



BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

HIV MONITORING QUARTERLY REPORT **FOR VANCOUVER COASTAL HEALTH**

FIRST QUARTER 2014



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. Motoi Matsukura 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. Mark Gilbert 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 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 Vancouver Coastal Health, 2009 Q2–2014 Q1

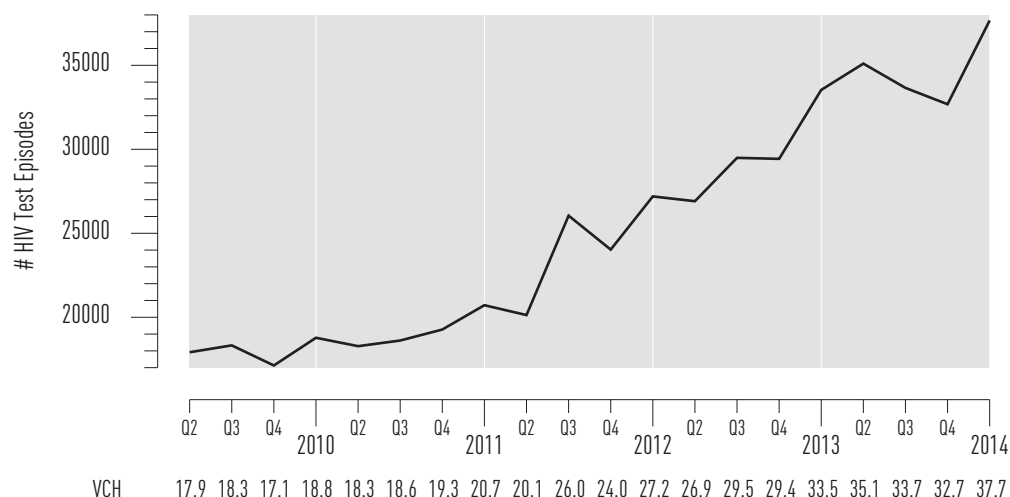
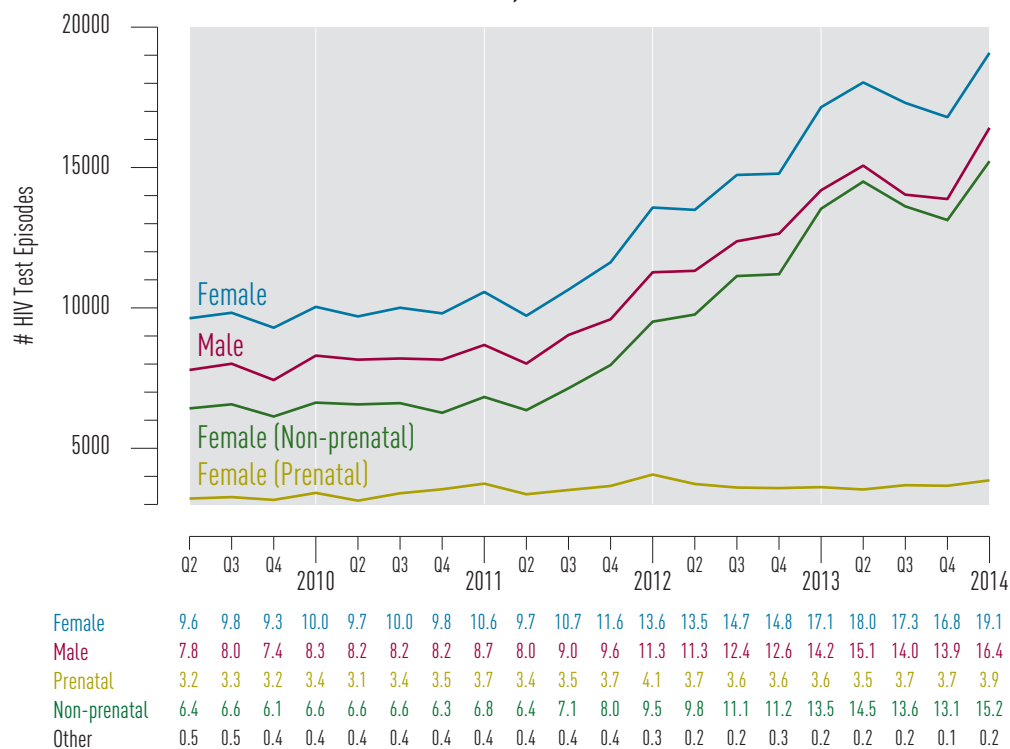


Figure 1.2 HIV Test Episodes by Gender and Prenatal Status for Vancouver Coastal Health, 2009 Q2–2014 Q1¹



1 NB: Testing does not include point of care tests.

Figure 1.3 HIV Test Episodes by Age Category for Vancouver Coastal Health, 2009 Q2–2014 Q1^{1,2}

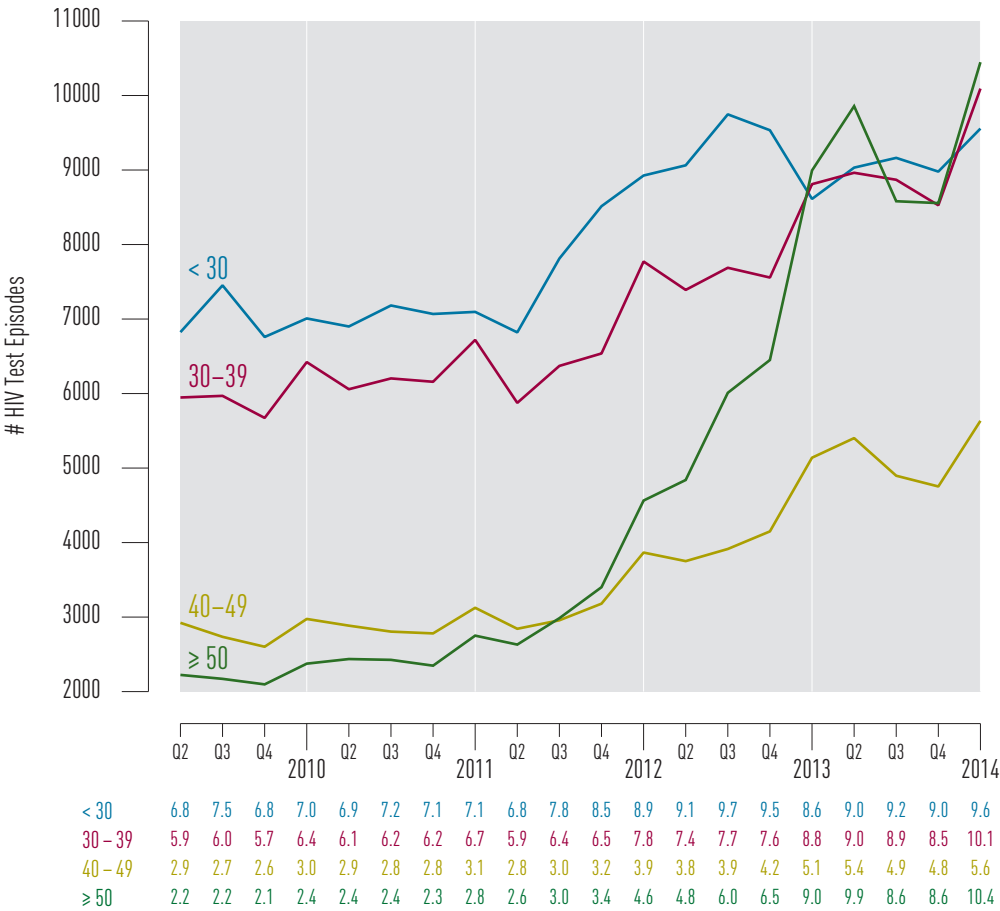
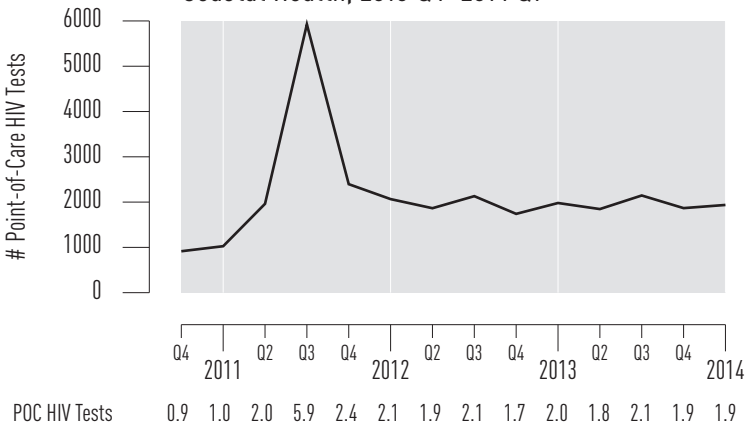


Figure 1.4 Point-of-Care HIV Tests for Vancouver Coastal Health, 2010 Q4–2014 Q1



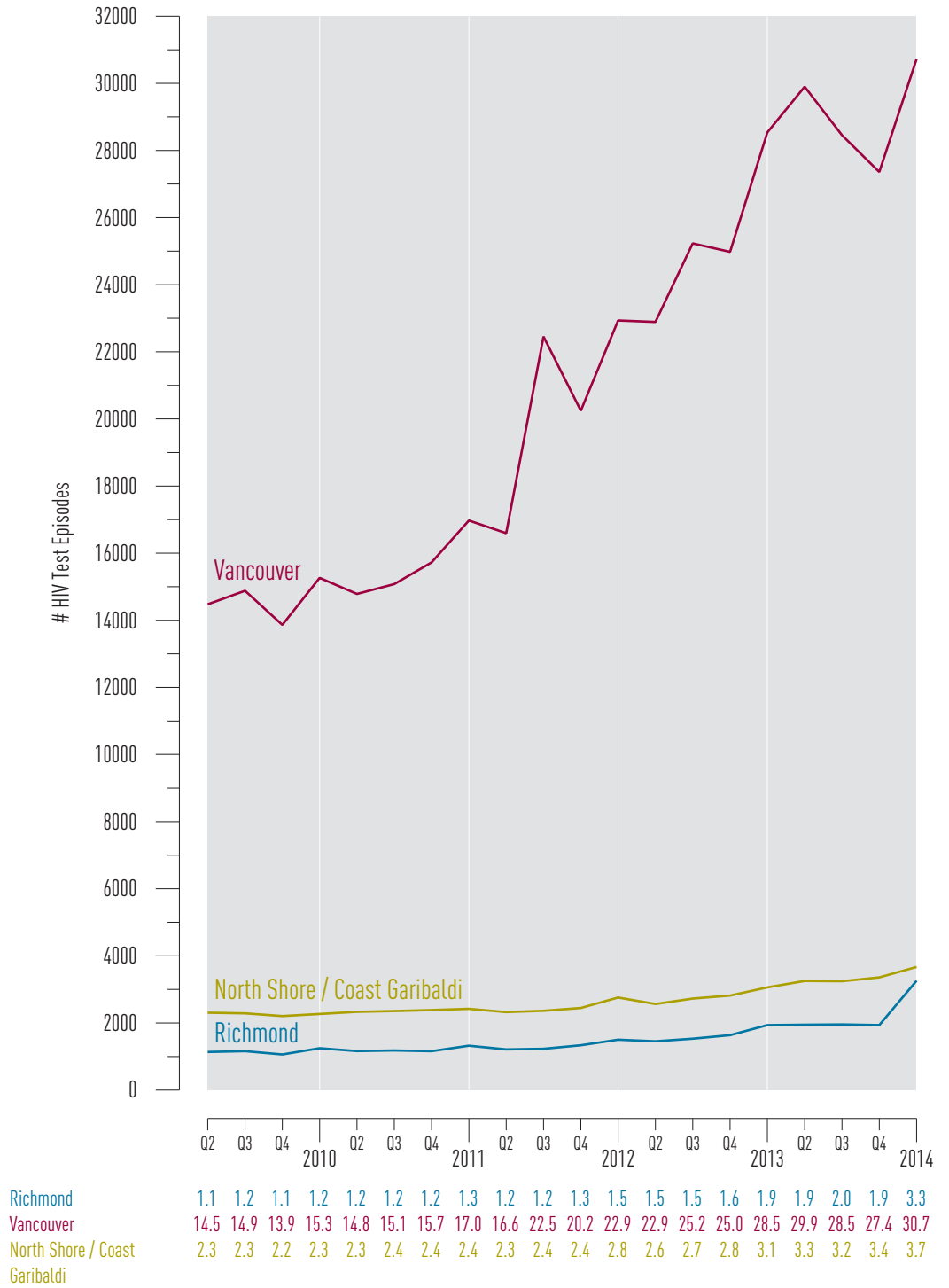
² Data Source: The BC Public Health Microbiology and Reference Laboratory (BCPHMRL) courtesy of the BC Centre for Disease Control (BCCDC).

Limitations:

- 1 Repeat tests in individuals who test using various identifiers may not be identified and these individuals may be counted more than once.
- 2 POC testing data is available from the fourth quarter of 2010 and onwards.

Figure 1.5

HIV Test Episodes for Vancouver Coastal Health, 2009 Q2–2014 Q1



Indicator 2. HIV Testing Rates

Figure 2.1 Rate of HIV Testing for Vancouver Coastal Health and HSDAs, 2009–2013 ¹

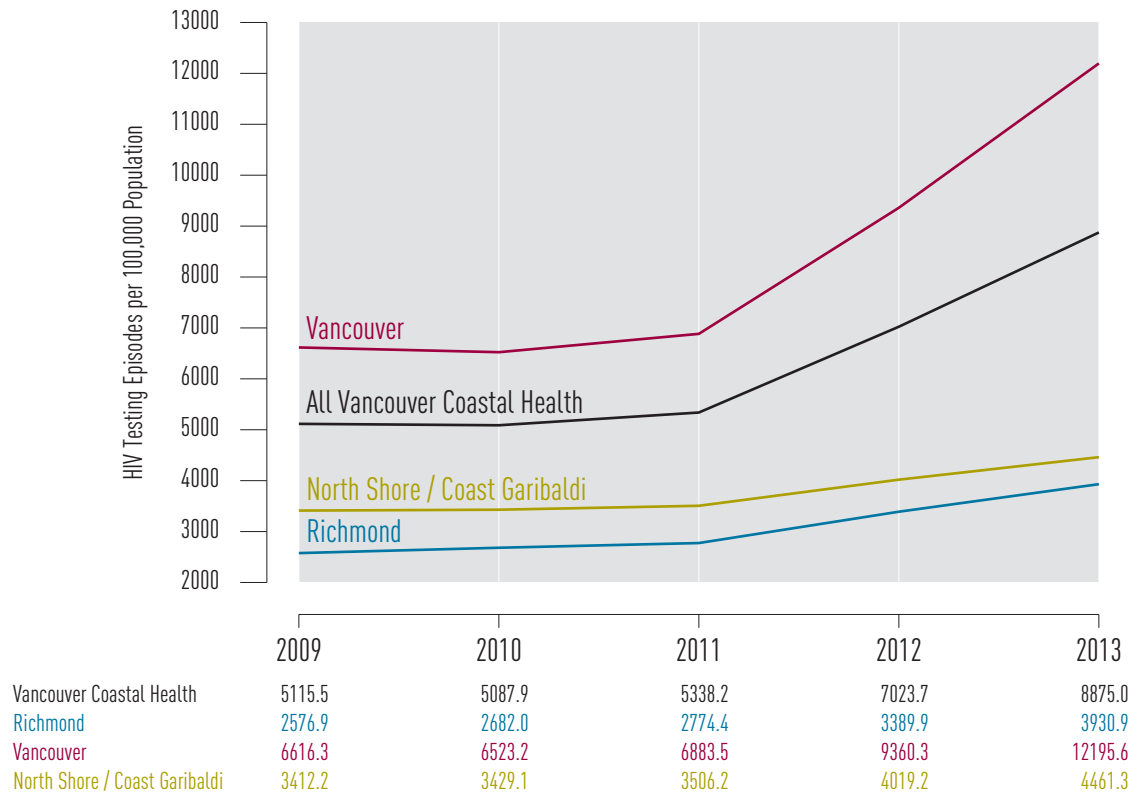


Figure 2.2 Rate of HIV Testing by Gender for Vancouver Coastal Health, 2009–2013 ¹

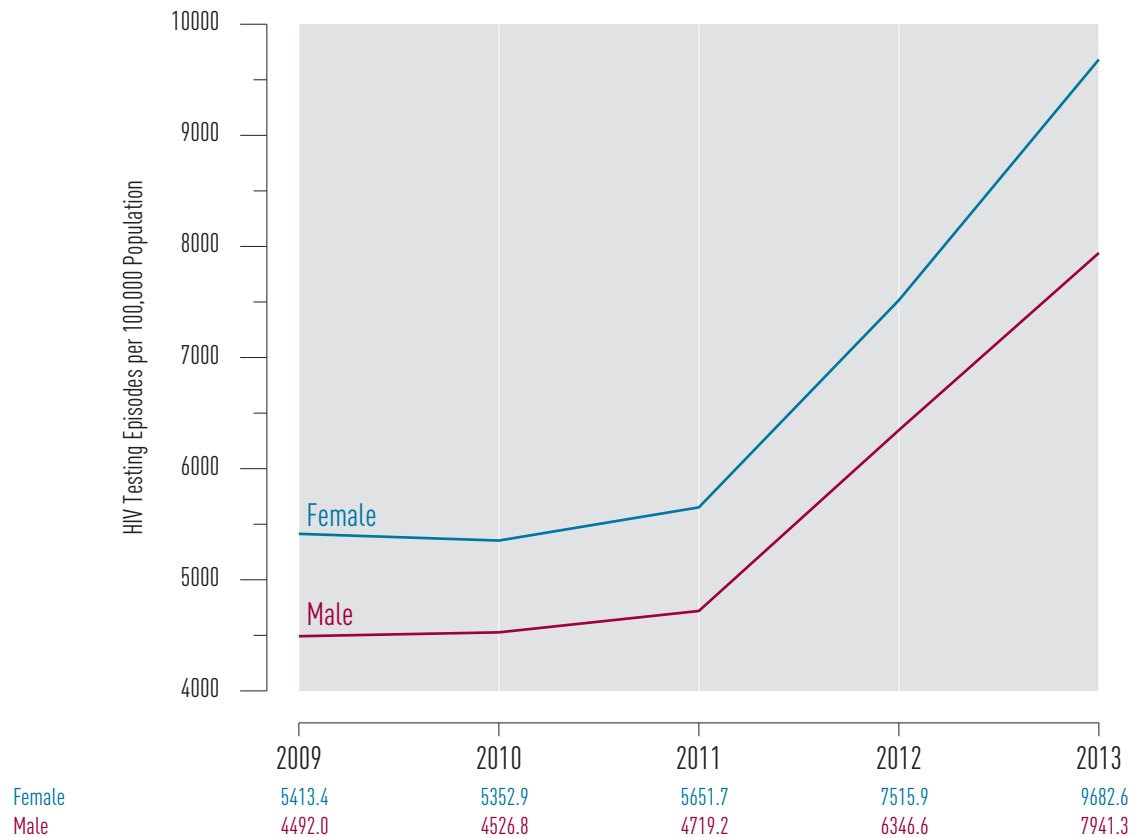
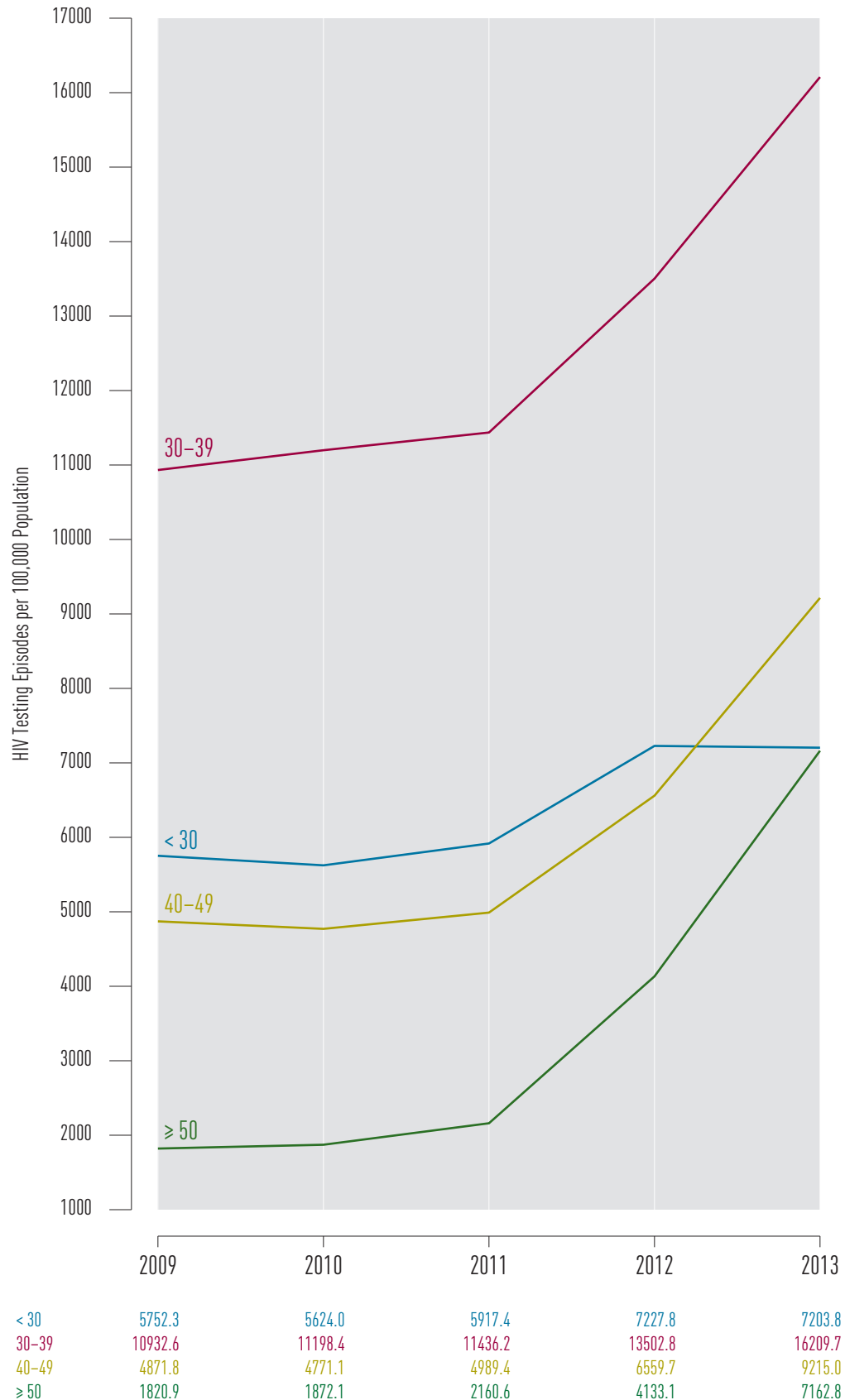


Figure 2.3 Rate of HIV Testing by Age Category for Vancouver Coastal Health, 2009–2013 ¹



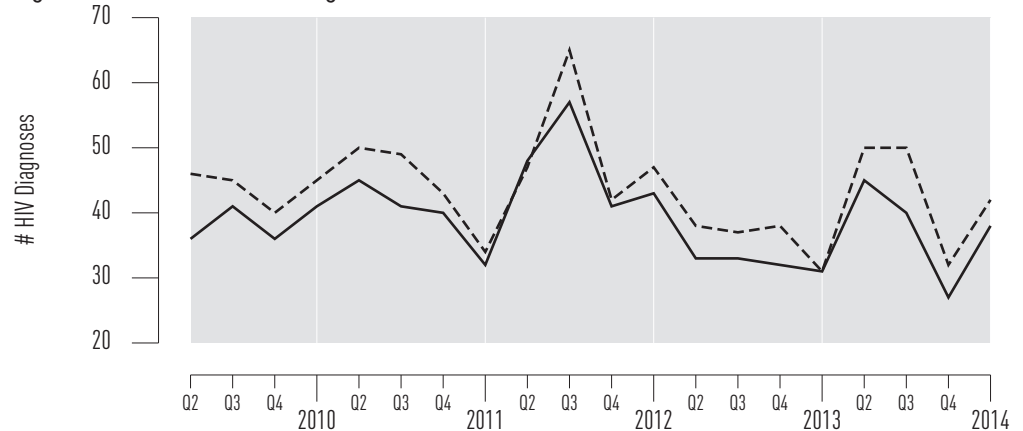
¹ NB: Testing does not include point of care tests.

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.

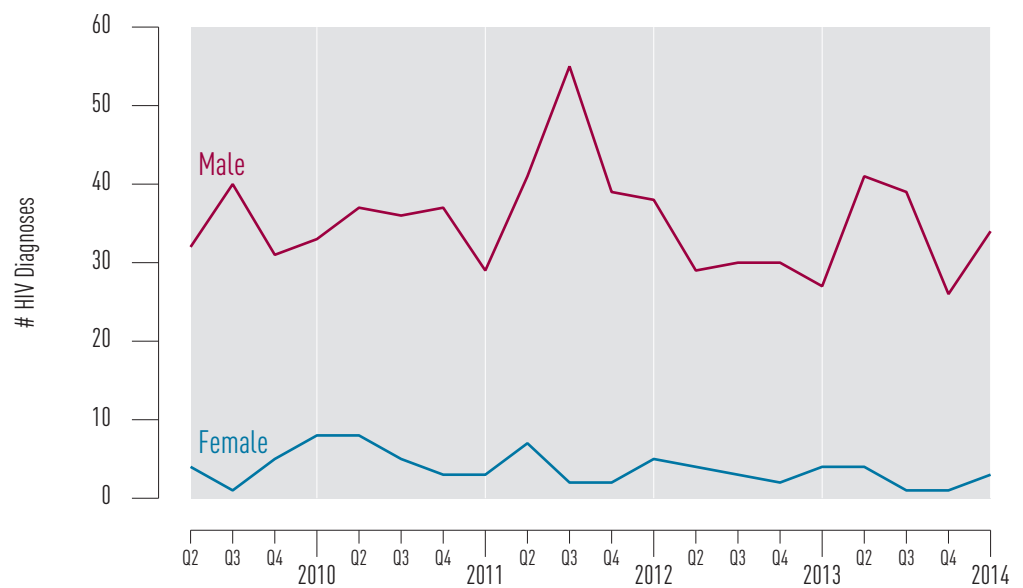
Indicator 3. New HIV Diagnoses

Figure 3.1 New HIV Diagnoses for Vancouver Coastal Health, 2009 Q2–2014 Q1 ³



Vancouver Coastal Health	By Client Residence	36	41	36	41	45	41	40	32	48	57	41	43	33	33	32	31	45	40	27	38
	By Provider Address	46	45	40	45	50	49	43	34	47	65	42	47	38	37	38	31	50	50	32	42

Figure 3.2 New HIV Diagnoses for Vancouver Coastal Health by Gender, 2009 Q2–2014 Q1 ³



Female	4	1	5	8	8	5	3	3	7	2	2	5	4	3	2	4	4	1	1	3
Male	32	40	31	33	37	36	37	29	41	55	39	38	29	30	30	27	41	39	26	34

³ Data Source: BCCDC. "By Provider Address" is graphed as dashed line in same colour.

Figure 3.3 New HIV Diagnoses for Vancouver Coastal Health by Age Category, 2009 Q2–2014 Q1 ³

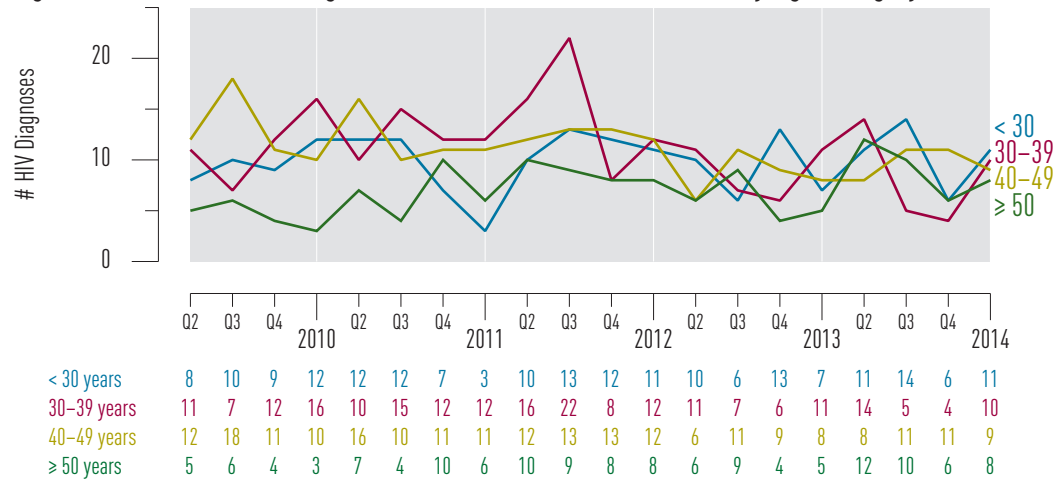
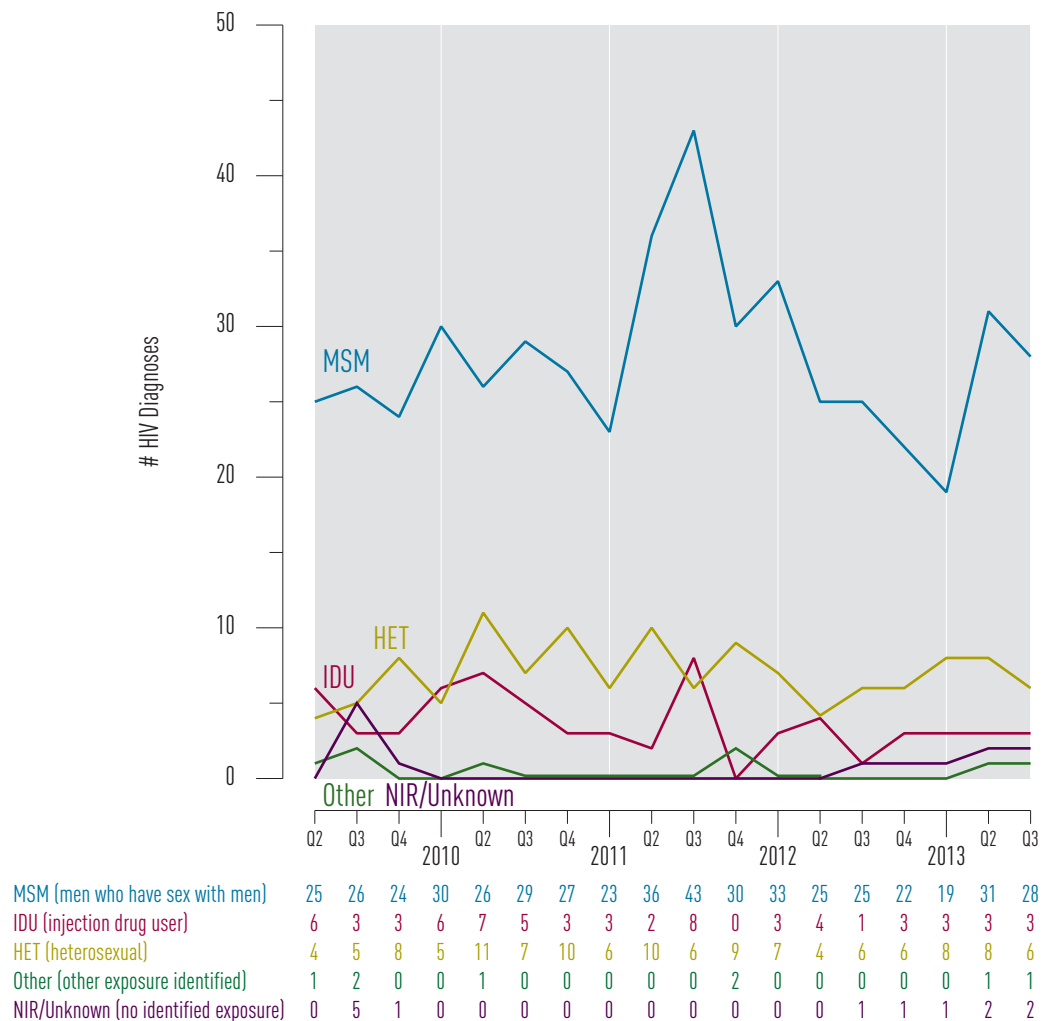


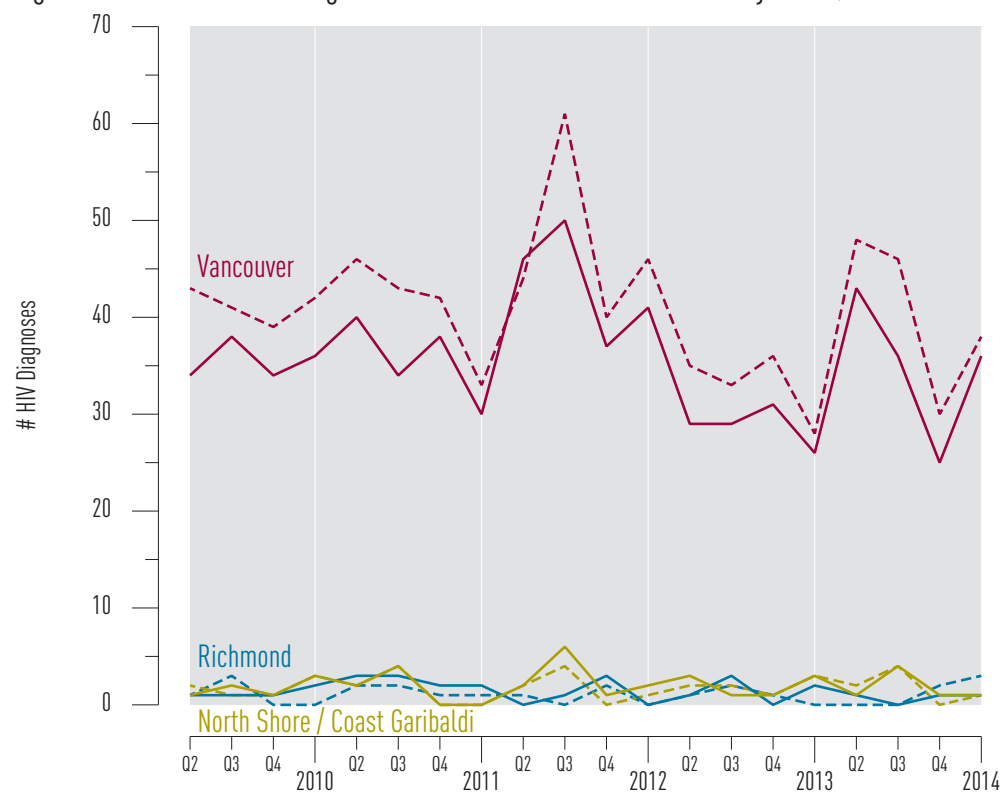
Figure 3.4 New HIV Diagnoses for Vancouver Coastal Health by Exposure Category, 2009 Q2–2013 Q3 ^{3,4}



³ Data Source: BCCDC. "By Provider Address" is graphed as dashed line in same colour.

⁴ MSM=men who have sex with men; IDU= injection drug user; HET=heterosexual. NIR=No identified risk/exposure.

Figure 3.5 New HIV Diagnoses for Vancouver Coastal Health by HSDA, 2009 Q2–2014 Q1 ³



Richmond	By Client Residence	1	1	1	2	3	3	2	2	0	1	3	0	1	3	0	2	1	0	1	1
	By Provider Address	1	3	0	0	2	2	1	1	1	0	2	0	1	2	1	0	0	0	2	3
Vancouver	By Client Residence	34	38	34	36	40	34	38	30	46	50	37	41	29	29	31	26	43	36	25	36
	By Provider Address	43	41	39	42	46	43	42	33	44	61	40	46	35	33	36	28	48	46	30	38
North Shore / Coast Garibaldi	By Client Residence	1	2	1	3	2	4	0	0	2	6	1	2	3	1	1	3	1	4	1	1
	By Provider Address	2	1	1	3	2	4	0	0	2	4	0	1	2	2	1	3	2	4	0	1

³ Data Source: BCCDC. "By Provider Address" is graphed as dashed line in same colour.

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 Vancouver Coastal Health, 2010–2013⁵

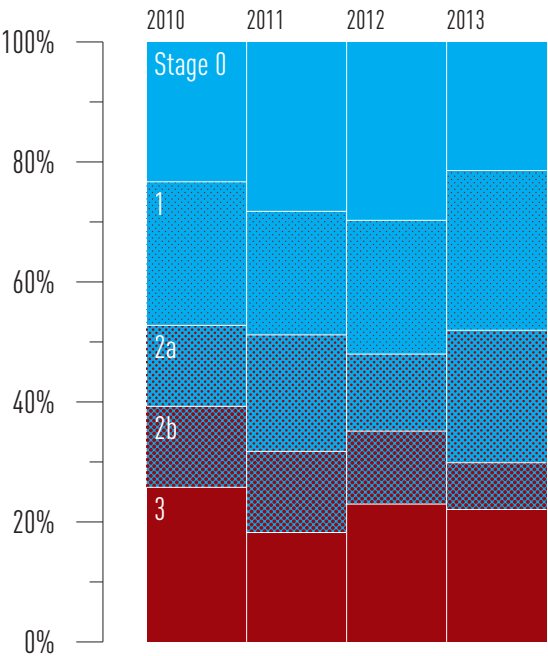
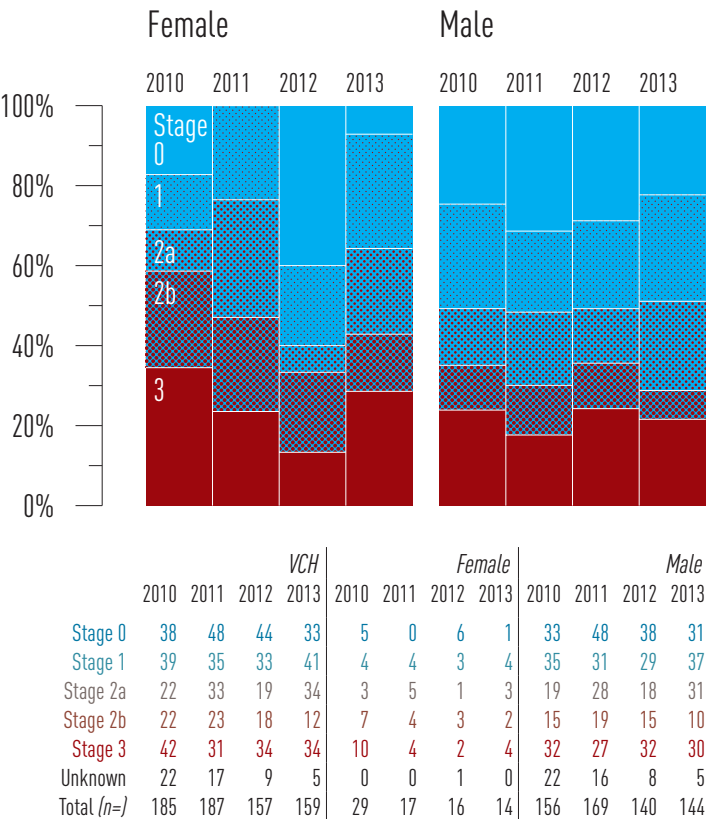


Figure 4.2 Stage of HIV Infection at Diagnosis by Gender for Vancouver Coastal Health, 2010–2013⁵



5 Data Source: BCCDC

Figure 4.3 Stage of HIV Infection at Diagnosis by Age Category for Vancouver Coastal Health, 2010–2013 ⁵

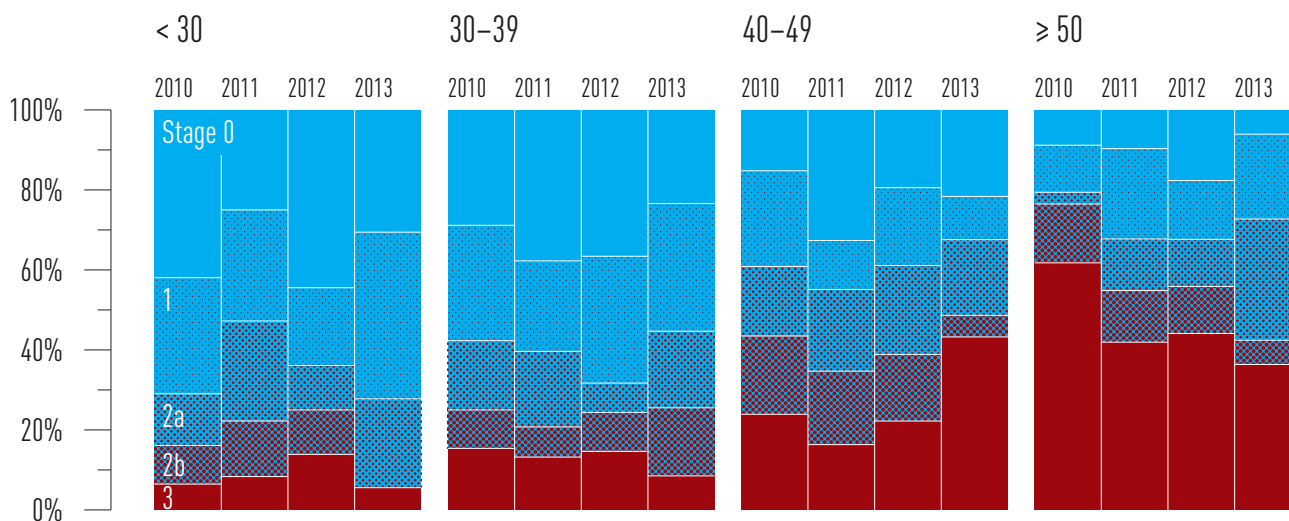
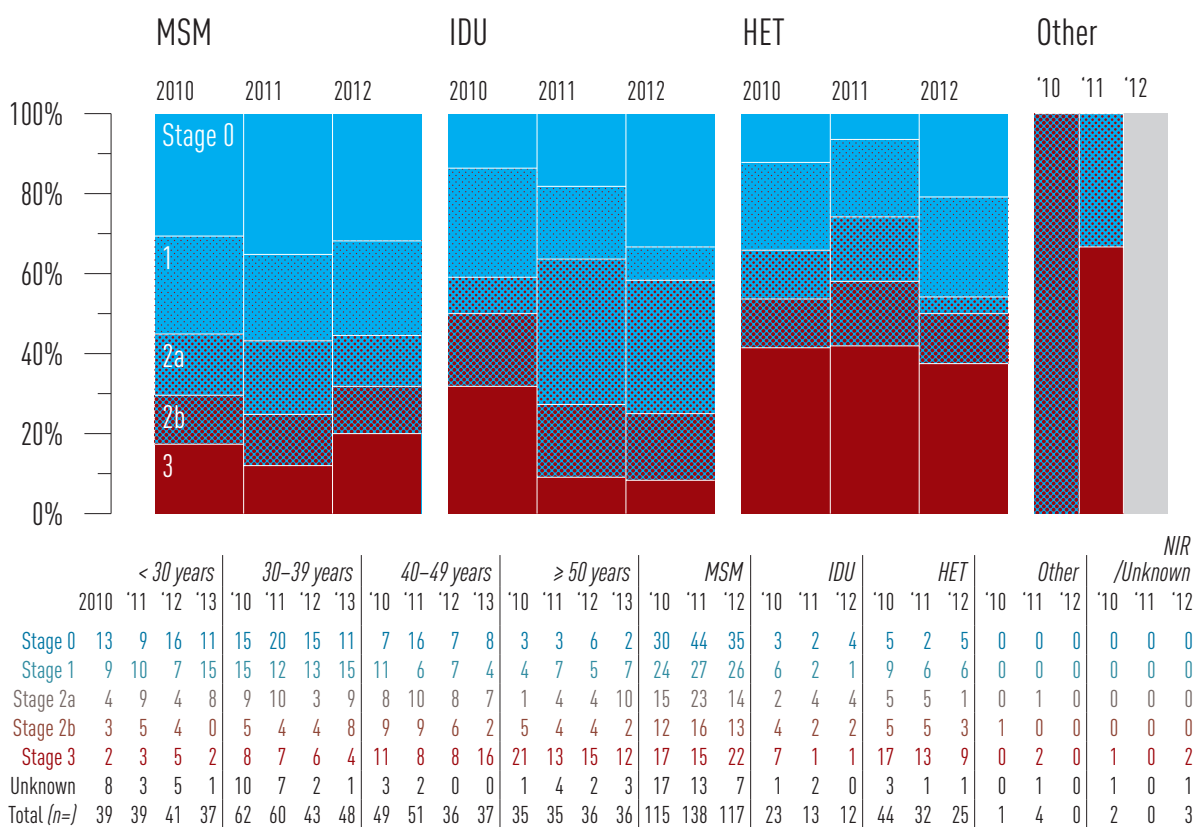


Figure 4.4 Stage of HIV Infection at Diagnosis by Exposure Category for Vancouver Coastal Health, 2010–2012 ^{5,6}



6 MSM=men who have sex with men; IDU= injection drug user; HET=heterosexual. NIR=No identified risk/exposure.

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. Linkage to HIV care, 3. Retention in HIV care, 4. On ART and 5. 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 (ie. 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 year 2012 in BC overall and stratified by sex and age for each Health Authority.

Figure 5.1 Estimated Cascade of Care for Vancouver Coastal Health, Year Ending 2014 Q1 ⁷

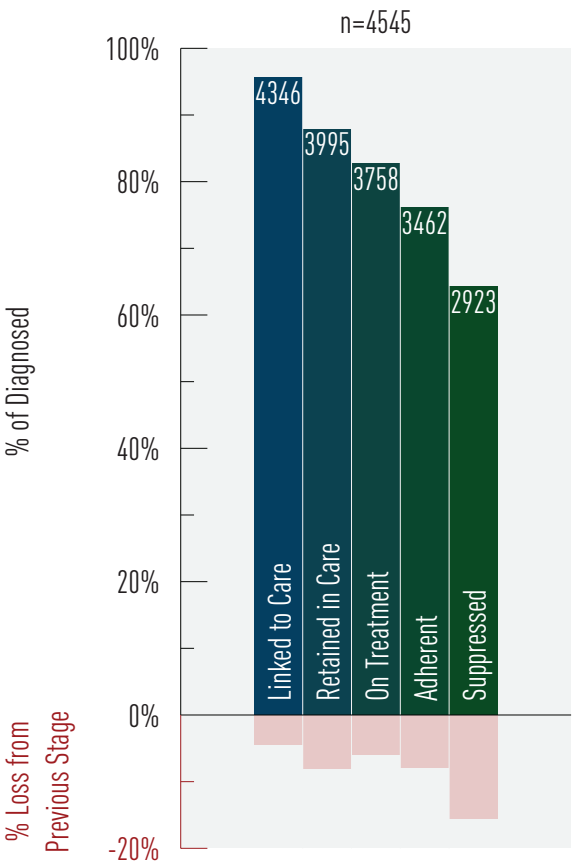
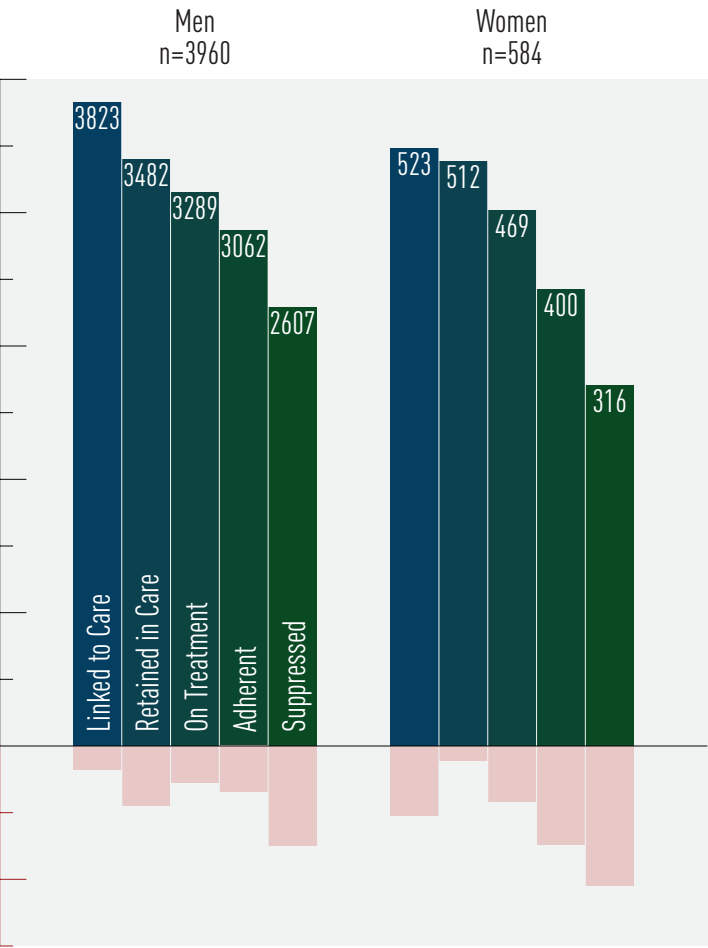


Figure 5.2 Estimated Cascade of Care for Vancouver Coastal Health by Gender, Year Ending 2014 Q1 ⁸



7,8 Data is for the period 2013 Q2–2014 Q1.

Data Sources:

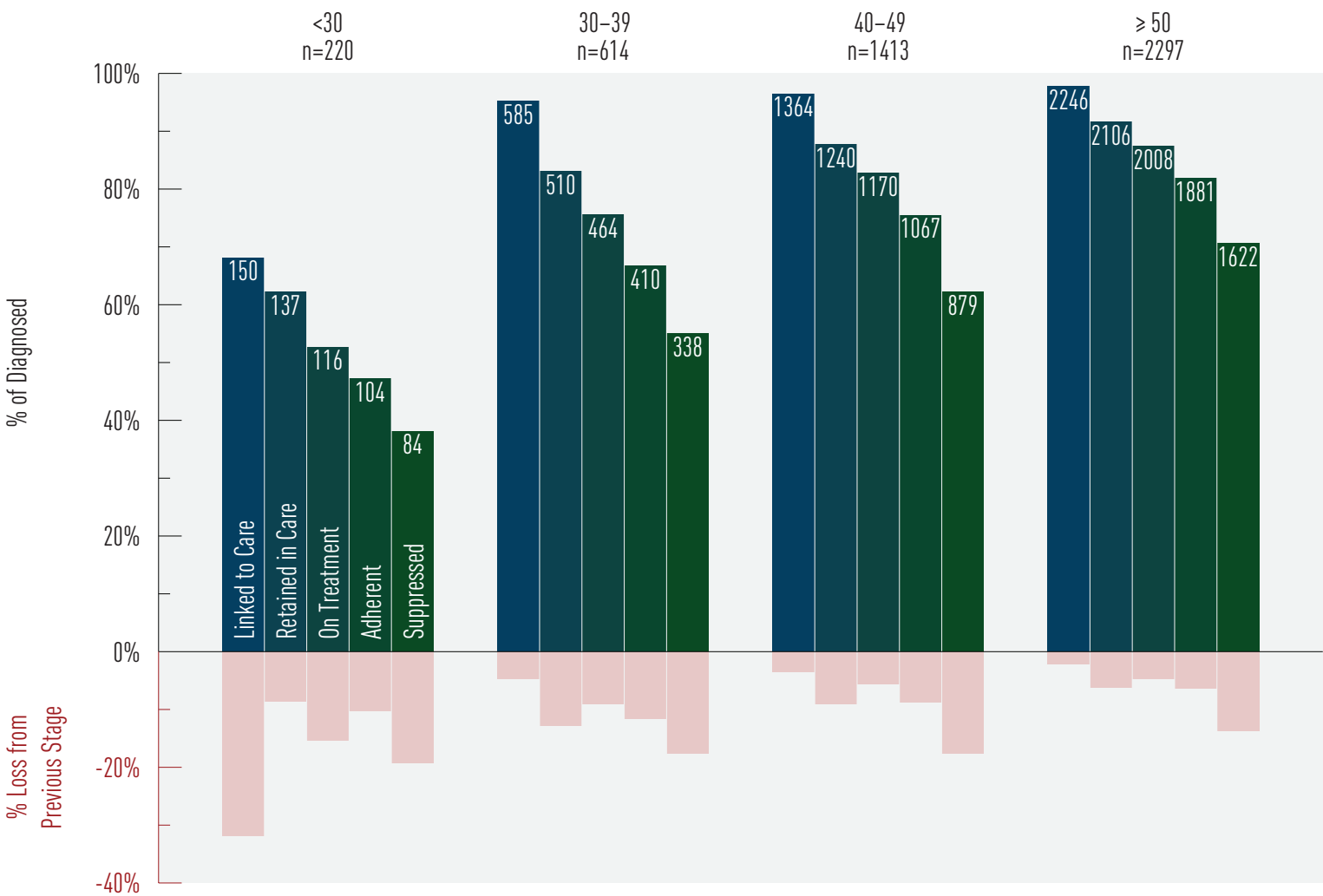
1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).

2 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.

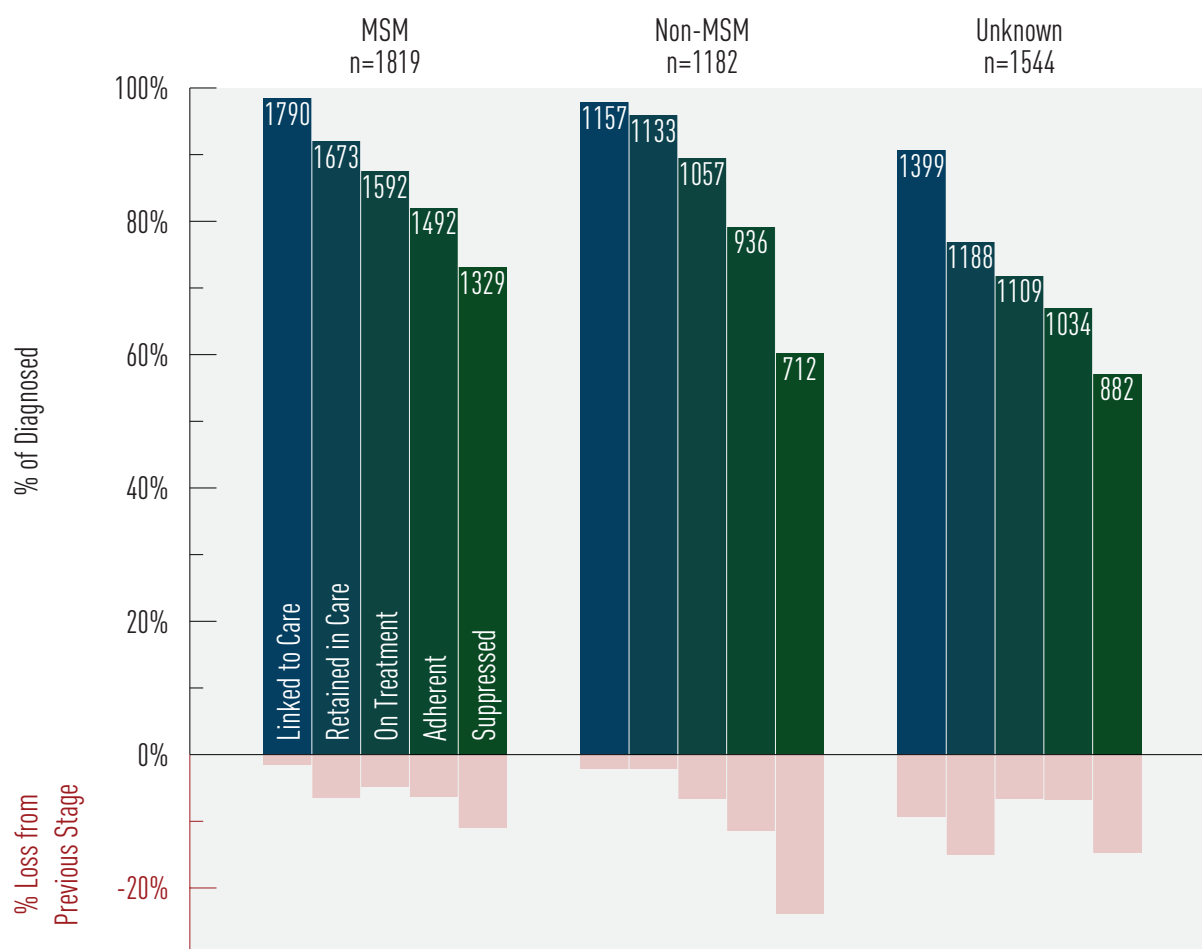
NB: Transgender has been assigned to their biological sex.

Figure 5.3 Estimated Cascade of Care for Vancouver Coastal Health by Age Category, Year Ending 2014 Q1 ⁹



⁹ Data is for the period 2013 Q2–2014 Q1.
Data Sources:
1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
2 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 Vancouver Coastal Health by MSM Status, Year Ending 2014 Q1 ¹⁰



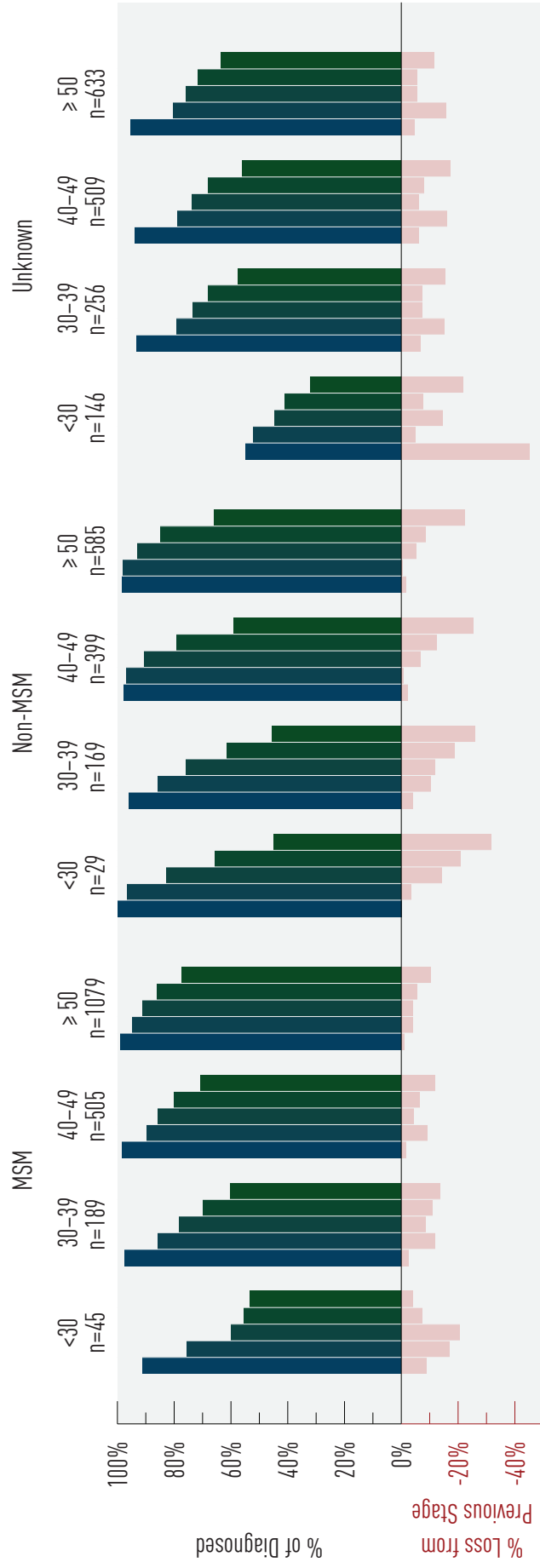
¹⁰ Data is for the period 2013 Q2–2014 Q1.

Data Sources:

- 1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- 2 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 5.5 Estimated Cascade of Care for Vancouver Coastal Health by Age Category and MSM Status, Year Ending 2014 Q1 ¹¹



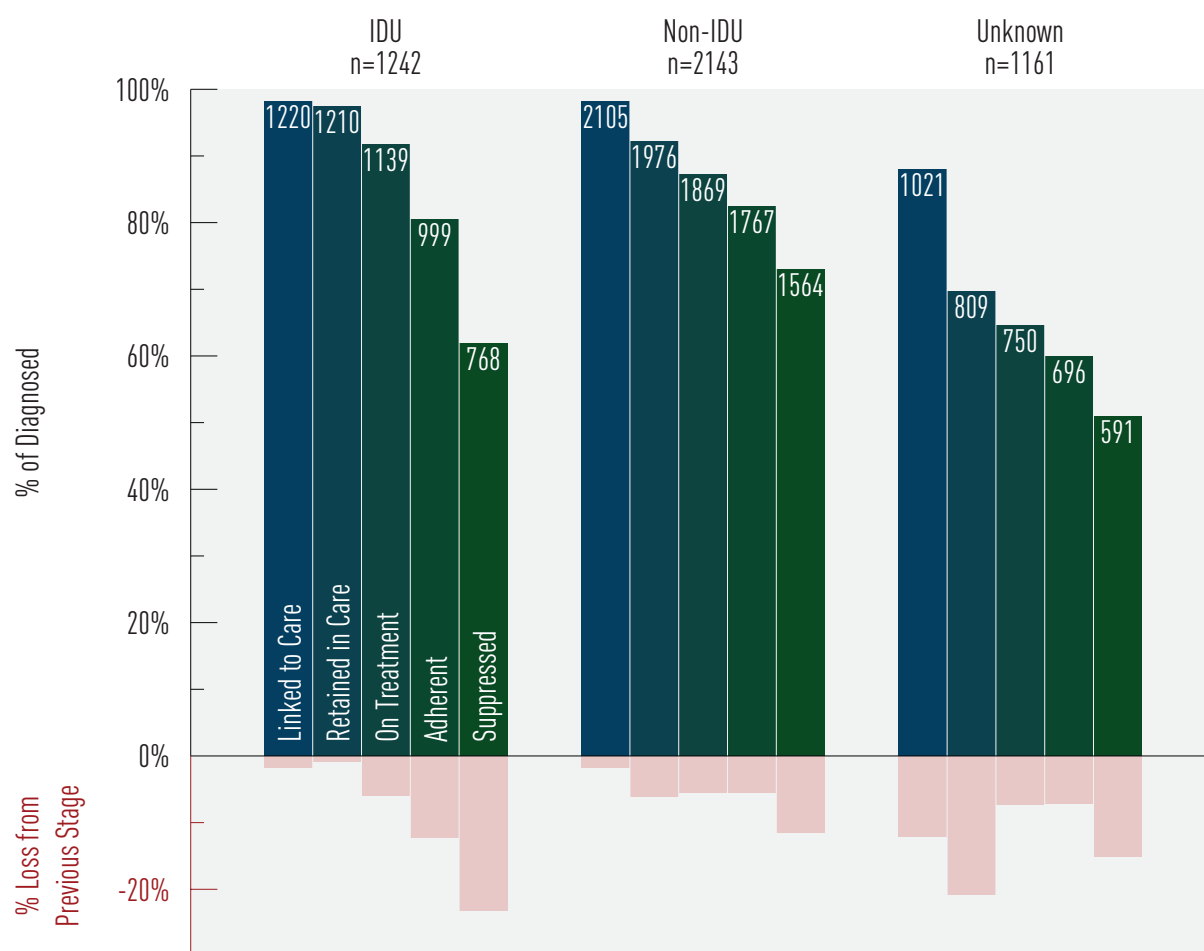
¹¹ Data is for the period 2013 Q2–2014 Q1.

Data Sources:

- 1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- 2 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 5.6 Estimated Cascade of Care for Vancouver Coastal Health by History of IDU, Year Ending 2014 Q1 ¹²



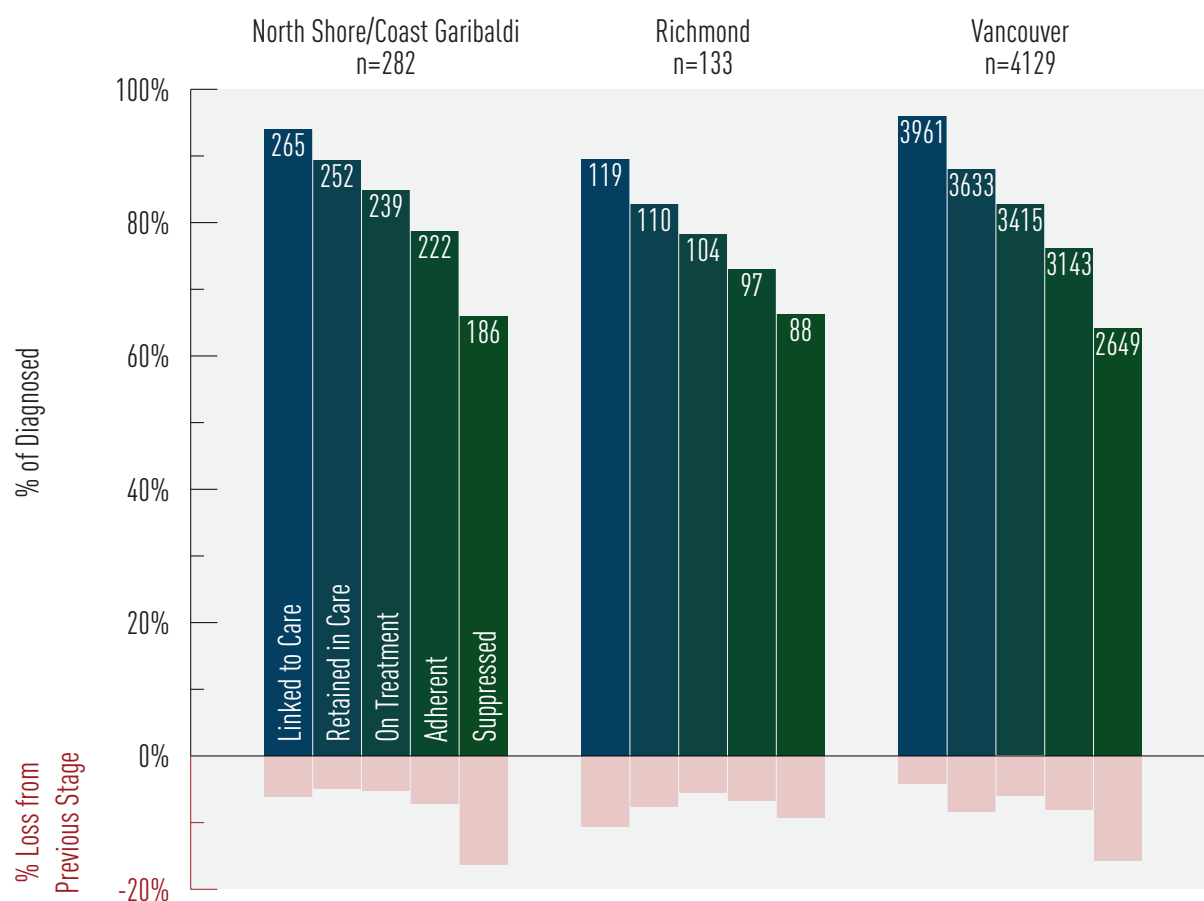
¹² Data is for the period 2013 Q2–2014 Q1.

Data Sources:

- 1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- 2 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 5.7 Estimated Cascade of Care for Vancouver Coastal Health by HSDA, Year Ending 2014 Q1 ¹³



¹³ Data is for the period 2013 Q2–2014 Q1.

Data Sources:

- 1 British Columbia Centre for Excellence Drug Treatment Program (DTP) Database (ARV use, VL and CD4 count).
- 2 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.

Indicator 6. The 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. The 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 Vancouver Coastal Health, 2012 Q2–2013 Q4 ¹⁴

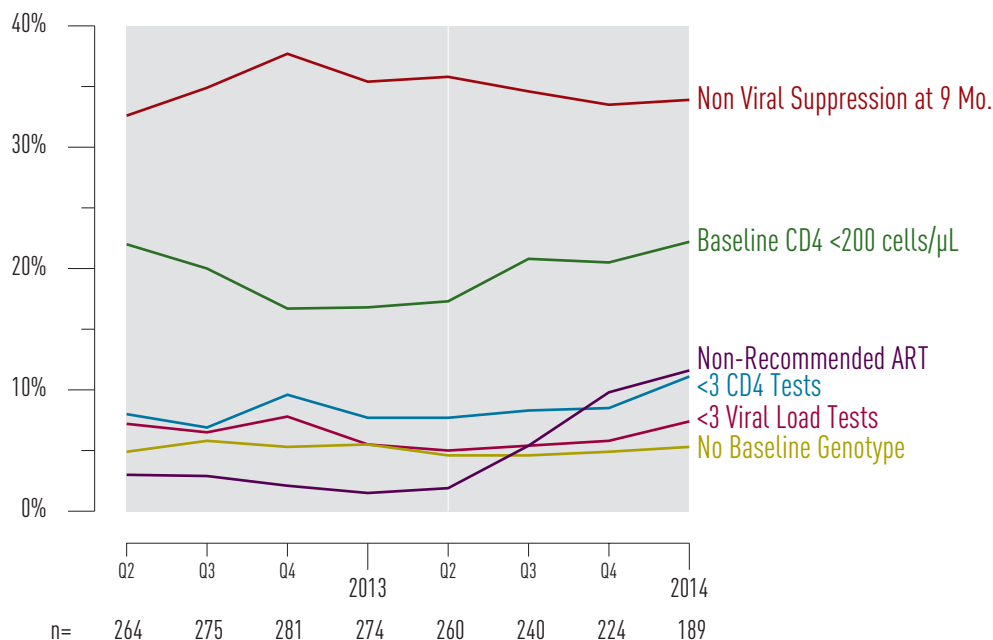
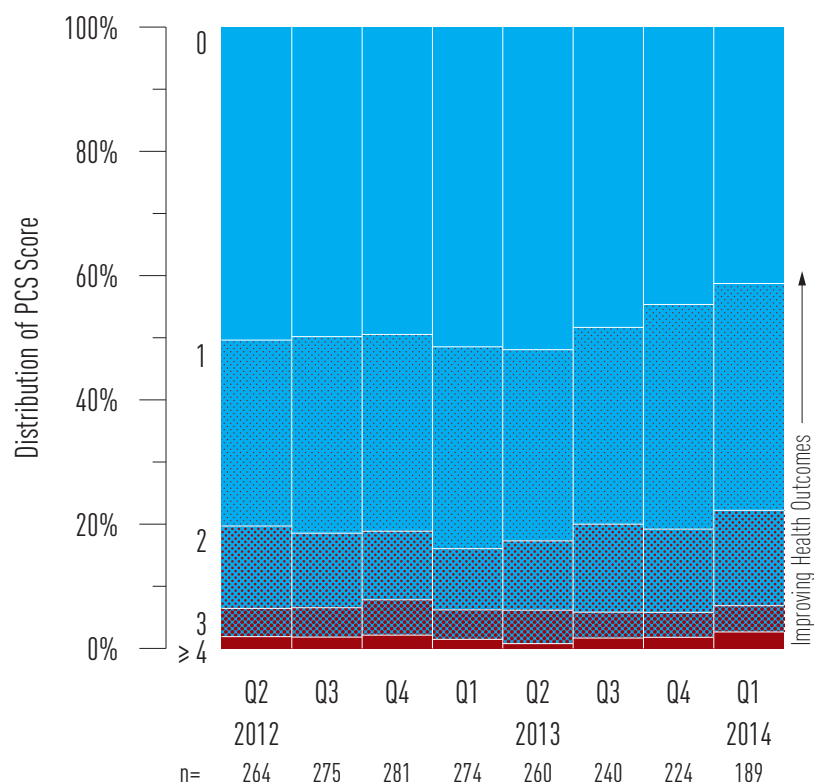


Figure 6.2 Historical Trends for PCS Score for Vancouver Coastal Health, 2012 Q2–2014 Q1 ^{14,15}



¹⁴ Data Source: British Columbia Centre for Excellence Drug Treatment Program (DTP) Database. Limitations: CD4 cell count capture is approximately 80%. Due to improvements in the automated system, some changes in data representation are expected compared to previous reports.

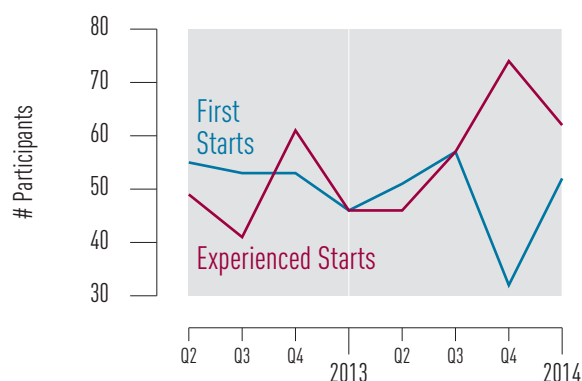
¹⁵ Each quarter's data is calculated as the sum of the 4 quarters leading up to it. e.g. 2013 Q1 is calculated from 2012 Q2 – 2013 Q1. NB: A score of 0 is the best score and a score of 4 or more is the worst score.

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.

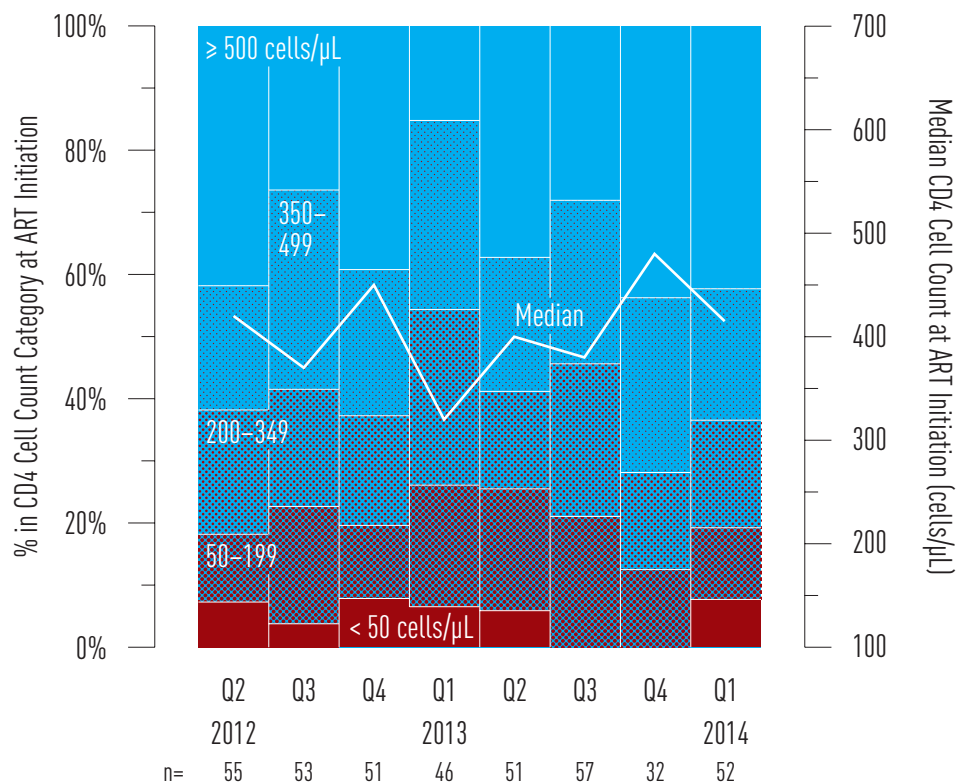
Indicator 7. New Antiretroviral Therapy Starts in Vancouver Coastal Health

Figure 7 BC-CfE Drug Treatment Program Enrollment: New ART Participants in Vancouver Coastal Health, 2012 Q2–2014 Q1¹⁶



Indicator 8. CD4 Cell Count at ART Initiation

Figure 8 CD4 Cell Count at ART Initiation of ART-Naïve DTP Participants in Vancouver Coastal Health, 2012 Q2–2014 Q1¹⁷



¹⁶ Data Source: Drug Treatment Program Database
Limitation: DTP participants are designated to an HA based on most current residence provided by the participant.

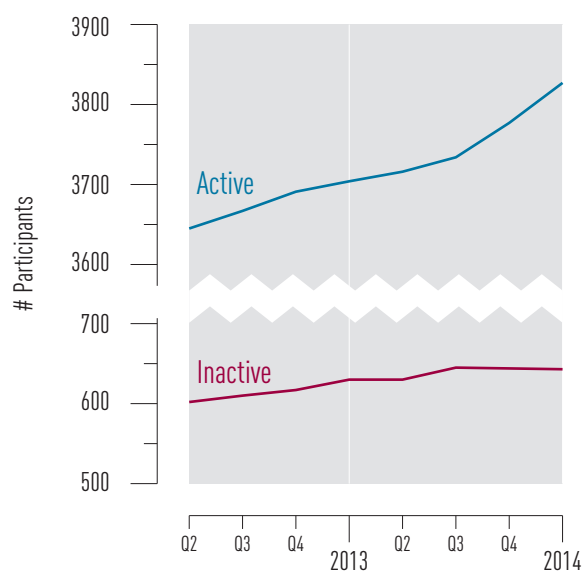
¹⁷ Data Source: Drug Treatment Program Database
Limitations: CD4 cell count data is approximately 80% complete.

Indicator 9. Active and Inactive DTP Participants

Table 3. Distribution of People on ART for Vancouver Coastal Health, 2014 Q1 ¹⁸

Age	< 30	138
	30–39	516
	40–49	1258
	≥ 50	1915
Gender	Male	3363
	Female	464
Exposure	MSM	1601
	IDU	1144
Total		3827

Figure 9 Active and Inactive DTP Participants in Vancouver Coastal Health, 2012 Q2–2014 Q1 ¹⁹



¹⁸ Data Source: Drug Treatment Program Database

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

Definitions:

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

'Unknown/not stated' defined as being on treatment in the current quarter, and city of residence unknown

¹⁹ Active DTP participants: are those who are prescribed one or more drugs in the last six months.

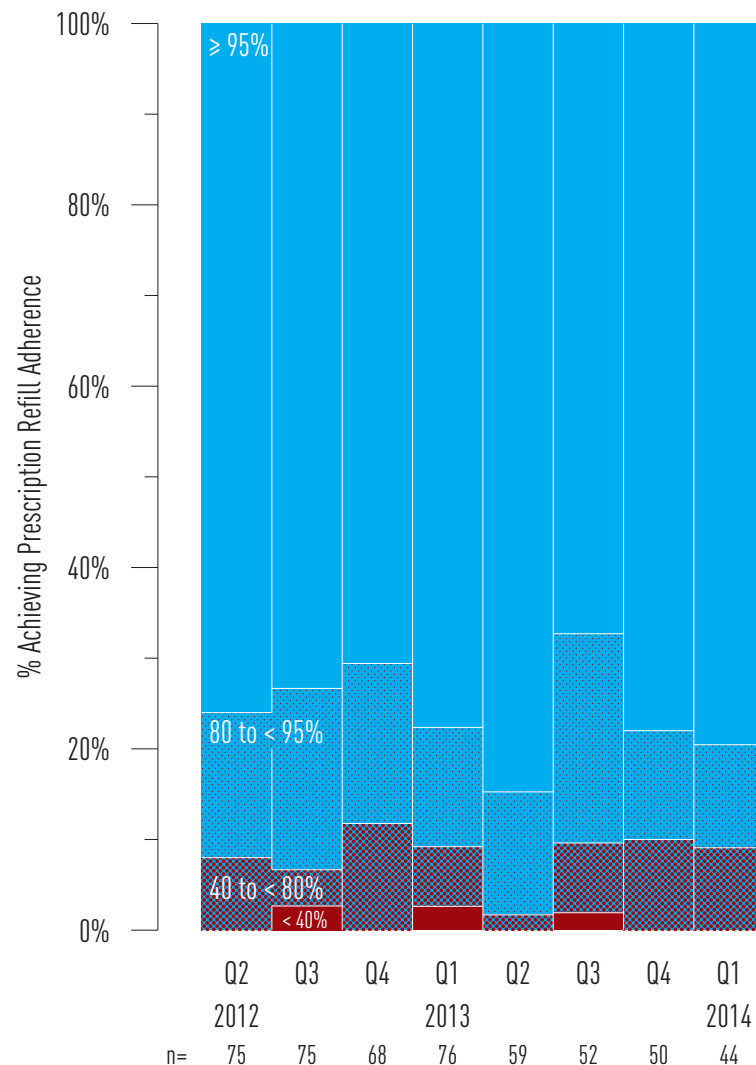
Inactive DTP Participants: Persons no longer prescribed drugs through the HIV/AIDS Drug Treatment Program in the last quarter.

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

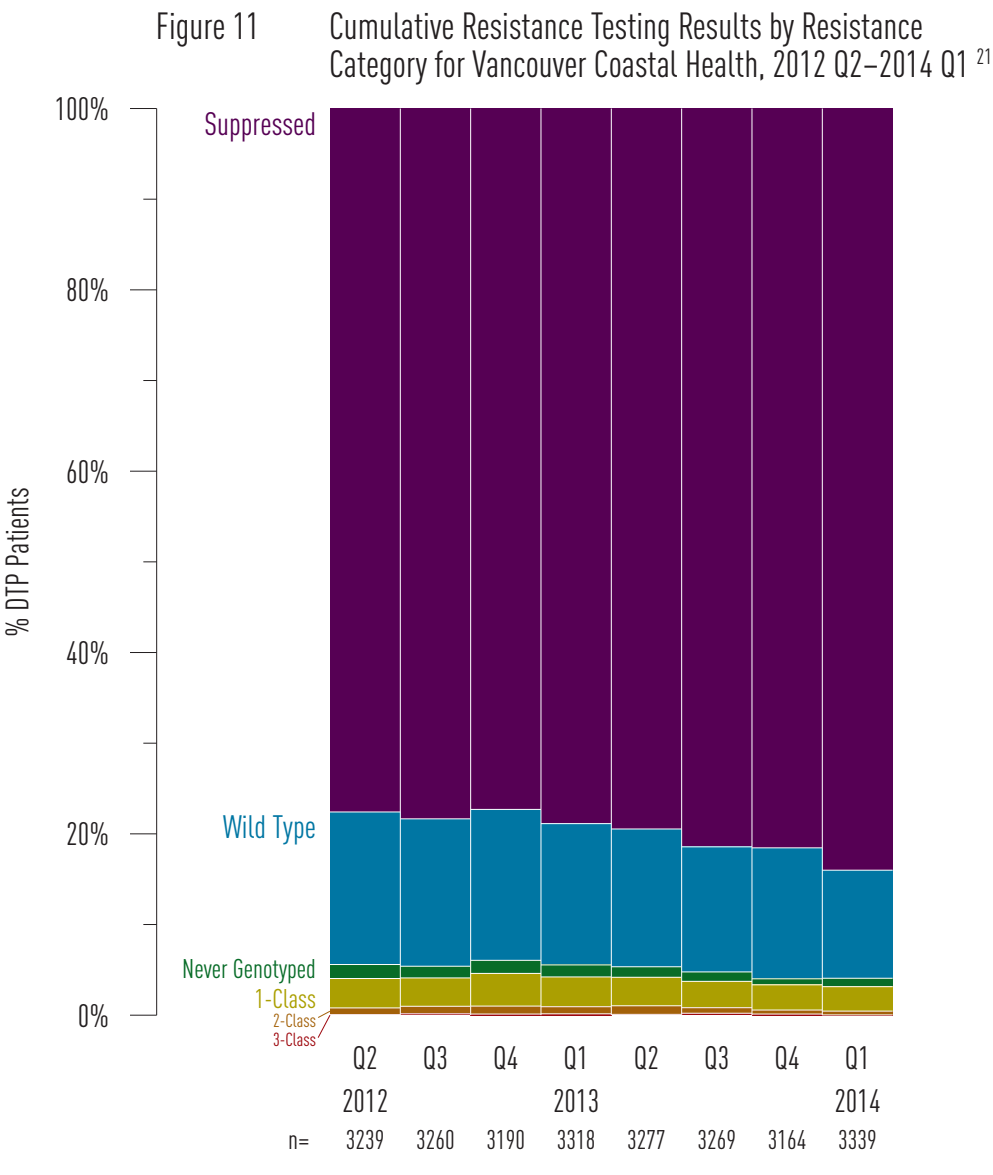
Figure 10 Distribution of Individuals by Adherence Level in 1st Year of Therapy, Based on Pharmacy Refill Compliance for Vancouver Coastal Health, 2012 Q2–2014 Q1²⁰



²⁰ Data Source: Drug Treatment Program Database
Limitation: Prescription refill adherence is used as a proxy for patient adherence.

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** or **three** 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.



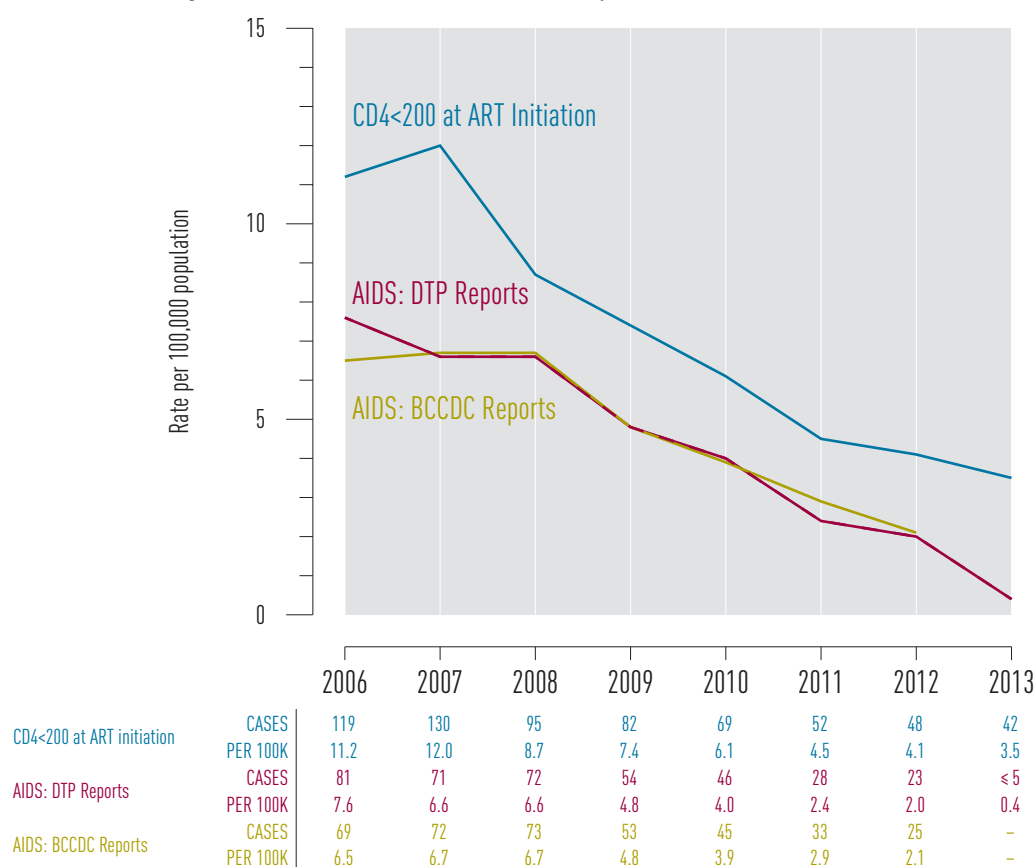
²¹ Data Source: Drug Treatment Program Database

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

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 Vancouver Coastal Health, 2006–2013²²

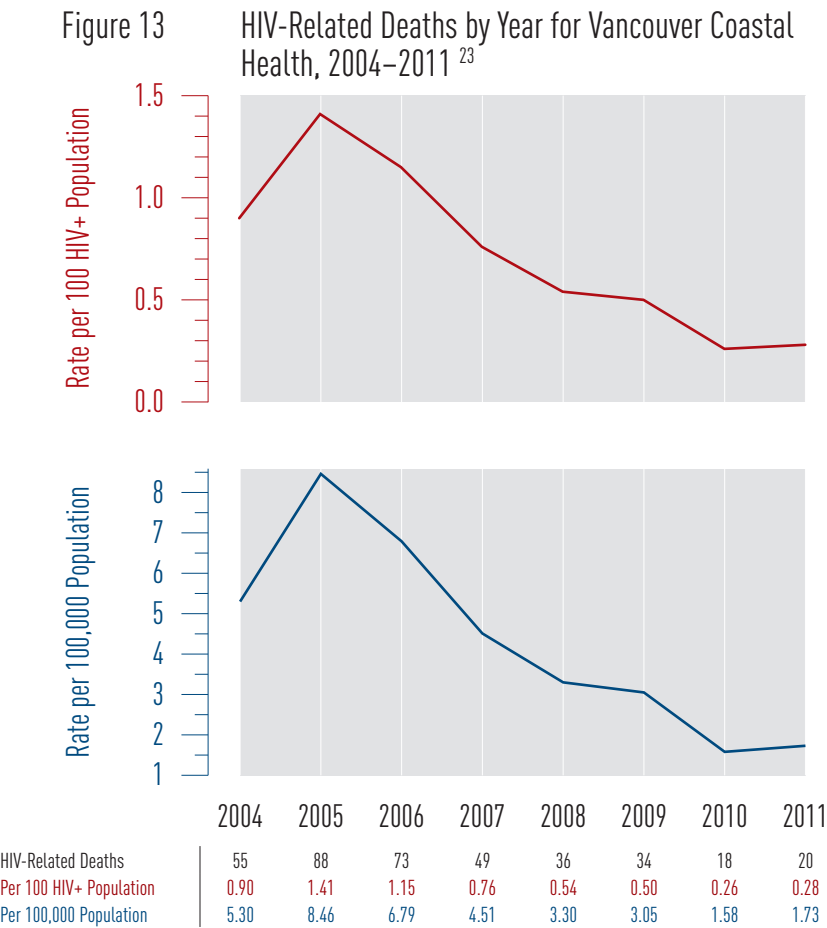


²² Data Source: DTP AIDS cases are obtained from the Drug Treatment Program Database; BCCDC AIDS cases are obtained from the BC-CDC; CD4<200 at ART initiation data came from the DTP database.

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.

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.



23 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)		2009		2010			2011			2012			2013			2014		
		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Vancouver Coastal Health		17.9	18.3	17.1	18.8	18.3	18.6	19.3	20.7	20.1	26.0	24.0	27.2	26.9	29.5	29.4	33.5	35.1
Gender	Female	9.6	9.8	9.3	10.0	9.7	10.0	9.8	10.6	9.7	10.7	11.6	13.6	13.5	14.7	14.8	17.1	18.0
	Male	7.8	8.0	7.4	8.3	8.2	8.2	8.2	8.7	8.0	9.0	9.6	11.3	11.3	12.4	12.6	14.2	15.1
	Other	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.2	0.2	0.3	0.2	0.2
Female (Prenatal)		3.2	3.3	3.2	3.4	3.1	3.4	3.5	3.7	3.4	3.5	3.7	4.1	3.7	3.6	3.6	3.5	3.7
Female (Non-prenatal)		6.4	6.6	6.1	6.6	6.6	6.6	6.3	6.8	6.4	7.1	8.0	9.5	9.8	11.1	11.2	13.5	14.5
Age	< 30	6.8	7.5	6.8	7.0	6.9	7.2	7.1	7.1	6.8	7.8	8.5	8.9	9.1	9.7	9.5	8.6	9.0
	30–39	5.9	6.0	5.7	6.4	6.1	6.2	6.2	6.7	5.9	6.4	6.5	7.8	7.4	7.7	7.6	8.8	9.0
	40–49	2.9	2.7	2.6	3.0	2.9	2.8	2.8	3.1	2.8	3.0	3.2	3.9	3.8	3.9	4.2	5.1	5.4
	≥ 50	2.2	2.2	2.1	2.4	2.4	2.4	2.3	2.8	2.6	3.0	3.4	4.6	4.8	6.0	6.5	9.0	9.9
POC HIV Tests								0.9	1.0	2.0	5.9	2.4	2.1	1.9	2.1	1.7	2.0	1.8
Richmond		1.1	1.2	1.1	1.2	1.2	1.2	1.2	1.3	1.2	1.2	1.3	1.5	1.5	1.5	1.6	1.9	1.9
Vancouver		14.5	14.9	13.9	15.3	14.8	15.1	15.7	17.0	16.6	22.5	20.2	22.9	22.9	25.2	25.0	28.5	29.9
North Shore / Coast Garibaldi		2.3	2.3	2.2	2.3	2.3	2.4	2.4	2.4	2.3	2.4	2.4	2.8	2.6	2.7	2.8	3.1	3.3

Indicator 2: Rate of HIV Testing per 100,000

		2009	2010	2011	2012	2013
Vancouver Coastal Health		5115.5	5087.9	5338.2	7023.7	8875.0
Richmond		2576.9	2682.0	2774.4	3389.9	3930.9
Vancouver		6616.3	6523.2	6883.5	9360.3	12195.6
North Shore / Coast Garibaldi		3412.2	3429.1	3506.2	4019.2	4461.3
Gender	Female	5413.4	5352.9	5651.7	7515.9	9682.6
	Male	4492.0	4526.8	4719.2	6346.6	7941.3
Age	< 30	5752.3	5624.0	5917.4	7227.8	7203.8
	30–39	10932.6	11198.4	11436.2	13502.8	16209.7
	40–49	4871.8	4771.1	4989.4	6559.7	9215.0
	≥ 50	1820.9	1872.1	2160.6	4133.1	7162.8

Indicator 3: New HIV Diagnoses		2009		2010			2011			2012			2013			2014		
		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Vancouver Coastal Health	By Client Residence	36	41	36	41	45	41	40	32	48	57	41	43	33	33	32	31	45
	By Provider Address	46	45	40	45	50	49	43	34	47	65	42	47	38	37	38	31	50
Gender	Female	4	1	5	8	8	5	3	3	7	2	2	5	4	3	2	4	4
	Male	32	40	31	33	37	36	37	29	41	55	39	38	29	30	30	27	41
Age	< 30	8	10	9	12	12	12	7	3	10	13	12	11	10	6	13	7	11
	30–39	11	7	12	16	10	15	12	12	16	22	8	12	11	7	6	11	14
	40–49	12	18	11	10	16	10	11	11	12	13	13	12	6	11	9	8	8
	≥ 50	5	6	4	3	7	4	10	6	10	9	8	8	6	9	4	5	12
Exposure	MSM	25	26	24	30	26	29	27	23	36	43	30	33	25	25	22	19	31
	IDU	6	3	3	6	7	5	3	3	2	8	0	3	4	1	3	3	3
	HET	4	5	8	5	11	7	10	6	10	6	9	7	4	6	6	8	8
	Other	1	2	0	0	1	0	0	0	0	0	2	0	0	0	0	1	1
	NIR/Unknown	0	5	1	0	0	0	0	0	0	0	0	0	0	1	1	1	2
Richmond	By Client Residence	1	1	1	2	3	3	2	2	0	1	3	0	1	3	0	2	1
	By Provider Address	1	3	0	0	2	2	1	1	1	0	2	0	1	2	1	0	0
Vancouver	By Client Residence	34	38	34	36	40	34	38	30	46	50	37	41	29	29	31	26	43
	By Provider Address	43	41	39	42	46	43	42	33	44	61	40	46	35	33	36	28	48
North Shore / Coast Garibaldi	By Client Residence	1	2	1	3	2	4	0	0	2	6	1	2	3	1	1	3	1
	By Provider Address	2	1	1	3	2	4	0	0	2	4	0	1	2	2	1	3	2

Indicator 4: Stage of HIV Infection at Baseline

	VCH				Female				Male				< 30 years				30–39 years				40–49 years			
	'10	'11	'12	'13	'10	'11	'12	'13	'10	'11	'12	'13	'10	'11	'12	'13	'10	'11	'12	'13	'10	'11	'12	'13
Stage 0	38	48	44	33	5	0	6	1	33	48	38	31	13	9	16	11	15	20	15	11	7	16	7	8
Stage 1	39	35	33	41	4	4	3	4	35	31	29	37	9	10	7	15	15	12	13	15	11	6	7	4
Stage 2a	22	33	19	34	3	5	1	3	19	28	18	31	4	9	4	8	9	10	3	9	8	10	8	7
Stage 2b	22	23	18	12	7	4	3	2	15	19	15	10	3	5	4	0	5	4	4	8	9	9	6	2
Stage 3	42	31	34	34	10	4	2	4	32	27	32	30	2	3	5	2	8	7	6	4	11	8	8	16
Unknown	22	17	9	5	0	0	1	0	22	16	8	5	8	3	5	1	10	7	2	1	3	2	0	0
Total	185	187	157	159	29	17	16	14	156	169	140	144	39	39	41	37	62	60	43	48	49	51	36	37

	≥ 50 years				MSM			IDU			Heterosexual			Other Exposure			NIR/Unknown		
	'10	'11	'12	'13	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012	2010	2011	2012
Stage 0	3	3	6	2	30	44	35	3	2	4	5	2	5	0	0	0	0	0	0
Stage 1	4	7	5	7	24	27	26	6	2	1	9	6	6	0	0	0	0	0	0
Stage 2a	1	4	4	10	15	23	14	2	4	4	5	5	1	0	1	0	0	0	0
Stage 2b	5	4	4	2	12	16	13	4	2	2	5	5	3	1	0	0	0	0	0
Stage 3	21	13	15	12	17	15	22	7	1	1	17	13	9	0	2	0	1	0	2
Unknown	1	4	2	3	17	13	7	1	2	0	3	1	1	0	1	0	1	0	1
Total	35	35	36	36	115	138	117	23	13	12	44	32	25	1	4	0	2	0	3

Indicator 5: HIV Cascade of Care

		DIAGNOSED	LINKED	RETAINED	ON ART	ADHERENT	SUPPRESSED
Vancouver Coastal Health		4545	4346	3995	3758	3462	2923
Age Category	< 30	220	150	137	116	104	84
	30–39	614	585	510	464	410	338
	40–49	1413	1364	1240	1170	1067	879
	≥ 50	2297	2246	2106	2008	1881	1622
Age Category and MSM Status	MSM	< 30	45	41	34	27	24
		30–39	189	184	162	148	114
		40–49	505	497	452	433	357
		≥ 50	1079	1067	1024	984	834
	Non-MSM	< 30	29	29	28	24	13
		30–39	169	162	145	128	77
		40–49	399	390	387	361	236
		≥ 50	585	576	574	544	386
	Unknown	< 30	146	80	76	65	47
		30–39	256	239	203	188	147
		40–49	509	477	401	376	286
		≥ 50	633	604	508	480	402
Gender	Male	3960	3823	3482	3289	3062	2607
	Female	584	523	512	469	400	316
Injection Drug Use	IDU	1242	1220	1210	1139	999	768
	Non-IDU	2143	2105	1976	1869	1767	1564
	Unknown	1161	1021	809	750	696	591
MSM Status	MSM	1819	1790	1673	1592	1492	1329
	Non-MSM	1182	1157	1133	1057	936	712
	Unknown	1544	1399	1188	1109	1034	882
Health Authority	Richmond	133	119	110	104	97	88
	Vancouver	4129	3961	3633	3415	3143	2649
	North Shore / Coast Garibaldi	282	265	252	239	222	186

Indicator 6: Programmatic Compliance Score (PCS)

	2012 Q2	Q3	Q4	2013 Q1	Q2	Q3	Q4	2014 Q1
< 3 CD4 Tests	8.0%	6.9%	9.6%	7.7%	7.7%	8.3%	8.5%	11.1%
< 3 Viral Load Tests	7.2%	6.5%	7.8%	5.5%	5.0%	5.4%	5.8%	7.4%
No Baseline Genotype	4.9%	5.8%	5.3%	5.5%	4.6%	4.6%	4.9%	5.3%
Baseline CD4 < 200 cells/μL	22.0%	20.0%	16.7%	16.8%	17.3%	20.8%	20.5%	22.2%
Non-Recommended ART	3.0%	2.9%	2.1%	1.5%	1.9%	5.4%	9.8%	11.6%
Non Viral suppression at 9 Mo.	32.6%	34.9%	37.7%	35.4%	35.8%	34.6%	33.5%	33.9%
PCS Score: 0	133	137	139	141	135	116	100	78
PCS Score: 1	79	87	89	89	80	76	81	69
PCS Score: 2	35	33	31	27	29	34	30	29
PCS Score: 3	12	13	16	13	14	10	9	8
PCS Score: 4 or more	5	5	6	4	2	4	4	5
Total (n=)	264	275	281	274	260	240	224	189

Indicator 7: New DTP ARV Participants

First Starts	55	53	53	46	51	57	32	52
Experienced Starts	49	41	61	46	46	57	74	62

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

CD4 ≥ 500	23	14	20	7	19	16	14	22
CD4 350–499	11	17	12	14	11	15	9	11
CD4 200–349	11	10	9	13	8	14	5	9
CD4 50–199	6	10	6	9	10	12	4	6
CD4 < 50	4	2	4	3	3	0	0	4
<i>CD4 Median (cells/μL)</i>	<i>420</i>	<i>370</i>	<i>450</i>	<i>320</i>	<i>400</i>	<i>380</i>	<i>480</i>	<i>415</i>
Total (n=)	55	53	51	46	51	57	32	52

Indicator 9: Active and Inactive DTP Participants

Active DTP Participants	3645	3667	3691	3704	3716	3734	3777	3827
Inactive DTP Participants	602	610	617	630	630	645	644	643

Indicator 10: Antiretroviral Adherence

≥ 95%	57	55	48	59	50	35	39	35
80% to < 95%	12	15	12	10	8	12	6	5
40% to < 80%	6	3	8	5	1	4	5	4
< 40%	0	2	0	2	0	1	0	0
Total (n=)	75	75	68	76	59	52	50	44

Indicator 11: Resistance Testing and Results

Suppressed	2513	2554	2466	2617	2604	2662	2580	2805
Wild Type	545	530	531	517	498	451	457	398
Never Genotyped	50	42	46	44	38	34	21	31
1-Class	105	102	115	109	103	95	88	90
2-Class	24	27	28	26	31	20	14	14
3-Class	2	5	4	5	3	7	4	1
Total (n=)	3239	3260	3190	3318	3277	3269	3164	3339

Indicator 12: AIDS-Defining Illness

	2006	2007	2008	2009	2010	2011	2012	2013
CD4 < 200 at ART initiation	Cases	119	130	95	82	69	52	42
	<i>Rate per 100,000</i>	<i>11.2</i>	<i>12.0</i>	<i>8.7</i>	<i>7.4</i>	<i>6.1</i>	<i>4.5</i>	<i>3.5</i>
AIDS Cases (DTP Reports)	Cases	81	71	72	54	46	28	≤ 5
	<i>Rate per 100,000</i>	<i>7.6</i>	<i>6.6</i>	<i>6.6</i>	<i>4.8</i>	<i>4.0</i>	<i>2.4</i>	<i>0.4</i>
AIDS Cases (BCCDC Reports)	Cases	69	72	73	53	45	33	–
	<i>Rate per 100,000</i>	<i>6.5</i>	<i>6.7</i>	<i>6.7</i>	<i>4.8</i>	<i>3.9</i>	<i>2.9</i>	<i>–</i>

Indicator 13: HIV-Related Mortality

	2004	2005	2006	2007	2008	2009	2010	2011
Vancouver Coastal Health	55	88	73	49	36	34	18	20
Per 100 HIV+ Population	0.90	1.41	1.15	0.76	0.54	0.50	0.26	0.28
Per 100,000 Population	5.30	8.46	6.79	4.51	3.30	3.05	1.58	1.73