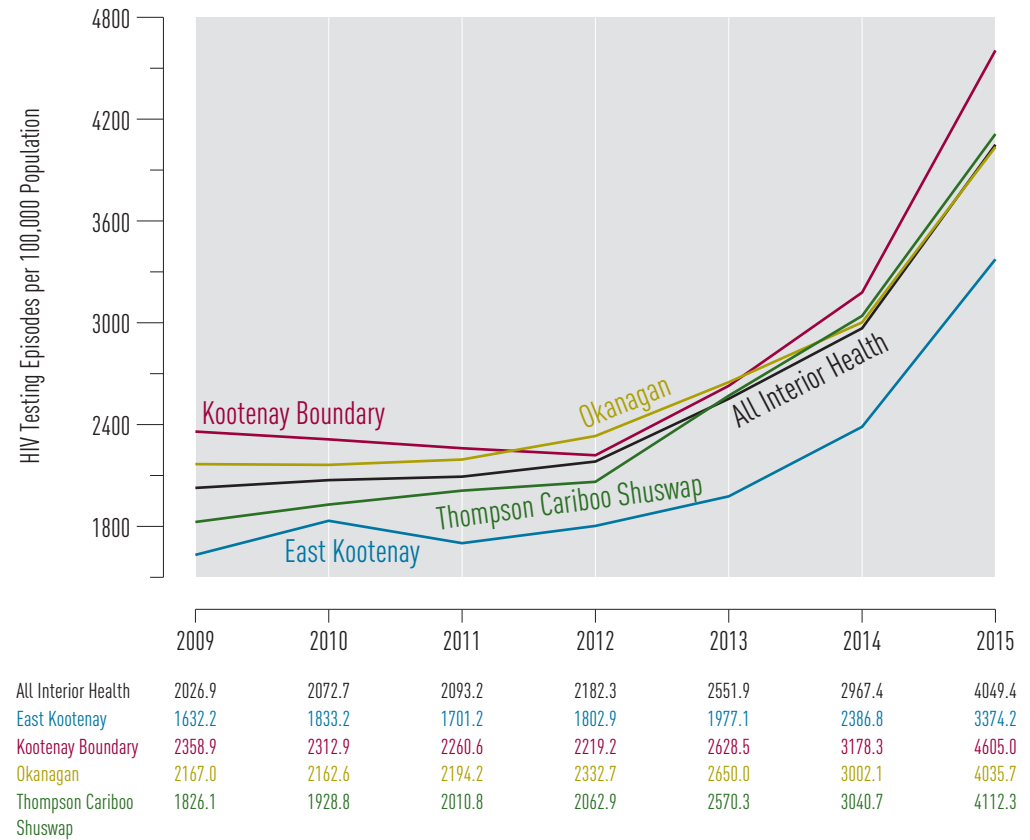


Figure 2.2 Rate of HIV Testing by Gender for Interior Health ²

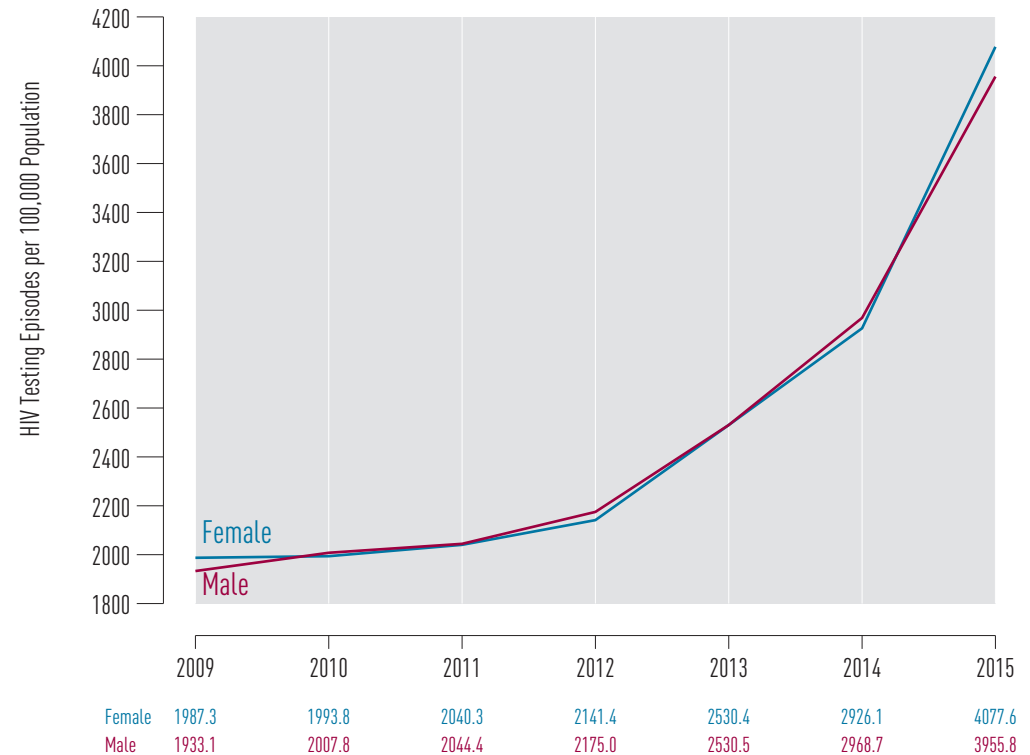
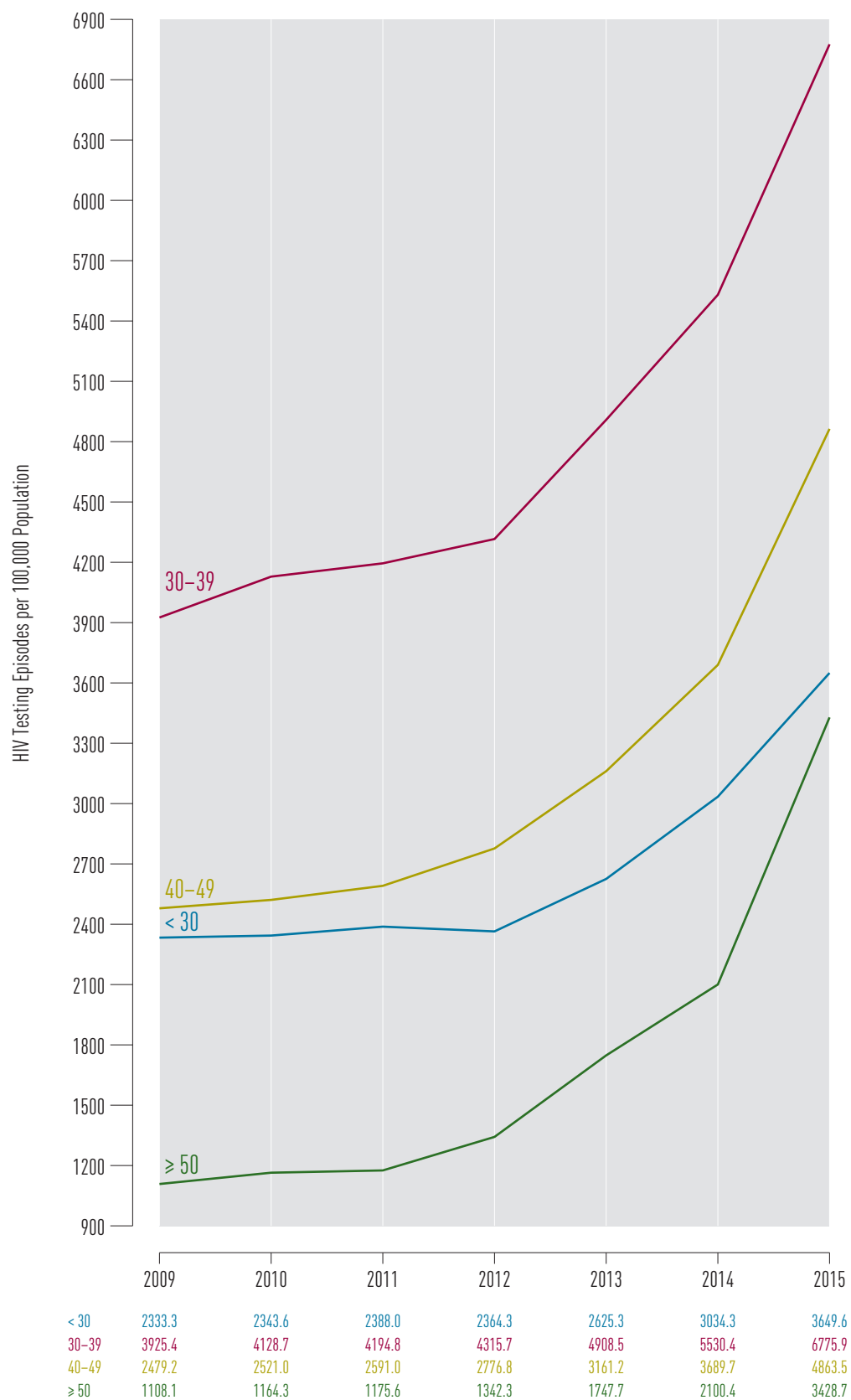


Figure 2.3 Rate of HIV Testing by Age Category for Interior Health ²



² Testing does not include point of care tests.

New HIV Diagnoses

Trends in HIV diagnoses by gender and exposure category are described. Interpreting HIV diagnoses must be done with consideration that trends are influenced by both changes in testing rate as well as changes in transmission rates. It is important to note that new HIV diagnoses cases and rates are not synonymous with HIV incidence as a person may have become infected with HIV long before they tested positive for HIV. However, as there is no reliable method for measuring HIV incidence, we follow trends in HIV diagnoses.

Indicator 3. New HIV Diagnoses

Figure 3.1 New HIV Diagnoses for Interior Health ³

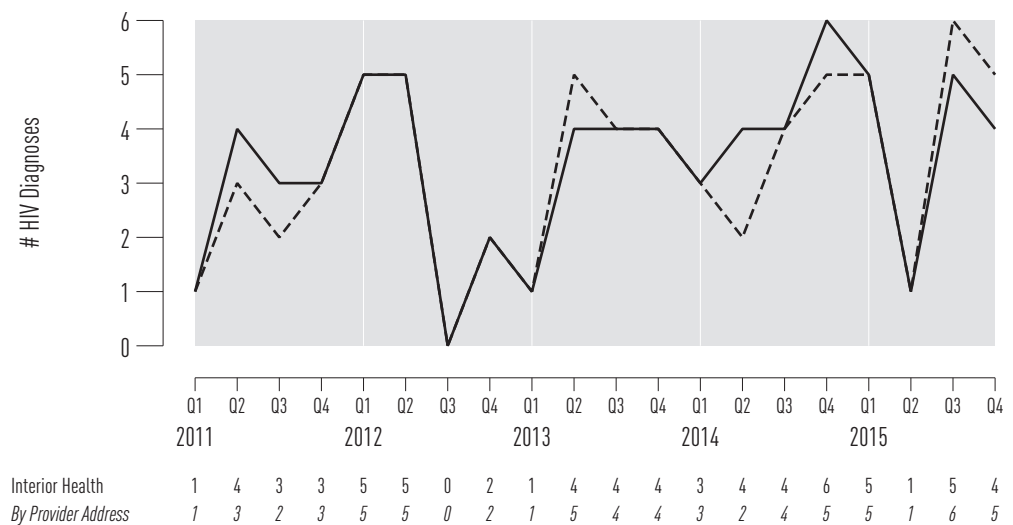
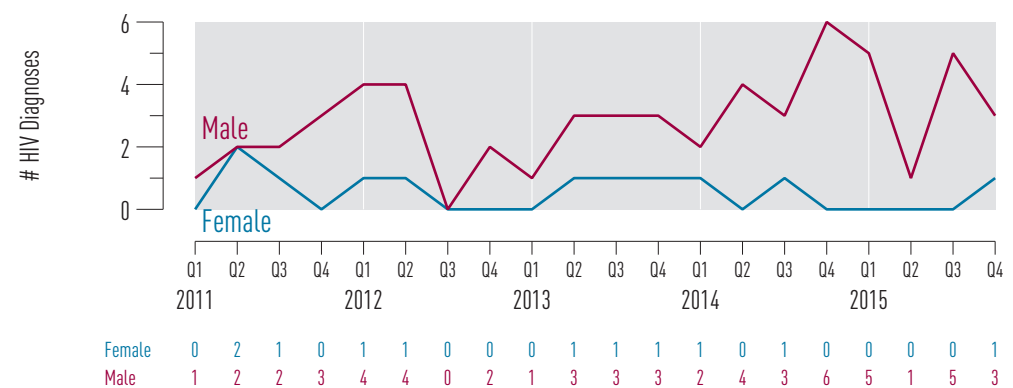
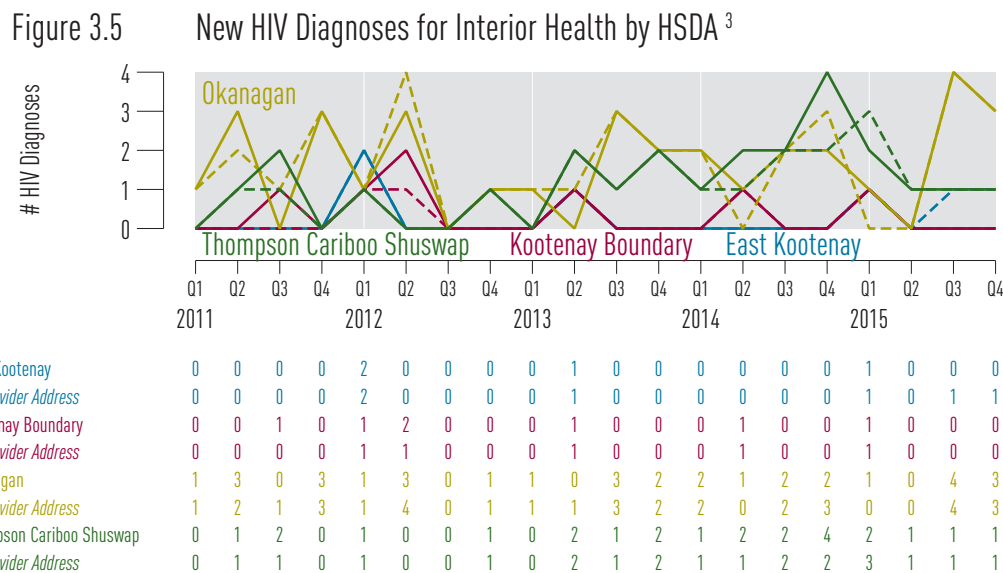
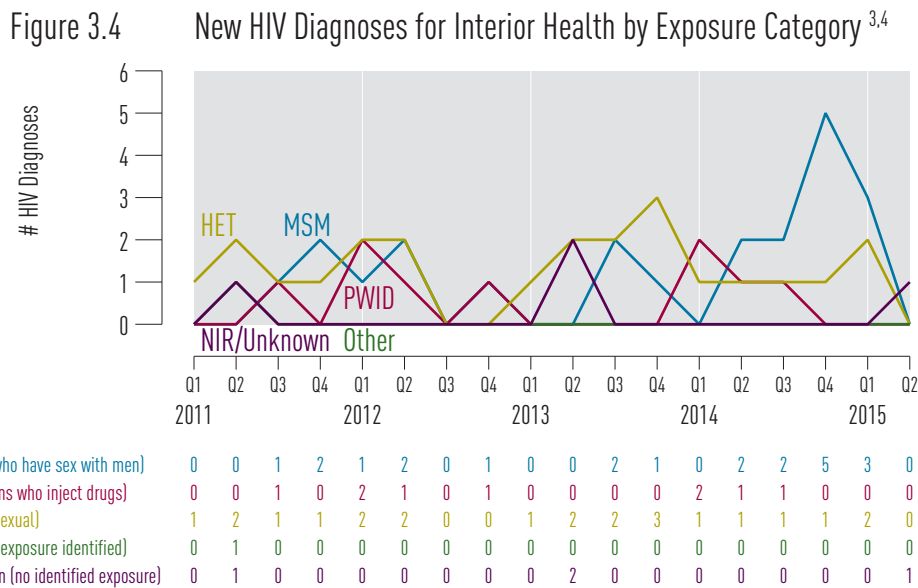
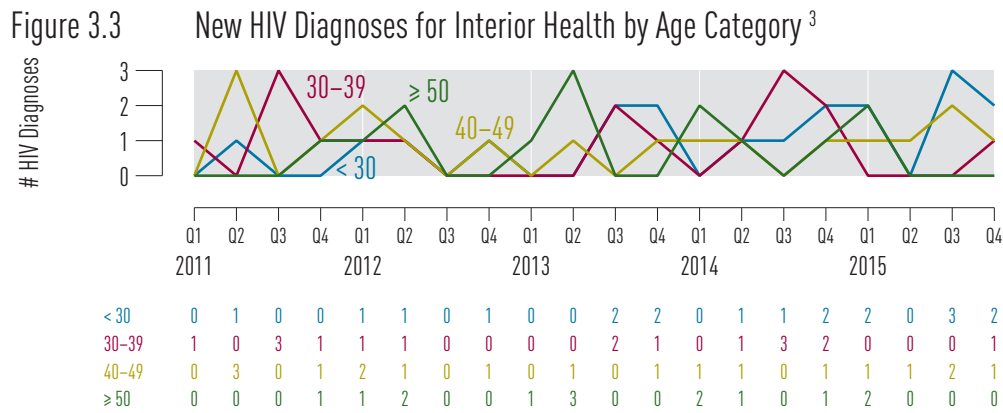


Figure 3.2 New HIV Diagnoses for Interior Health by Gender ³



³ Data Source: BCCDC. When present, “By Provider Address” is graphed as dashed line in same colour.



³ Data Source: BCCDC. When present, “By Provider Address” is graphed as dashed line in same colour.

⁴ MSM=men who have sex with men; PWID=people who inject drugs; HET=heterosexual. NIR=No identified risk/exposure.

Stage of HIV Infection at Diagnosis

Classification of stage of HIV infection, in the absence of information regarding recent testing history, is reliant on clinical information available at the time of diagnosis, including first CD4+ cell count, laboratory results suggestive of acute HIV infection, and clinical presentation with an AIDS-defining illness (Table 1). The benefits of Treatment as Prevention (TasP) are maximized when antiretroviral therapy (ART) is initiated at high CD4 cell counts. Accordingly, it is preferable that individuals newly diagnosed with HIV be in the early stages of HIV infection (stage 0 or 1) to allow for early ART initiation.

N.B. Interpretation of Stage of HIV Infection at Diagnosis should proceed with caution. Early increases in diagnosis at late stage (i.e., low CD4 counts) may represent a “catching up” of previously missed long term infected individuals rather than a trend toward diagnosis at later stage of infection.

Indicator 4. Stage of HIV Infection at Diagnosis

Table 1 Staging Classifications of Infection at Time of HIV Diagnosis Based on CDC HIV Surveillance Case Definitions

Stage	Criteria		
0	Laboratory criteria met for acute HIV infection, or previous negative or indeterminate HIV test within 180 days of first confirmed positive HIV test.		
1	Stage 0 not met	CD4 ≥500	No AIDS case report
2a		CD4 350–499	
2b		CD4 200–349	
3		(CD4 <200	AIDS case report)
Unknown		No available CD4	No AIDS case report

Figure 4.1 Stage of HIV Infection at Diagnosis for Interior Health, 2010–2014⁵

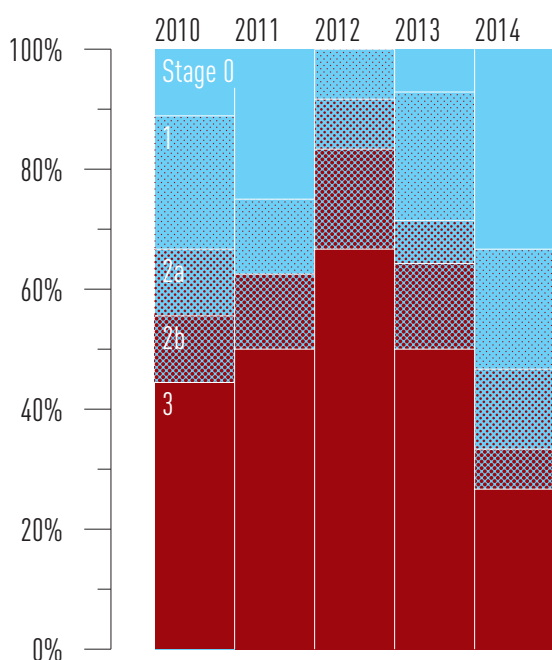


Figure 4.2 Stage of HIV Infection at Diagnosis by Gender for Interior Health, 2010–2014⁵



	Interior Health					Female					Male				
	2010	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14
Stage 0	1	2	0	1	5	1	0	0	0	1	0	2	0	1	4
Stage 1	2	1	1	3	3	1	0	0	1	1	1	1	1	2	2
Stage 2a	1	0	1	1	2	0	0	0	1	0	1	0	1	0	2
Stage 2b	1	1	2	2	1	1	0	1	0	0	0	1	1	2	1
Stage 3	4	4	8	7	4	0	1	1	1	0	4	3	7	6	3
Unknown	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0
Total (n=)	10	9	12	14	15	3	1	2	3	2	7	8	10	11	12

Figure 4.3 Stage of HIV Infection at Diagnosis by Age Category for Interior Health, 2010–2014 ⁵

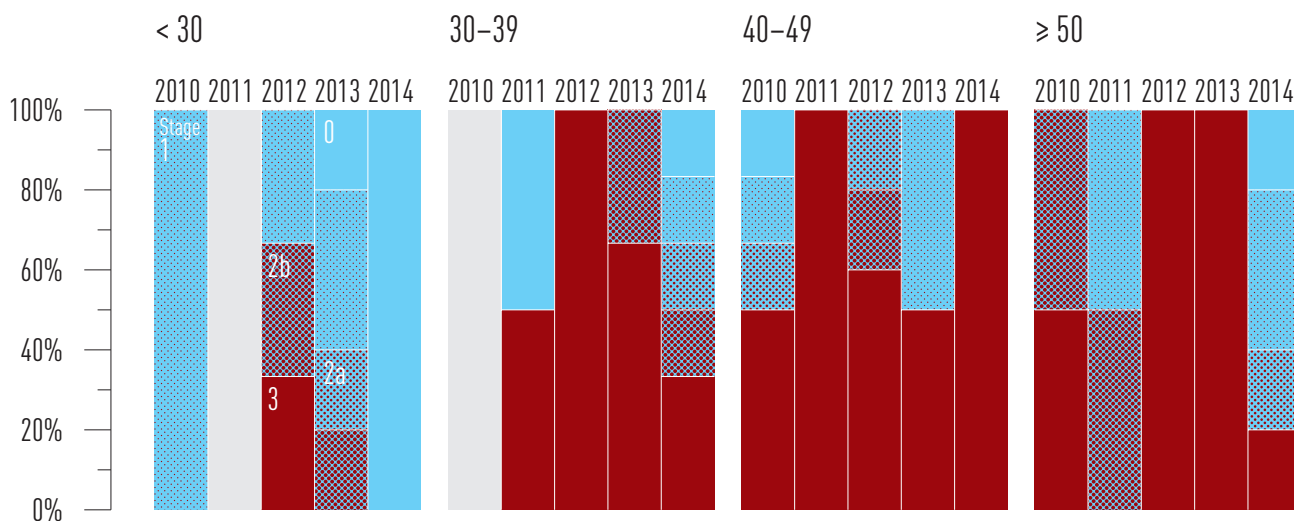
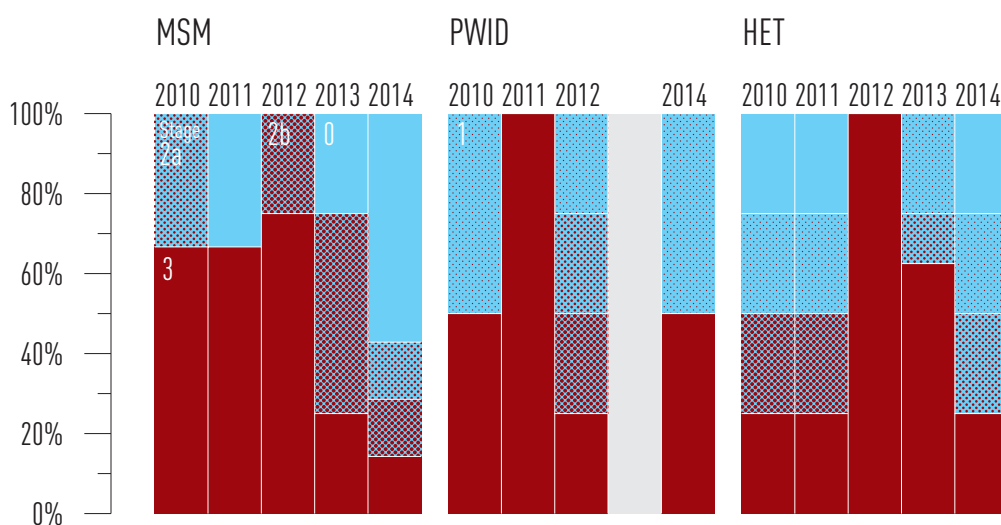


Figure 4.4 Stage of HIV Infection at Diagnosis by Exposure Category for Interior Health, 2010–2014 ^{5,6}



	< 30 years					30–39 years					40–49 years					≥ 50 years					MSM					PWID					Heterosexual					Other					NIR/Unknown				
	2010	11	12	13	14	10	11	12	13	14	10	11	12	13	14	10	11	12	13	14	10	11	12	13	14	10	11	12	13	14	10	11	12	13	14	10	11	12	13	14					
Stage 0	0	0	0	1	3	0	2	0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	0	1	4	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0		
Stage 1	1	0	1	2	0	0	0	0	0	1	1	0	0	1	0	0	1	0	0	2	0	0	0	0	0	1	0	1	0	2	1	1	1	0	2	1	0	0	0	0	0	1	0	0	
Stage 2a	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	
Stage 2b	0	0	1	1	0	0	0	0	1	1	0	0	1	0	0	1	1	0	0	0	0	0	1	2	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stage 3	0	0	1	0	0	0	2	1	2	2	3	2	3	1	1	1	0	3	4	1	2	2	3	1	1	1	1	1	0	2	1	1	4	5	1	0	0	0	0	0	0	1	0	0	
Unknown	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total (n=)	1	0	3	5	3	0	4	1	3	6	7	3	5	2	1	2	2	3	4	5	4	3	4	4	7	2	1	4	0	4	4	4	4	8	4	0	0	0	0	0	1	0	2	0	

⁵ Data Source: BCCDC

⁶ MSM=men who have sex with men; PWID=people who inject drugs; HET=heterosexual. NIR=No identified risk/exposure.

HIV Cascade of Care

Indicator 5. HIV Cascade of Care

The success of seek, test, treat and retain (STTR) strategies like STOP is reliant on early diagnosis of HIV, linking newly diagnosed HIV-positive persons with ongoing care, retaining persons in HIV-care; initiating ART based on best evidenced practices and maintaining optimal ART adherence to ensure a suppressed viral load. These stages of HIV-care can be summarized as: 1. HIV diagnosis, 2. Linked to HIV care, 3. Retained in HIV care, 4. On ART, 5. Adherent to ART and 6. Achieving a suppressed VL; collectively, they are referred to as the cascade of care. Leakage between any of these stages of HIV-care means a reduction in the potential of ART as a benefit to the HIV-positive individual and as an HIV transmission prevention method on a population level. Thus, when interpreting trends in the cascade of care, we strive to see increases along each step of the cascade of care (i.e. reduced attrition) with the ultimate goal being 100% within each stage of the cascade. Monitoring the Cascade of Care provides a picture as to where deficiencies lie in the delivery and uptake of HIV-care. In this section we present the cascade of care for the period 2015 Q1–2015 Q4 in Interior Health and stratified by sex and age.

Figure 5.1 Estimated Cascade of Care for Interior Health, 2015 ⁷

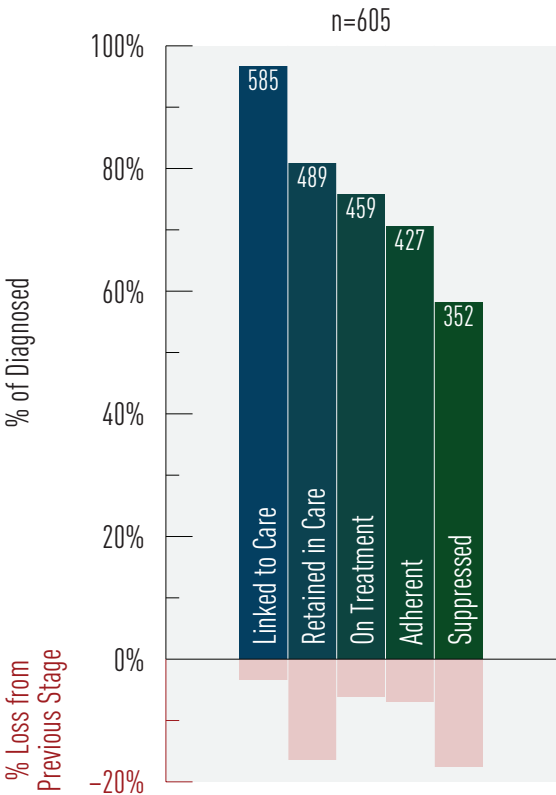
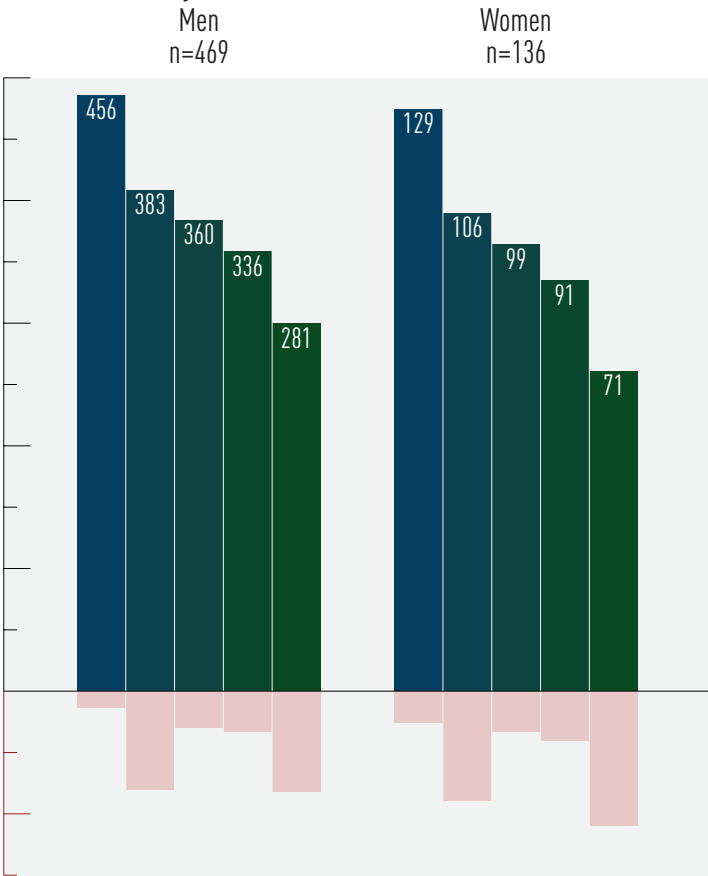


Figure 5.2 Estimated Cascade of Care for Interior Health by Gender, 2015 ⁷



⁷ Data is for the period 2015 Q1–2015 Q4.

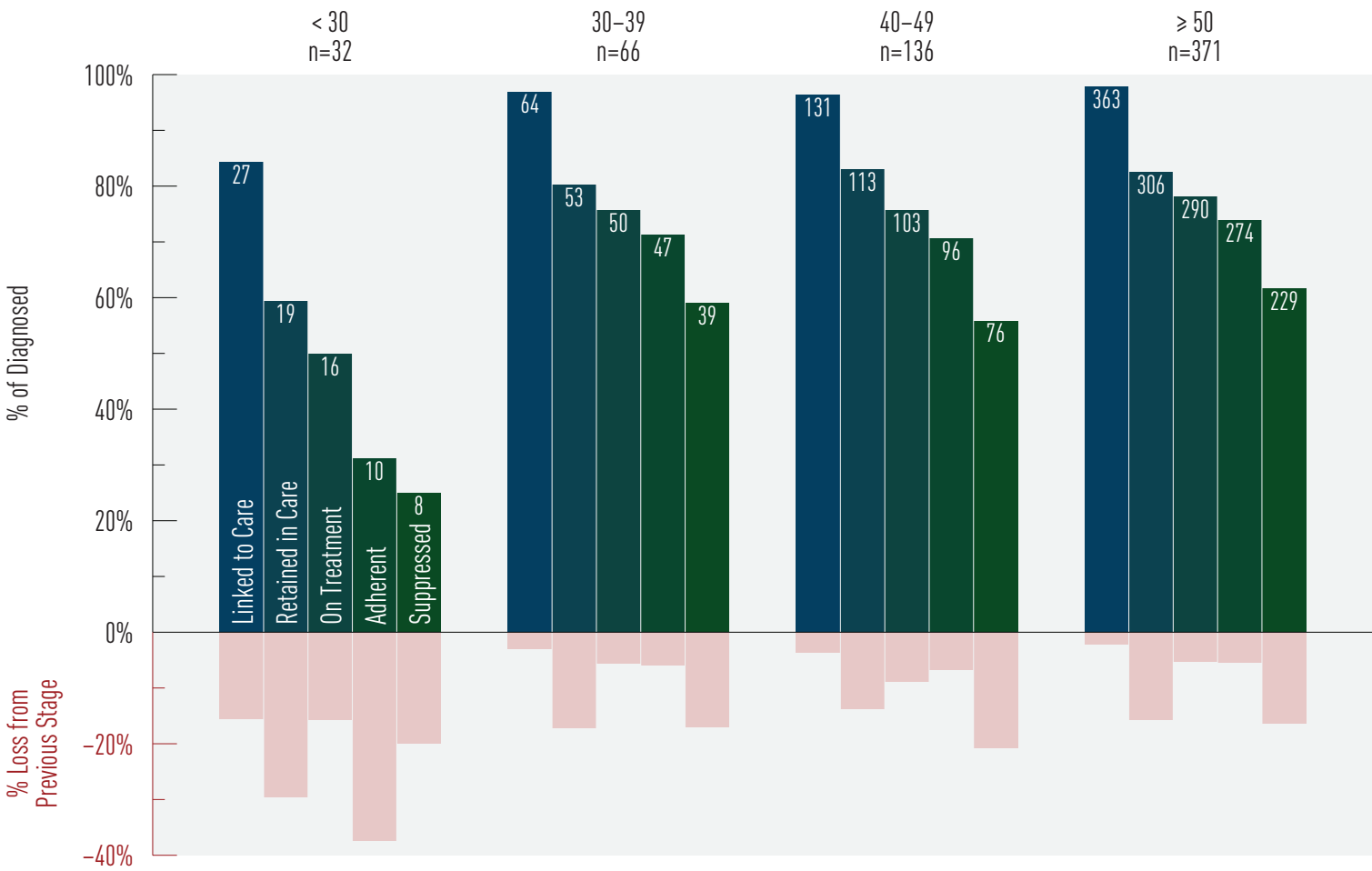
Data Sources:

- i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).

Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider. If the most recent HA of residence is not updated then the designated HA may be incorrect.

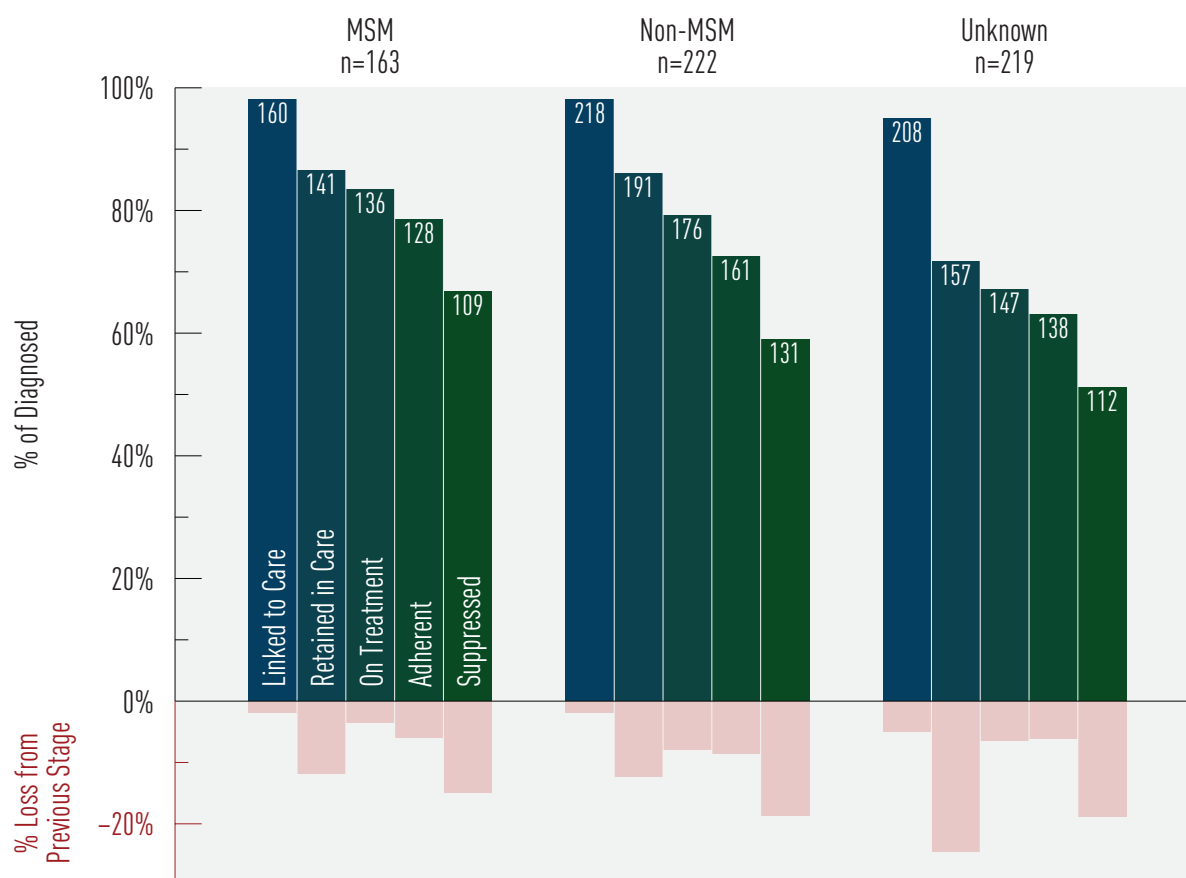
NB: Transgender have been assigned to their biological sex.

Figure 5.3 Estimated Cascade of Care for Interior Health by Age Category, 2015 ⁸



⁸ Data is for the period 2015 Q1–2015 Q4.
Data Sources:
i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).
Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider.
If the most recent HA of residence is not updated then the designated HA may be incorrect.

Figure 5.4 Estimated Cascade of Care for Interior Health by MSM Status, 2015 ⁹



⁹ Data is for the period 2015 Q1–2015 Q4.

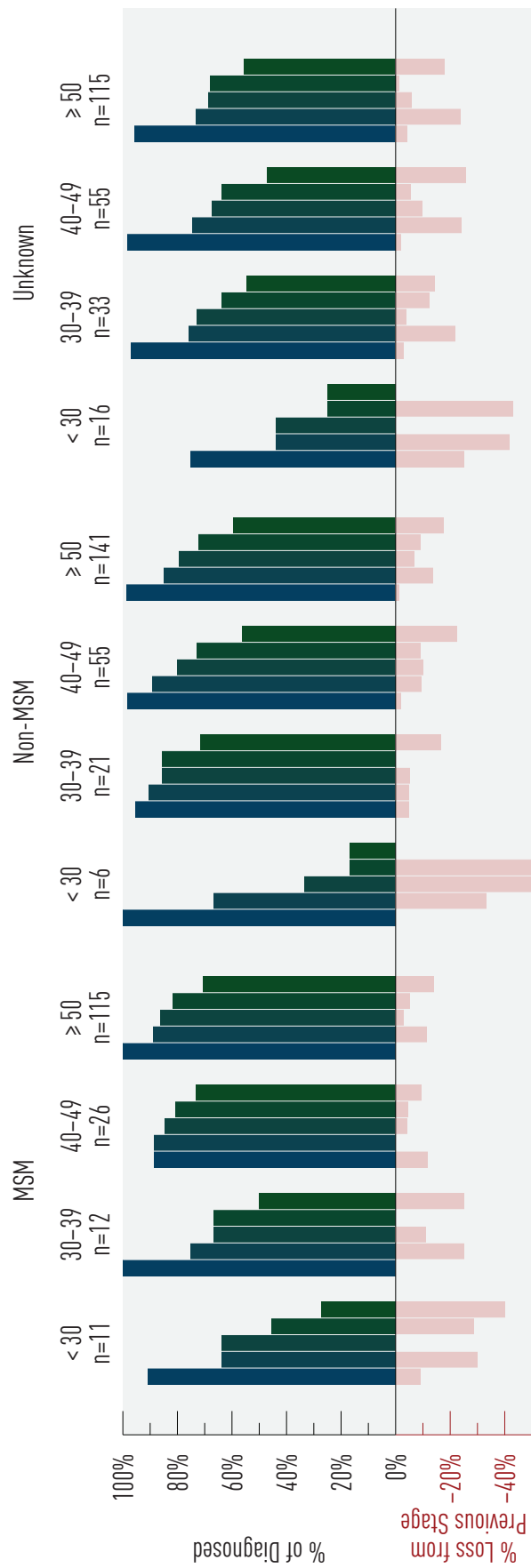
Data Sources:

- i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).

Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider. If the most recent HA of residence is not updated then the designated HA may be incorrect.

Recent updates to the DTP database have allowed for more comprehensive information on HIV risk group category. As a result, 2014 Q4 data may differ significantly from preceding reports in terms of total numbers ascribed to each risk group.

Figure 5.5 Estimated Cascade of Care for Interior Health by Age Category and MSM Status, 2015 ⁹



⁹ Data is for the period 2015 Q1-2015 Q4.

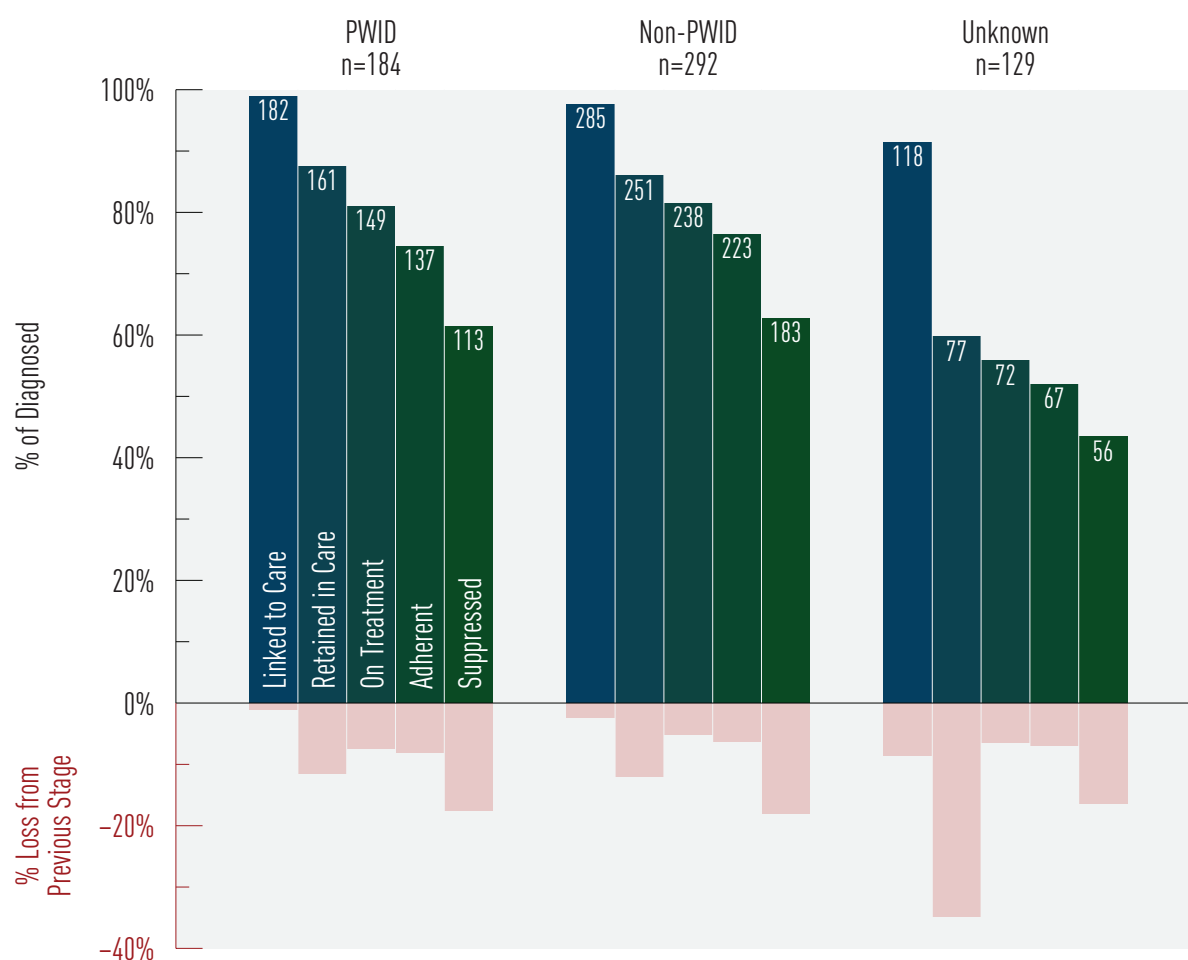
Data Sources:

- i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).

Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider. If the most recent HA of residence is not updated then the designated HA may be incorrect.

Recent updates to the DTP database have allowed for more comprehensive information on HIV risk group category. As a result, 2014 Q4 data may differ significantly from preceding reports in terms of total numbers ascribed to each risk group.

Figure 5.6 Estimated Cascade of Care for Interior Health by PWID Status, 2015 ⁹



⁹ Data is for the period 2015 Q1–2015 Q4.

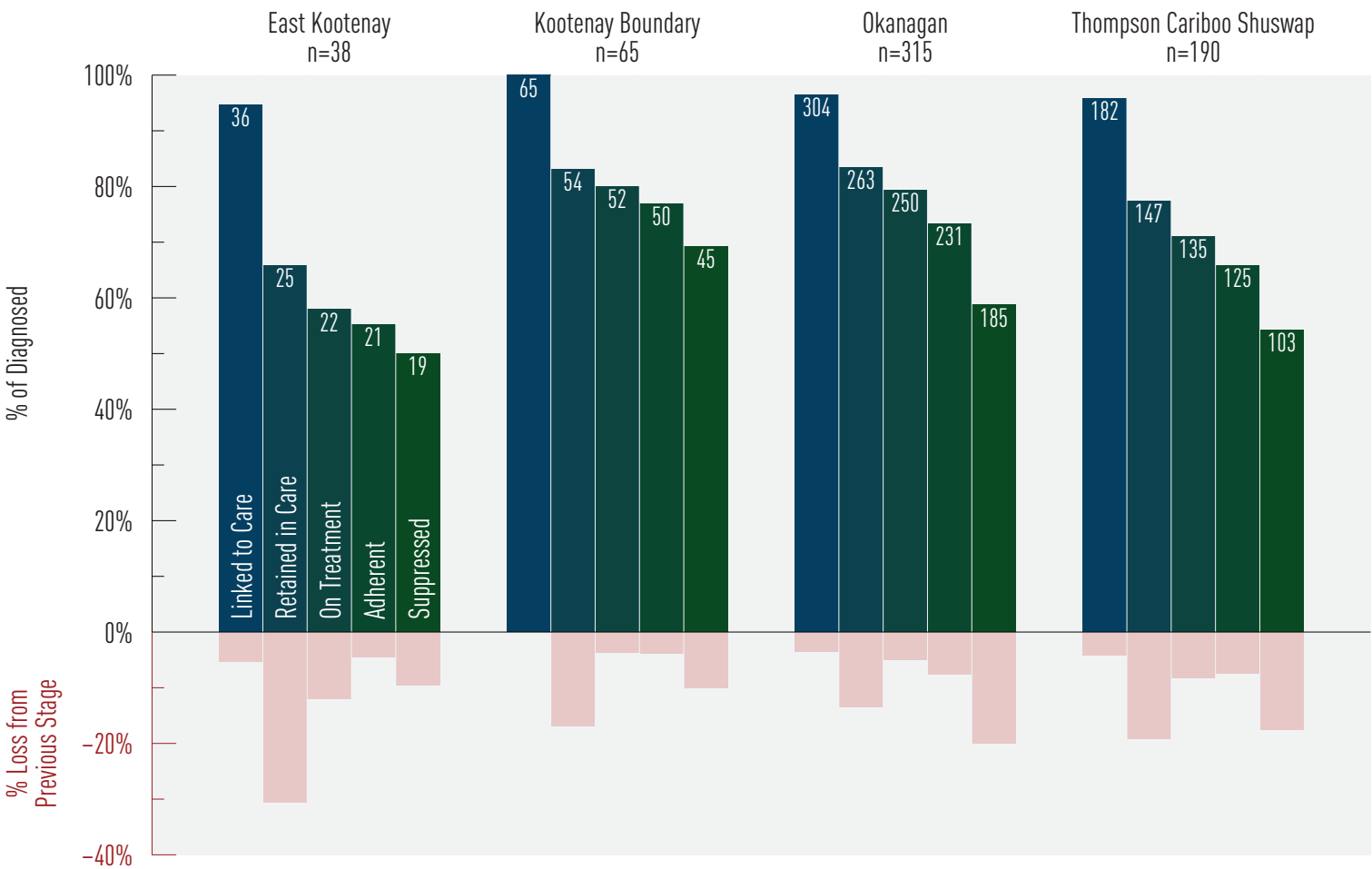
Data Sources:

- i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).

Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider. If the most recent HA of residence is not updated then the designated HA may be incorrect.

Recent updates to the DTP database have allowed for more comprehensive information on HIV risk group category. As a result, 2014 Q4 data may differ significantly from preceding reports in terms of total numbers ascribed to each risk group.

Figure 5.7 Estimated Cascade of Care for Interior Health by HSDA, 2015 ⁹



⁹ Data is for the period 2015 Q1–2015 Q4.
Data Sources:
i British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
ii Administrative data (ex. MSP billings; hospitalization data from the Discharge Abstract Database (DAD)).
Limitations: HA assignment is based on the most recent HA of residence of the patient, if not available of the HIV-care provider. If the most recent HA of residence is not updated then the designated HA may be incorrect.
Recent updates to the DTP database have allowed for more comprehensive information on HIV risk group category. As a result, 2014 Q4 data may differ significantly from preceding reports in terms of total numbers ascribed to each risk group.

Programmatic Compliance Score

Indicator 6. Programmatic Compliance Score (PCS)

The Programmatic Compliance Score (PCS) is a summary measure of risk of future death, immunologic failure and virologic failure from all causes for people who are starting ART for the first time. It is composed of patient- and physician-driven effects. PCS scores range from 0–6 with higher scores indicative of poorer health outcomes and greater risk of death. Table 1 provides mortality, immunologic failure and virologic failure probabilities for given PCS scores. We interpret an individual with a $PCS \geq 4$ as being 22 times more likely to die, almost 10 times more likely to have immunologic failure and nearly 4 times as likely to demonstrate virologic failure compared to those individuals with a PCS score of 0. A detailed description of how the PCS score is calculated and its validation can be found in the technical report. In short, PCS scores are calculated by summing the results (yes=1, no=0) of six un-weighted non-performance indicators based on IAS–USA treatment guidelines:

1. having <3 CD4 cell count tests in the first year after starting antiretroviral therapy (ART);
2. having <3 plasma viral load (VL) tests in the first year after starting ART;
3. not having drug resistance testing done prior to starting ART;
4. starting on a non-recommended ART regimen;
5. starting therapy with $CD4 < 200$ cells/ μ L; and
6. not achieving viral suppression within 9 months since ART initiation.

In this section we provide PCS scores and their components over time for the province of BC. A decline to 0%, (i.e., all individuals having a score of 0) is the eventual goal.

Table 2. Probability of Mortality, Immunologic Failure and Virologic Failure based on the Programmatic Compliance Score

Programmatic Compliance Score	Mortality Risk Ratio (95% Confidence Interval)	Immunologic Failure Risk Ratio (95% CI)	Virologic Failure Risk Ratio (95% CI)
0 (Best score)	1 (–)	1 (–)	1 (–)
1	3.81 (1.73–8.42)	1.39 (1.04–1.85)	1.32 (1.05–1.67)
2	7.97 (3.70–17.18)	2.17 (1.54–3.04)	1.86 (1.46–2.38)
3	11.51 (5.28–25.08)	2.93 (1.89–4.54)	2.98 (2.16–4.11)
4 or more (Worst score)	22.37 (10.46–47.84)	9.71 (5.72–16.47)	3.80 (2.52–5.73)

Reference: Lima VD, Le A, Nosyk B, Barrios R, Yip B, et al. (2012) Development and Validation of a Composite Programmatic Assessment Tool for HIV Therapy. PLoS ONE 7(11): e47859. doi:10.1371/journal.pone.0047859

Figure 6.1 PCS Components for Interior Health, 2014 Q1–2015 Q4 ¹⁰

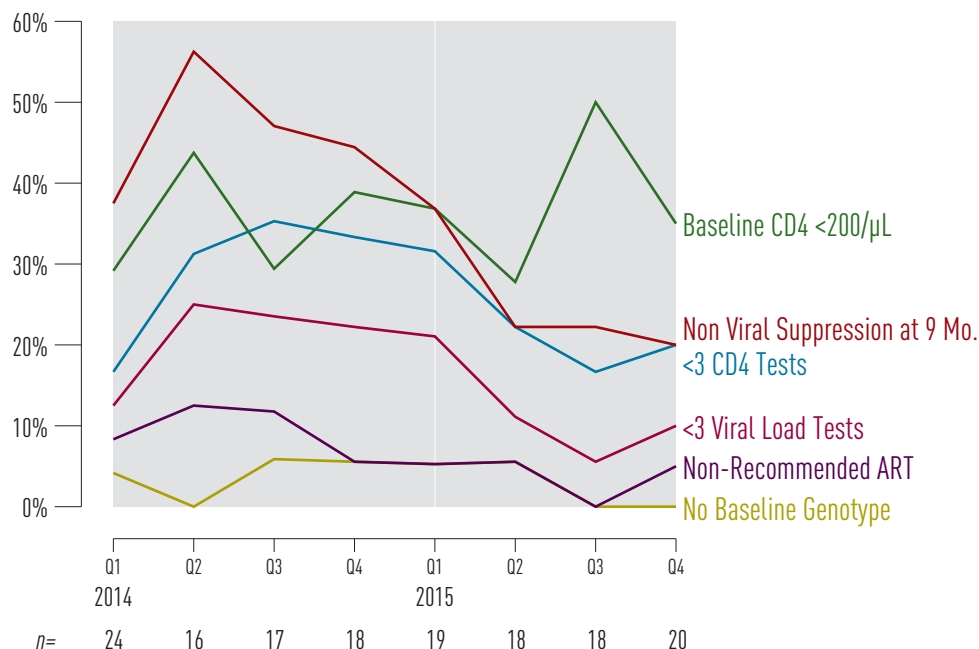
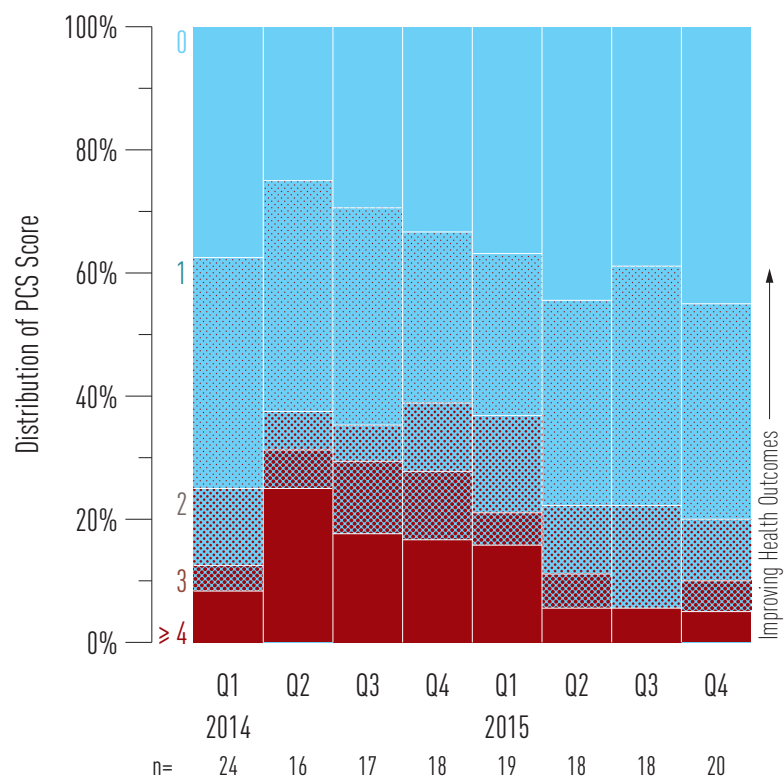


Figure 6.2 Historical Trends for PCS Score for Interior Health, 2014 Q1–2015 Q4 ^{10,11}



¹⁰ Data Source: British Columbia Centre for Excellence Drug Treatment Program (DTP) Database.
Limitations: CD4 cell count capture is approximately 80%.

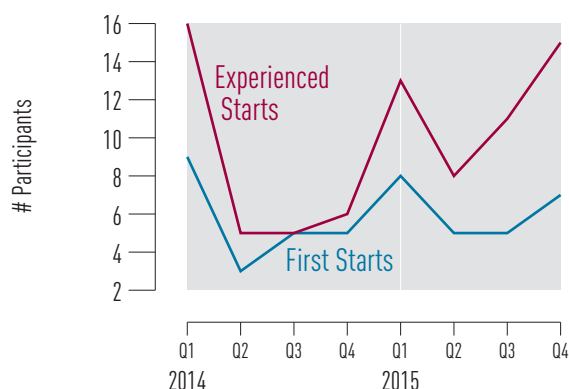
¹¹ Each quarter's data is calculated as the sum of the 4 quarters leading up to it. e.g. 2013 Q1 is calculated from 2012 Q2 – 2013 Q1.
NB: A score of 0 is the best score and a score of 4 or more is the worst score.

Antiretroviral Uptake

In this section we present trends in ART uptake, the number and proportion of new HIV treatment initiations and the number of active and inactive DTP participants. Trends in ART uptake should be interpreted under the consideration of changing BC HIV treatment guidelines. BC HIV treatment guidelines are updated regularly by the BC-CfE Therapeutic Guidelines Committee and reflect those of the International AIDS Society. Most recent changes were made in 2012 and HIV treatment is now recommended for all HIV-positive adults regardless of CD4 cell count; as evidence demonstrates that early initiation of HIV treatment maximizes both the individual's health outcomes as well as the potential of ART as a form of HIV transmission prevention at a population level. As such, trends in the number and proportion of persons on ART and new ART starts (in both naïve and experienced persons) are expected to increase over time at higher CD4 cell counts.

Indicator 7. New Antiretroviral Therapy Starts in Interior Health

Figure 7 BC-CfE Drug Treatment Program Enrollment: New ART Participants in Interior Health, 2014 Q1–2015 Q4 ¹²



Indicator 8. CD4 Cell Count at ART Initiation

Figure 8 CD4 Cell Count at ART Initiation of ART-Naïve DTP Participants in Interior Health, 2014 Q1–2015 Q4 ¹³

The majority of cells in this figure have $n \leq 5$, which is considered statistically insignificant as well as a possible risk to patient privacy. For this reason, this figure has been omitted. Authorized parties may contact the British Columbia Centre for Excellence in HIV/AIDS to obtain this information.

¹² Data Source: Drug Treatment Program Database

Limitation: DTP participants are designated to an HA based on most current residence provided by the participant.

¹³ Data Source: Drug Treatment Program Database

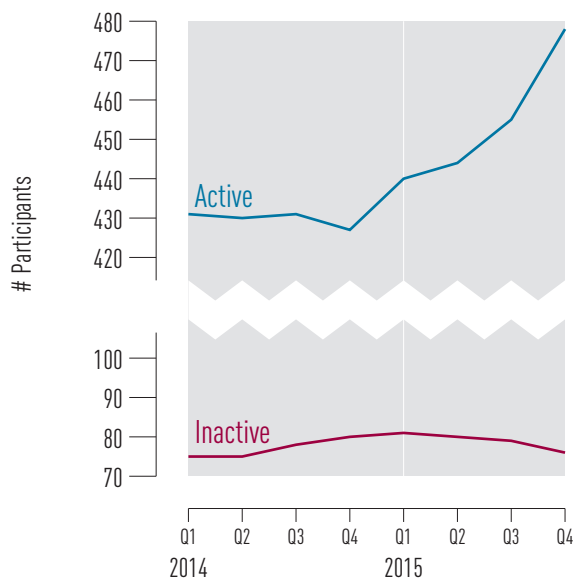
Limitations: CD4 cell count data is approximately 80% complete.

Indicator 9. Active and Inactive DTP Participants

Table 3. Distribution of People on ART for Interior Health, 2015 Q4 ¹⁴

Age	< 30	18
	30–39	59
	40–49	111
	≥ 50	290
Gender	Male	380
	Female	98
Exposure	MSM	143
	PWID	153
Total		478

Figure 9 Active and Inactive DTP Participants for Interior Health, 2014 Q1–2015 Q4 ¹⁵



¹⁴ Data Source: Drug Treatment Program Database
Limitation: DTP participants are designated to an HA based on most current residence provided by the participant.

Recent updates to the DTP database provides for improved classification allowing some individuals previously classified as 'unknown' to be reclassified into specific risk groups. This update is in effect from 2014Q4 and may result in noticeable changes of numbers in each risk group category compared to previous reports.

Definition:

'On antiretroviral therapy' defined as being on treatment in the current quarter

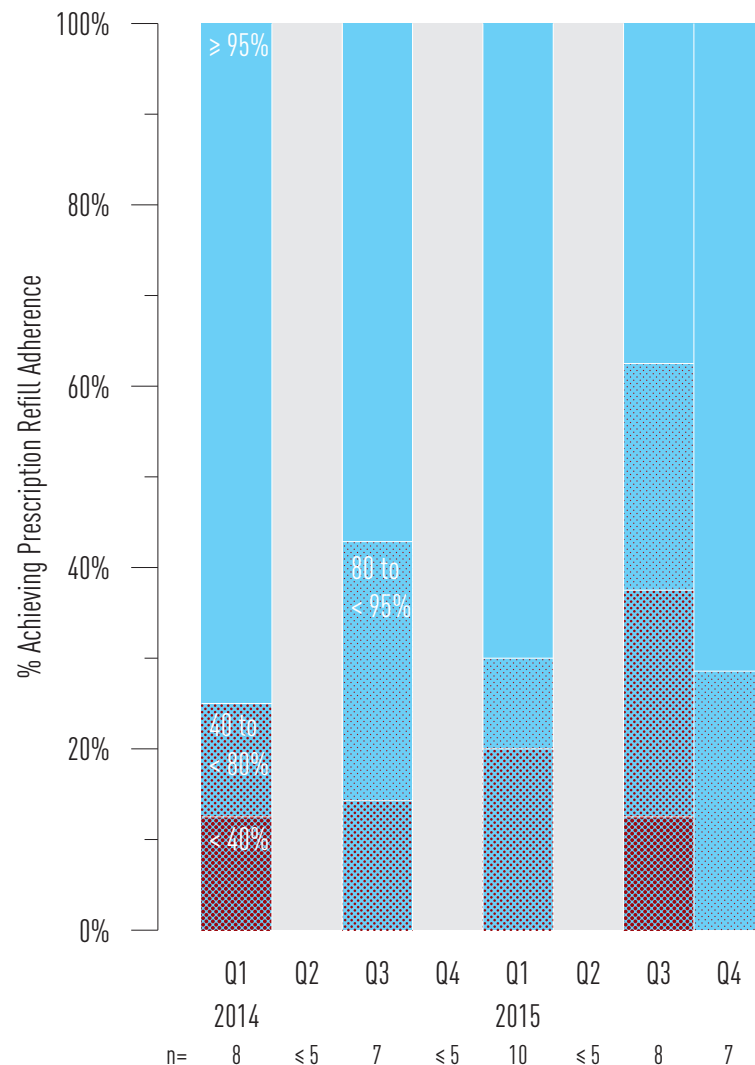
¹⁵ Active DTP participants: An individual who has had medication prescribed at least once in the preceding quarter.
Inactive DTP participants: Persons no longer prescribed drugs through the HIV/AIDS Drug Treatment Program in the last quarter.

Antiretroviral Adherence Level

In this section we present trends in prescription refill adherence levels for individuals in their first year of treatment. Given that the benefits of ART are compromised in the presence of imperfect ART adherence, we expect to see the proportion of persons on ART achieving **near perfect adherence** (ie. $\geq 95\%$) to increase with time. Furthermore, it is important that trends in the proportion of ART users achieving prescription refill adherence of $\geq 95\%$ keep pace with new ART starts and increase among those continuing on ART.

Indicator 10. Antiretroviral Adherence

Figure 10 Distribution of Individuals by Adherence Level in 1st Year of Therapy, Based on Pharmacy Refill Compliance for Interior Health, 2014 Q1–2015 Q4 ¹⁶



¹⁶ Data Source: Drug Treatment Program Database

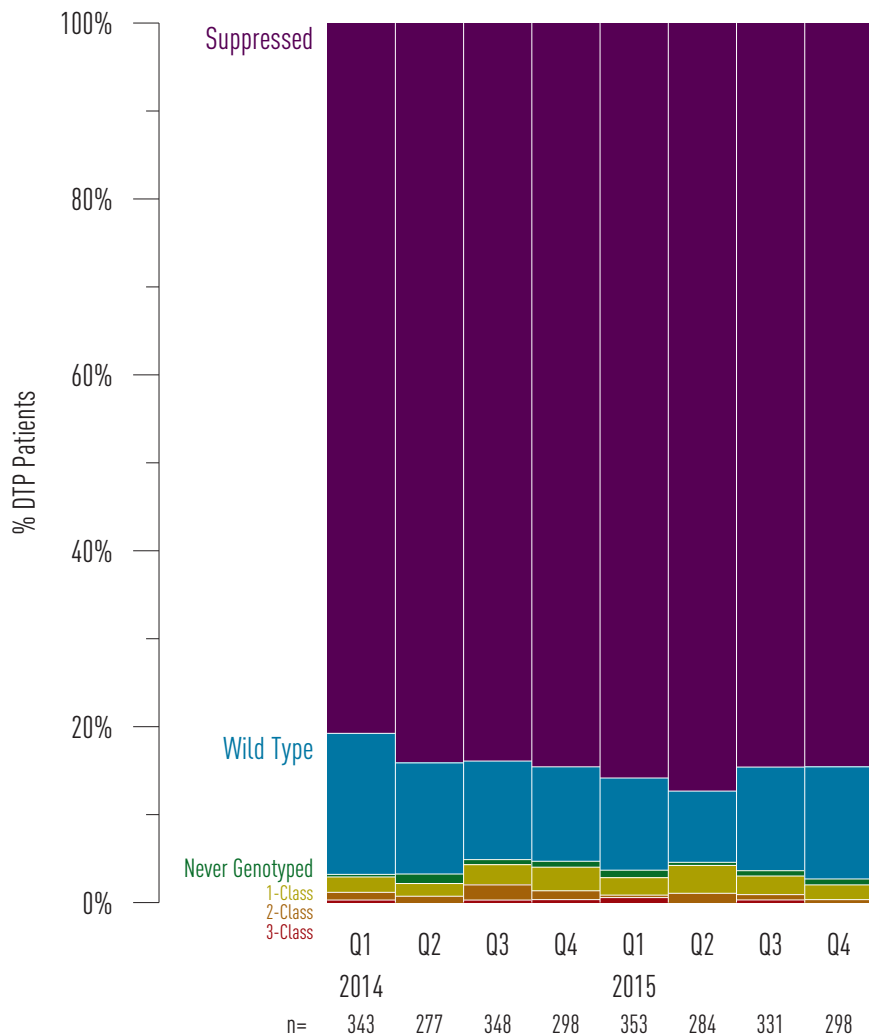
Limitation: Prescription refill adherence is used as a proxy for patient adherence.

Resistance Testing and Results

Indicator 11. Resistance Testing and Results

In this section, we present trends in cumulative resistance testing by resistance category: **Suppressed** (where a DTP participant's viral load is too low to be genotyped); **Wild Type** (where no HIV treatment resistances were discovered), **Never Genotyped**, and Resistances to **one, two, three, or four** HIV treatment classes. Resistance testing prior to ART initiation is recommended in the BC HIV treatment primary care guidelines. Thus, it is expected that trends over time should find all persons enrolled in the DTP to have been genotyped. Trends over time should also show an increase in the proportion of DTP participants achieving a suppressed status and an increase in resistance testing should not lead to an increase in the number of ART resistances occurring.

Figure 11 Cumulative Resistance Testing Results by Resistance Category for Interior Health, 2014 Q1–2015 Q4 ¹⁷



¹⁷ Data Source: Drug Treatment Program Database

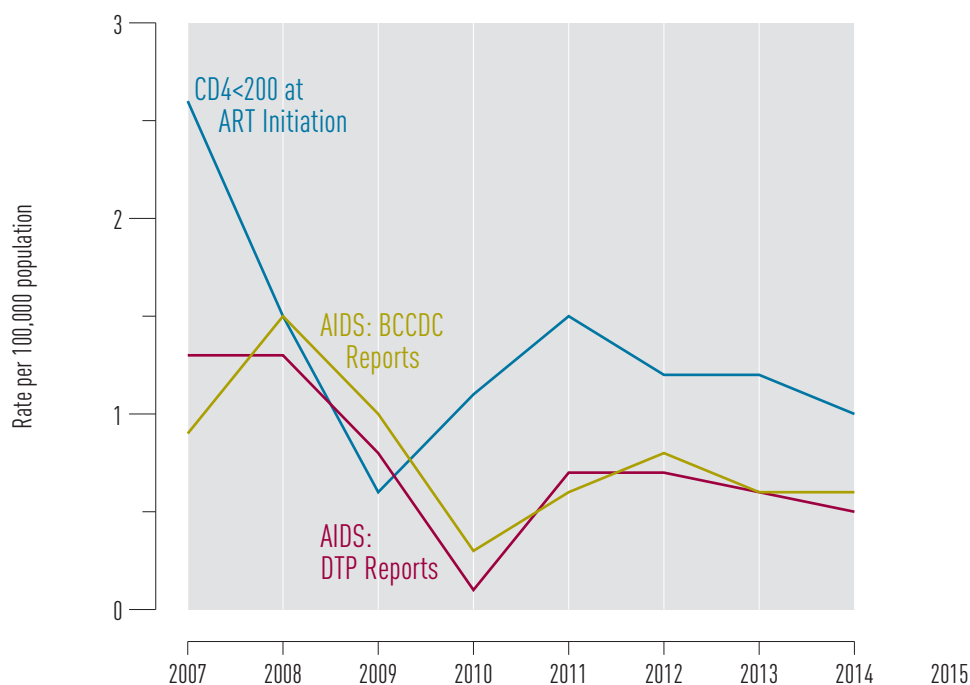
Limitation: DTP participants are designated to a HA based on most current residence provided by the participant.

AIDS-Defining Illness

Indicator 12. AIDS-Defining Illness

Improvements in ART and the expansion of ART province-wide has led to very low numbers of recorded AIDS cases across BC. However, interpreting trends in AIDS cases is challenging as AIDS reporting is passive in BC and it is likely that they are under-reported across all Health Authorities. In addition to under-reporting, methods of reporting AIDS cases are inconsistent across HA's and do not truly reflect the current reality of new AIDS diagnoses. Efforts will need to be made to improve under- and inconsistent reporting of AIDS cases across all HA's. The table below shows AIDS cases using three definitions. First, AIDS cases were defined as the number of physician-reported AIDS defining illness (ADI) in a given year. AIDS case reporting is a passive process and physicians can voluntarily report AIDS cases to the BCCDC or DTP. As such, we have plotted both **BCCDC reports** and **DTP reported AIDS cases**. We also show the proportion of persons **initiating ART with a CD4<200 cells/μL**.

Figure 12 AIDS Case Rate and Reports for Interior Health ¹⁸



CD4<200 at ART initiation	CASES	18	11	≤ 5	8	11	9	9	7	8
	PER 100K	2.6	1.5	0.6	1.1	1.5	1.2	1.2	1.0	-
AIDS: DTP Reports	CASES	9	9	6	≤ 5	≤ 5	≤ 5	≤ 5	≤ 5	≤ 5
	PER 100K	1.3	1.3	0.8	0.1	0.7	0.7	0.6	0.5	-
AIDS: BCCDC Reports	CASES	6	11	7	≤ 5	≤ 5	6	≤ 5	≤ 5	-
	PER 100K	0.9	1.5	1.0	0.3	0.6	0.8	0.6	0.6	-

¹⁸ Data Source: DTP AIDS cases are obtained from the Drug Treatment Program Database; BCCDC AIDS cases are obtained from the BCCDC; CD4<200 at ART initiation data came from the DTP database.

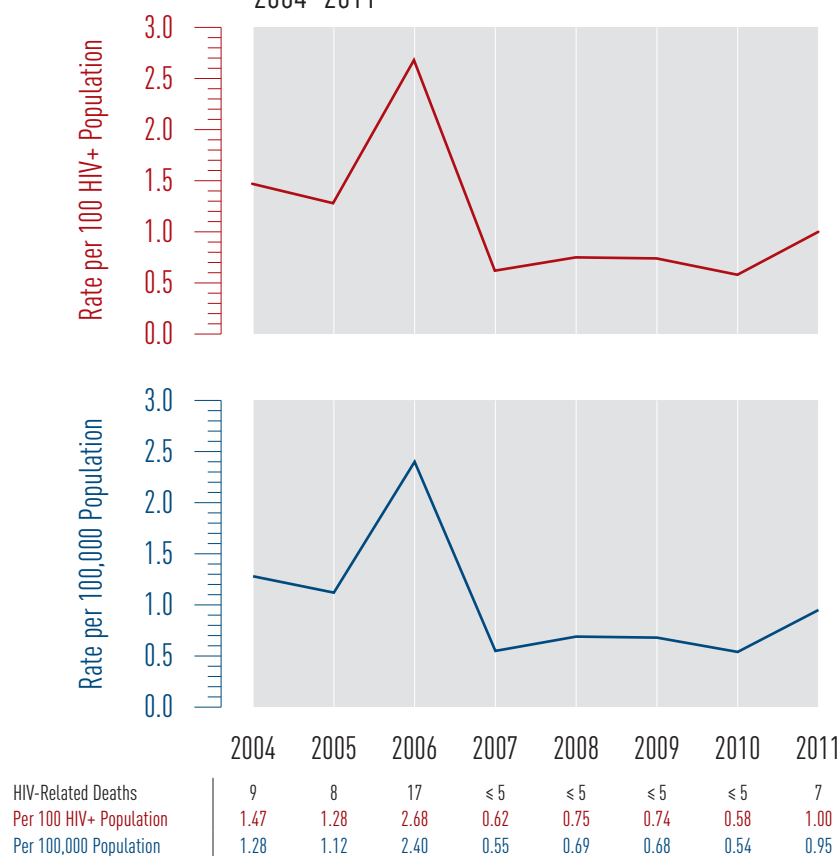
Limitation: AIDS case reporting was investigated using 3 definitions: First, using AIDS cases reported in AIDS case report forms from the DTP; Second, using AIDS cases reported via the BCCDC and third, using a CD4 cell count of <200 cells/μL at time of ART initiation using DTP data. AIDS case reporting is passive in BC, thus; AIDS case reporting is not well captured. The DTP sends out AIDS reporting forms to physicians annually. The BCCDC uses DTP AIDS case reports as well as physician AIDS case reports made directly to the BCCDC. Interpreting AIDS case reports should be done with these limitations in mind. AIDS data is updated annually as very few AIDS cases reports are reported in general and trends would be difficult to notice if reported quarterly.

HIV-Related Mortality

Indicator 13. HIV-Related Mortality

Evidence indicates that individuals who initiate treatment with recommended ART in a timely fashion may live near normal lifespans. Excess mortality among HIV positive persons is, therefore, an important measure of HIV care with a goal of minimizing HIV-related mortality in British Columbia.

Figure 13 HIV-Related Deaths by Year for Interior Health, 2004–2011¹⁹



¹⁹ Data Source: BC Vital Statistics

Limitation:

1. DTP participants are designated to an HA based on most current residence provided by the participant.
2. Mortality data is updated annually.
3. The most recent available data was used.

Appendices

Indicator 1: Test Episodes (thousands)		2011				2012				2013				2014				2015			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Interior Health		4.1	3.8	3.9	4.1	4.1	4.0	4.3	4.2	4.4	4.7	4.6	4.9	5.3	5.5	5.6	5.9	6.6	7.1	7.9	9.1
Gender	Female	2.0	2.0	2.0	2.1	2.1	2.0	2.1	2.0	2.1	2.3	2.2	2.4	2.6	2.6	2.7	2.8	3.2	3.5	3.9	4.5
	Male	2.0	1.8	1.8	2.0	2.0	1.9	2.1	2.1	2.2	2.3	2.3	2.4	2.6	2.8	2.7	2.9	3.2	3.4	3.8	4.4
	Other	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Age	< 30	1.5	1.4	1.4	1.5	1.5	1.4	1.5	1.4	1.4	1.5	1.6	1.6	1.8	1.7	1.8	1.8	2.0	2.0	2.2	2.4
	30–39	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.9	1.0	1.0	1.0	1.0	1.1	1.2	1.2	1.2	1.4	1.4	1.5	1.6
	40–49	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.9	1.0	1.0	1.1	1.3
	≥ 50	1.0	0.8	0.9	1.0	1.0	1.1	1.1	1.1	1.2	1.4	1.3	1.5	1.5	1.7	1.7	1.8	2.2	2.5	2.8	3.7
POC HIV Tests (not in thousands)		0	10	34	21	26	28	20	27	38	38	40	37	93	86	163	202	180	130	179	188
East Kootenay		0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.5	0.5	0.4	0.5	0.5	0.6	0.8	0.8
	Female	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4
	Male	0.2	0.1	0.1	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4
Kootenay Boundary		0.5	0.4	0.4	0.5	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.8	0.8	0.8	1.0
	Female	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.5
	Male	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.5
Okanagan		2.2	2.0	2.1	2.3	2.3	2.3	2.4	2.1	2.2	2.5	2.4	2.5	2.7	2.8	2.8	2.9	3.4	3.4	4.0	4.6
	Female	1.1	1.0	1.1	1.1	1.2	1.2	1.2	1.0	1.0	1.2	1.1	1.2	1.3	1.3	1.4	1.4	1.6	1.7	1.9	2.2
	Male	1.0	0.9	1.0	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.2	1.3	1.3	1.4	1.3	1.4	1.6	1.6	1.9	2.2
Thompson Cariboo Shuswap		1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.2	1.3	1.4	1.4	1.4	1.6	1.7	1.7	1.8	2.0	2.2	2.3	2.8
	Female	0.6	0.6	0.5	0.5	0.5	0.5	0.5	0.6	0.7	0.7	0.7	0.7	0.8	0.8	0.8	0.8	1.0	1.0	1.1	1.4
	Male	0.6	0.5	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.9	0.9	1.0	1.1	1.1	1.3

Indicator 2: **Rate of HIV Testing per 100,000**

		2009	2010	2011	2012	2013	2014	2015
All Interior Health		2026.9	2072.7	2093.2	2182.3	2551.9	2967.4	4049.4
East Kootenay		1632.2	1833.2	1701.2	1802.9	1977.1	2386.8	3374.2
Kootenay Boundary		2358.9	2312.9	2260.6	2219.2	2628.5	3178.3	4605.0
Okanagan		2167.0	2162.6	2194.2	2332.7	2650.0	3002.1	4035.7
Thompson Cariboo Shuswap		1826.1	1928.8	2010.8	2062.9	2570.3	3040.7	4112.3
Gender	Female	1987.3	1993.8	2040.3	2141.4	2530.4	2926.1	4077.6
	Male	1933.1	2007.8	2044.4	2175.0	2530.5	2968.7	3955.8
Age	< 30	2333.3	2343.6	2388.0	2364.3	2625.3	3034.3	3649.6
	30–39	3925.4	4128.7	4194.8	4315.7	4908.5	5530.4	6775.9
	40–49	2479.2	2521.0	2591.0	2776.8	3161.2	3689.7	4863.5
	≥ 50	1108.1	1164.3	1175.6	1342.3	1747.7	2100.4	3428.7

Indicator 3: New HIV Diagnoses		2011				2012				2013				2014				2015			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Interior Health	By Client Residence	1	4	3	3	5	5	0	2	1	4	4	4	3	4	4	6	5	1	5	4
	By Provider Address	1	3	2	3	5	5	0	2	1	5	4	4	3	2	4	5	5	1	6	5
Gender	Female	0	2	1	0	1	1	0	0	0	1	1	1	1	0	1	0	0	0	0	1
	Male	1	2	2	3	4	4	0	2	1	3	3	3	2	4	3	6	5	1	5	3
Age	< 30	0	1	0	0	1	1	0	1	0	0	2	2	0	1	1	2	2	0	3	2
	30–39	1	0	3	1	1	1	0	0	0	0	2	1	0	1	3	2	0	0	0	1
	40–49	0	3	0	1	2	1	0	1	0	1	0	1	1	1	0	1	1	1	2	1
	≥ 50	0	0	0	1	1	2	0	0	1	3	0	0	2	1	0	1	2	0	0	0
Exposure	MSM	0	0	1	2	1	2	0	1	0	0	2	1	0	2	2	5	3	0	–	–
	PWID	0	0	1	0	2	1	0	1	0	0	0	0	2	1	1	0	0	0	–	–
	HET	1	2	1	1	2	2	0	0	1	2	2	3	1	1	1	1	2	0	–	–
	Other	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	–	–
	NIR/Unknown	0	1	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	1	–	–
East Kootenay	By Client Residence	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0
	By Provider Address	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0	1	0	1	1
Kootenay Boundary	By Client Residence	0	0	1	0	1	2	0	0	0	1	0	0	0	1	0	0	1	0	0	0
	By Provider Address	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	1	0	0	0
Okanagan	By Client Residence	1	3	0	3	1	3	0	1	1	0	3	2	2	1	2	2	1	0	4	3
	By Provider Address	1	2	1	3	1	4	0	1	1	1	3	2	2	0	2	3	0	0	4	3
Thompson Cariboo Shuswap	By Client Residence	0	1	2	0	1	0	0	1	0	2	1	2	1	2	2	4	2	1	1	1
	By Provider Address	0	1	1	0	1	0	0	1	0	2	1	2	1	1	2	2	3	1	1	1

Indicator 4: Stage of HIV Infection at Baseline

	Interior Health					Female					Male					< 30 years					30–39 years					40–49 years				
	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14
Stage 0	1	2	0	1	5	1	0	0	0	1	0	2	0	1	4	0	0	0	1	3	0	2	0	0	1	1	0	0	0	0
Stage 1	2	1	1	3	3	1	0	0	1	1	1	1	1	2	2	1	0	1	2	0	0	0	0	0	1	1	0	0	1	0
Stage 2a	1	0	1	1	2	0	0	0	1	0	1	0	1	0	2	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0
Stage 2b	1	1	2	2	1	1	0	1	0	0	0	1	1	2	1	0	0	1	1	0	0	0	0	1	1	0	0	1	0	0
Stage 3	4	4	8	7	4	0	1	1	1	0	4	3	7	6	3	0	0	1	0	0	0	2	1	2	2	3	2	3	1	1
Unknown	1	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0
Total	10	9	12	14	15	3	1	2	3	2	7	8	10	11	12	1	0	3	5	3	0	4	1	3	6	7	3	5	2	1
	≥ 50 years					MSM					PWID					Heterosexual					Other Exposure					NIR/Unknown				
	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14	'10	'11	'12	'13	'14
Stage 0	0	0	0	0	1	0	1	0	1	4	0	0	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0
Stage 1	0	1	0	0	2	0	0	0	0	0	1	0	1	0	2	1	1	0	2	1	0	0	0	0	0	0	0	0	1	0
Stage 2a	0	0	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
Stage 2b	1	1	0	0	0	0	0	1	2	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Stage 3	1	0	3	4	1	2	2	3	1	1	1	1	1	0	2	1	1	4	5	1	0	0	0	0	0	0	0	0	1	0
Unknown	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Total	2	2	3	4	5	4	3	4	4	7	2	1	4	0	4	4	4	4	8	4	0	0	0	0	0	0	1	0	2	0

Indicator 5: HIV Cascade of Care			DIAGNOSED	LINKED	RETAINED	ON ART	ADHERENT	SUPPRESSED
Interior Health			605	585	489	459	427	352
Age Category	< 30		32	27	19	16	10	8
	30–39		66	64	53	50	47	39
	40–49		136	131	113	103	96	76
	≥ 50		371	363	306	290	274	229
Age Category and MSM Status	MSM	< 30	11	10	7	7	5	3
		30–39	12	12	9	8	8	6
		40–49	26	23	23	22	21	19
		≥ 50	115	115	102	99	94	81
	Non-MSM	< 30	6	6	4	2	1	1
		30–39	21	20	19	18	18	15
		40–49	55	54	49	44	40	31
		≥ 50	141	139	120	112	102	84
	Unknown	< 30	16	12	7	7	4	4
		30–39	33	32	25	24	21	18
		40–49	55	54	41	37	35	26
		≥ 50	115	110	84	79	78	64
Gender	Male		469	456	383	360	336	281
	Female		136	129	106	99	91	71
Injection Drug Use	PWID		184	182	161	149	137	113
	Non-PWID		292	285	251	238	223	183
	Unknown		129	118	77	72	67	56
MSM Status	MSM		163	160	141	136	128	109
	Non-MSM		222	218	191	176	161	131
	Unknown		219	208	157	147	138	112
Health Authority	East Kootenay		38	36	25	22	21	19
	Kootenay Boundary		65	65	54	52	50	45
	Okanagan		315	304	263	250	231	185
	Thompson Cariboo Shuswap		190	182	147	135	125	103

Indicator 6: **Programmatic Compliance Score (PCS)**

	2014 Q1	Q2	Q3	Q4	2015 Q1	Q2	Q3	Q4
< 3 CD4 Tests	16.7%	31.2%	35.3%	33.3%	31.6%	22.2%	16.7%	20.0%
< 3 Viral Load Tests	12.5%	25.0%	23.5%	22.2%	21.1%	11.1%	5.6%	10.0%
No Baseline Genotype	4.2%	0.0%	5.9%	5.6%	5.3%	5.6%	0.0%	0.0%
Baseline CD4 < 200 cells/μL	29.2%	43.8%	29.4%	38.9%	36.8%	27.8%	50.0%	35.0%
Non-Recommended ART	8.3%	12.5%	11.8%	5.6%	5.3%	5.6%	0.0%	5.0%
Non Viral suppression at 9 Mo.	37.5%	56.2%	47.1%	44.4%	36.8%	22.2%	22.2%	20.0%
PCS Score: 0	9	4	5	6	7	8	7	9
PCS Score: 1	9	6	6	5	5	6	7	7
PCS Score: 2	3	1	1	2	3	2	3	2
PCS Score: 3	1	1	2	2	1	1	0	1
PCS Score: 4 or more	2	4	3	3	3	1	1	1
Total (n=)	24	16	17	18	19	18	18	20

Indicator 7: New DTP ARV Participants

	2014 Q1	Q2	Q3	Q4	2015 Q1	Q2	Q3	Q4
First Starts	9	3	5	5	8	5	5	7
Experienced Starts	16	5	5	6	13	8	11	15

Indicator 8: CD4 Cell Count at ART Initiation for ARV-Naïve DTP Participants

CD4 ≥ 500	2	–	–	–	1	–	–	1
CD4 350–499	0	–	–	–	2	–	–	0
CD4 200–349	4	–	–	–	2	–	–	2
CD4 50–199	3	–	–	–	0	–	–	4
CD4 < 50	0	–	–	–	2	–	–	0
<i>CD4 Median (cells/μL)</i>	<i>270</i>	<i>–</i>	<i>–</i>	<i>–</i>	<i>310</i>	<i>–</i>	<i>–</i>	<i>190</i>
Total (n=)	9	≤ 5	≤ 5	≤ 5	7	≤ 5	≤ 5	7

Indicator 9: Active and Inactive DTP Participants

Active DTP Participants	431	430	431	427	440	444	455	478
Inactive DTP Participants	75	75	78	80	81	80	79	76

Indicator 10: Antiretroviral Adherence

≥ 95%	6	–	4	–	7	–	3	5
80% to < 95%	0	–	2	–	1	–	2	2
40% to < 80%	1	–	1	–	2	–	2	0
< 40%	1	–	0	–	0	–	1	0
Total (n=)	8	≤ 5	7	≤ 5	10	≤ 5	8	7

Indicator 11: Resistance Testing and Results

Suppressed	277	233	292	252	303	248	280	252
Wild Type	55	35	39	32	37	23	39	38
Never Genotyped	1	3	2	2	3	1	2	2
1-Class	6	4	8	8	7	9	7	5
2-Class	3	2	6	3	1	3	2	1
3-Class	1	0	1	1	2	0	1	0
Total (n=)	343	277	348	298	353	284	331	298

Indicator 12: AIDS-Defining Illness

	2007	2008	2009	2010	2011	2012	2013	2014	2015
CD4 < 200 at ART initiation	Cases	18	11	≤ 5	8	11	9	9	8
	<i>Rate per 100,000</i>	<i>2.6</i>	<i>1.5</i>	<i>0.6</i>	<i>1.1</i>	<i>1.5</i>	<i>1.2</i>	<i>1.2</i>	<i>–</i>
AIDS Cases (DTP Reports)	Cases	9	9	6	≤ 5	≤ 5	≤ 5	≤ 5	≤ 5
	<i>Rate per 100,000</i>	<i>1.3</i>	<i>1.3</i>	<i>0.8</i>	<i>0.1</i>	<i>0.7</i>	<i>0.7</i>	<i>0.6</i>	<i>–</i>
AIDS Cases (BCCDC Reports)	Cases	6	11	7	≤ 5	≤ 5	6	≤ 5	–
	<i>Rate per 100,000</i>	<i>0.9</i>	<i>1.5</i>	<i>1.0</i>	<i>0.3</i>	<i>0.6</i>	<i>0.8</i>	<i>0.6</i>	<i>–</i>

Indicator 13: HIV-Related Mortality

	2004	2005	2006	2007	2008	2009	2010	2011
Interior Health	9	8	17	≤ 5	≤ 5	≤ 5	≤ 5	7
Per 100 HIV+ Population	1.47	1.28	2.68	0.62	0.75	0.74	0.58	1.00
Per 100,000 Population	1.28	1.12	2.40	0.55	0.69	0.68	0.54	0.95