



BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

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

FOURTH QUARTER 2016



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



First Nations Health Authority
Health through wellness



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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, BC Vital Statistics, 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. James Nakagawa is responsible for compiling and publishing this report. Lilith Swetland is the editor of this report. Paul Sereda, Dr. Viviane Lima and Nada Gataric perform analysis of Indicators 5–13. This report was conceived and guided by Dr. Julio Montaner.



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

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. Olga Mazo, 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 Vancouver Coastal Health

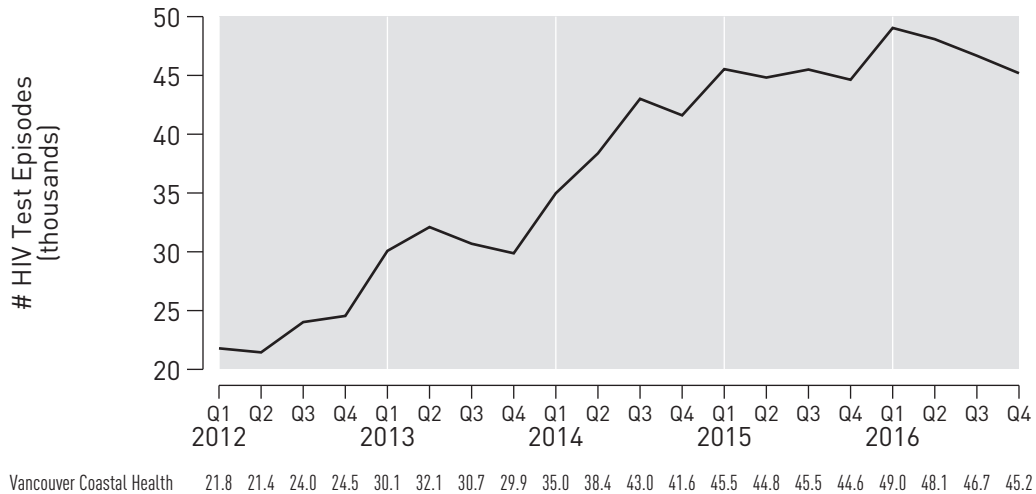


Figure 1.2 HIV Test Episodes by Gender for Vancouver Coastal Health ¹

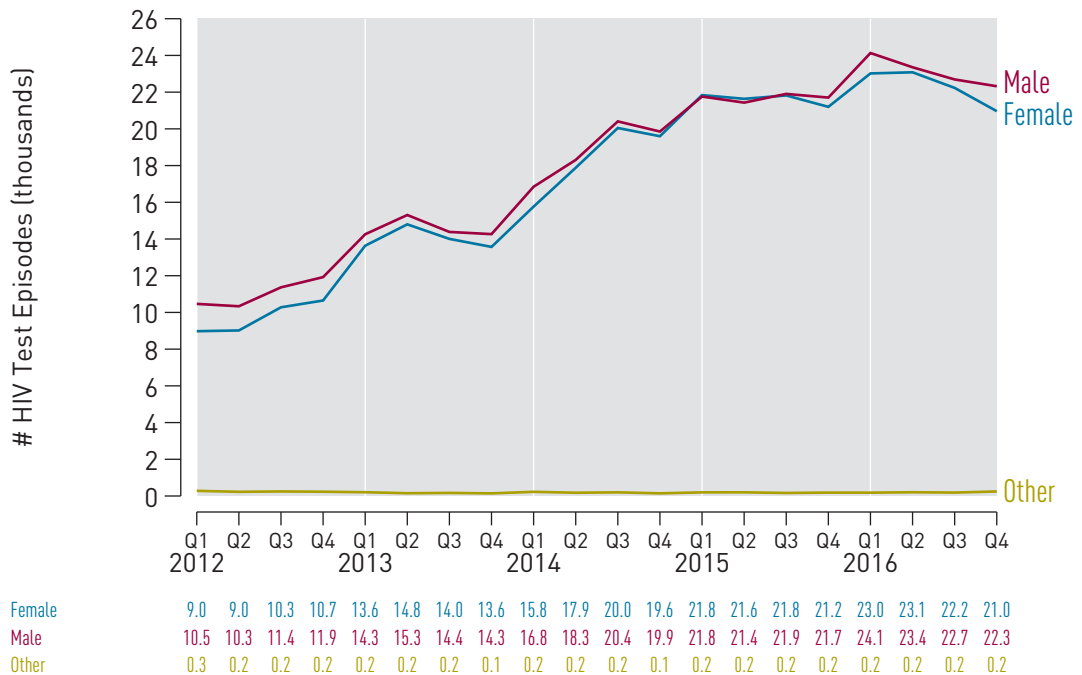


Figure 1.3 HIV Test Episodes by Age Category for Vancouver Coastal Health ^{1,2}

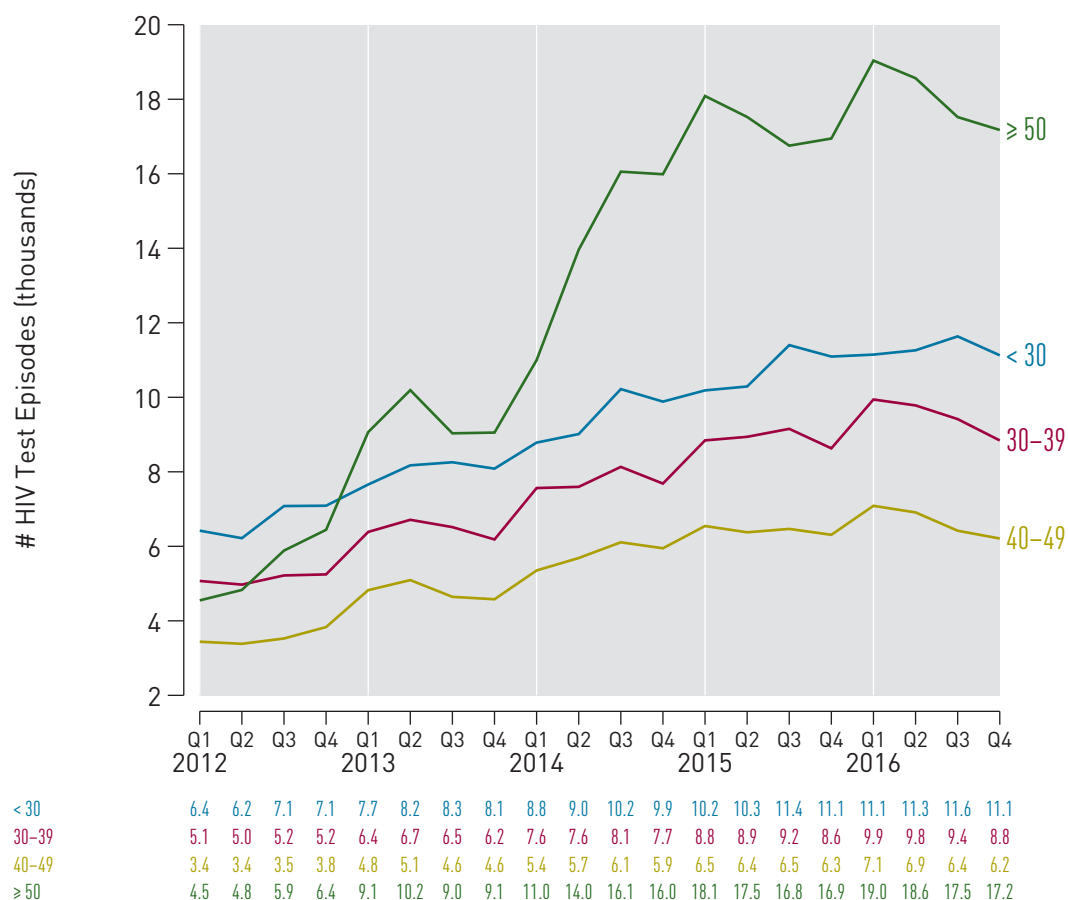
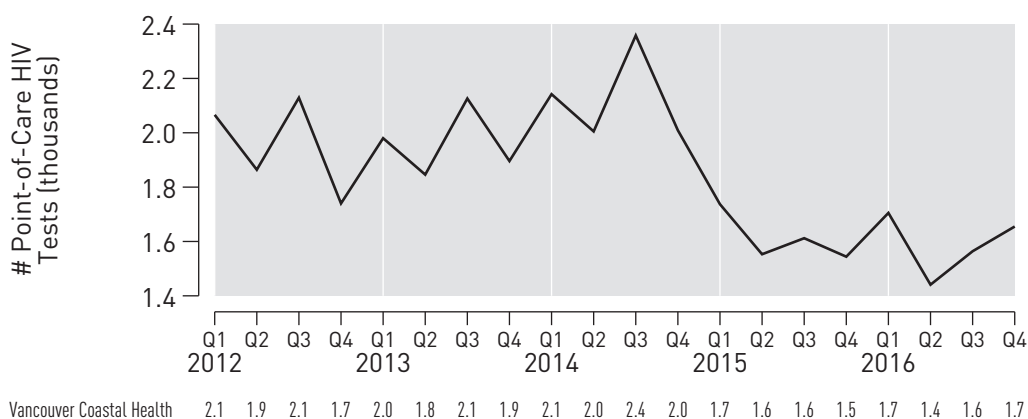


Figure 1.4 Point-of-Care HIV Tests for Vancouver Coastal Health



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

Limitation: Repeat tests in individuals who test using various identifiers may not be identified and these individuals may be counted more than once.

2 Testing does not include point of care tests.

Figure 1.5 HIV Test Episodes for Vancouver Coastal Health by HSDA ¹

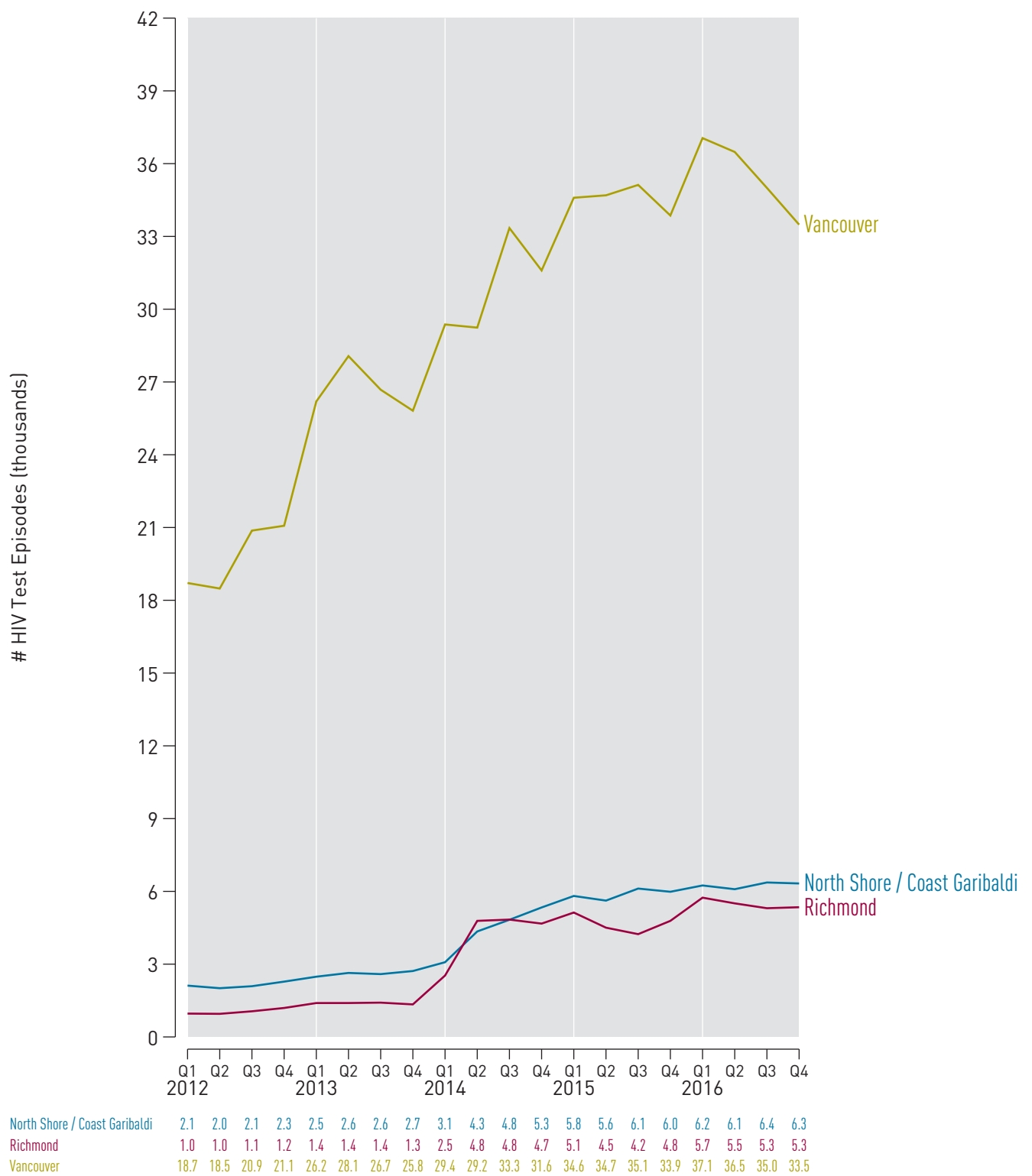


Figure 1.6 HIV Test Episodes for Non-prenatal Females in Vancouver Coastal Health by HSDA ¹

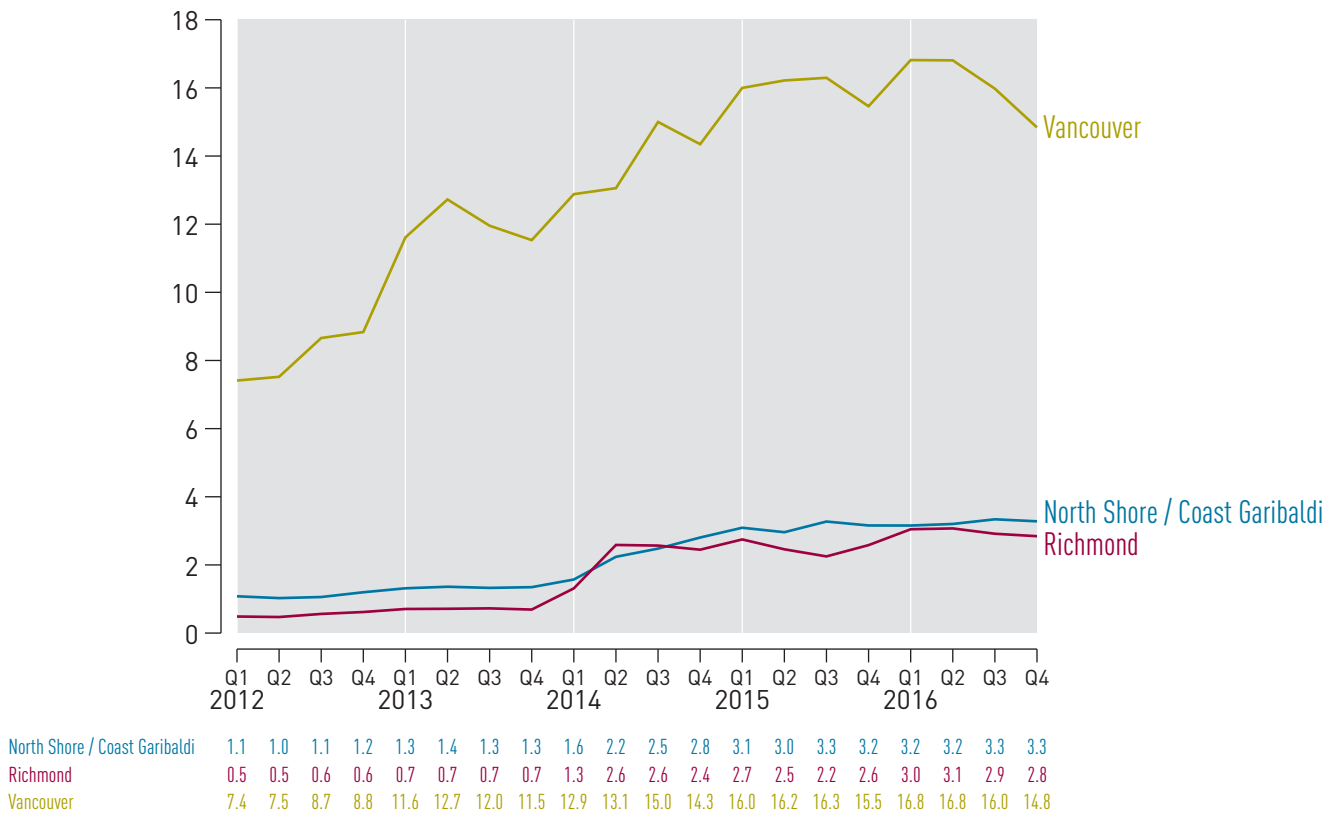
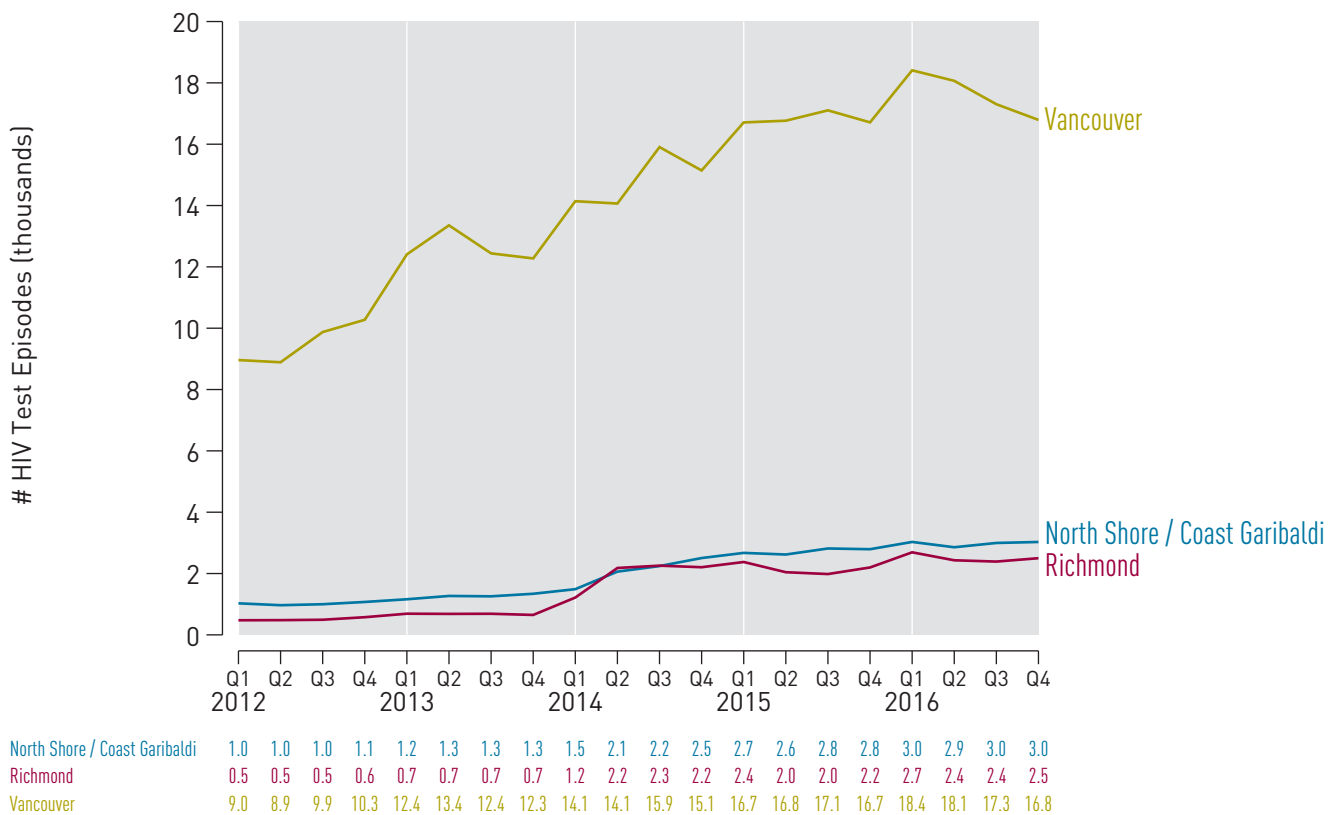


Figure 1.7 HIV Test Episodes for Males in Vancouver Coastal Health by HSDA ¹



Indicator 2. HIV Testing Rates

Figure 2.1 Rate of HIV Testing for Vancouver Coastal Health and HSDAs ²

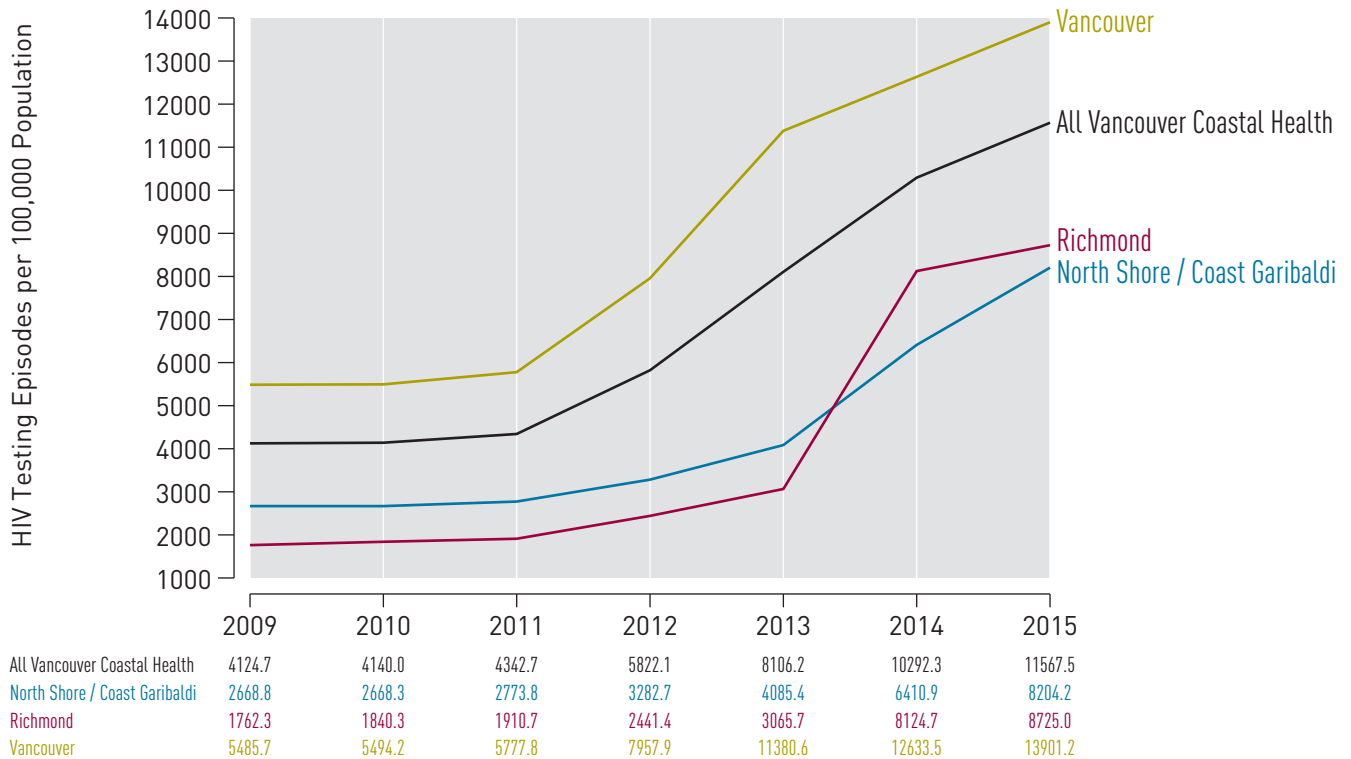


Figure 2.2 Rate of HIV Testing by Gender for Vancouver Coastal Health ²

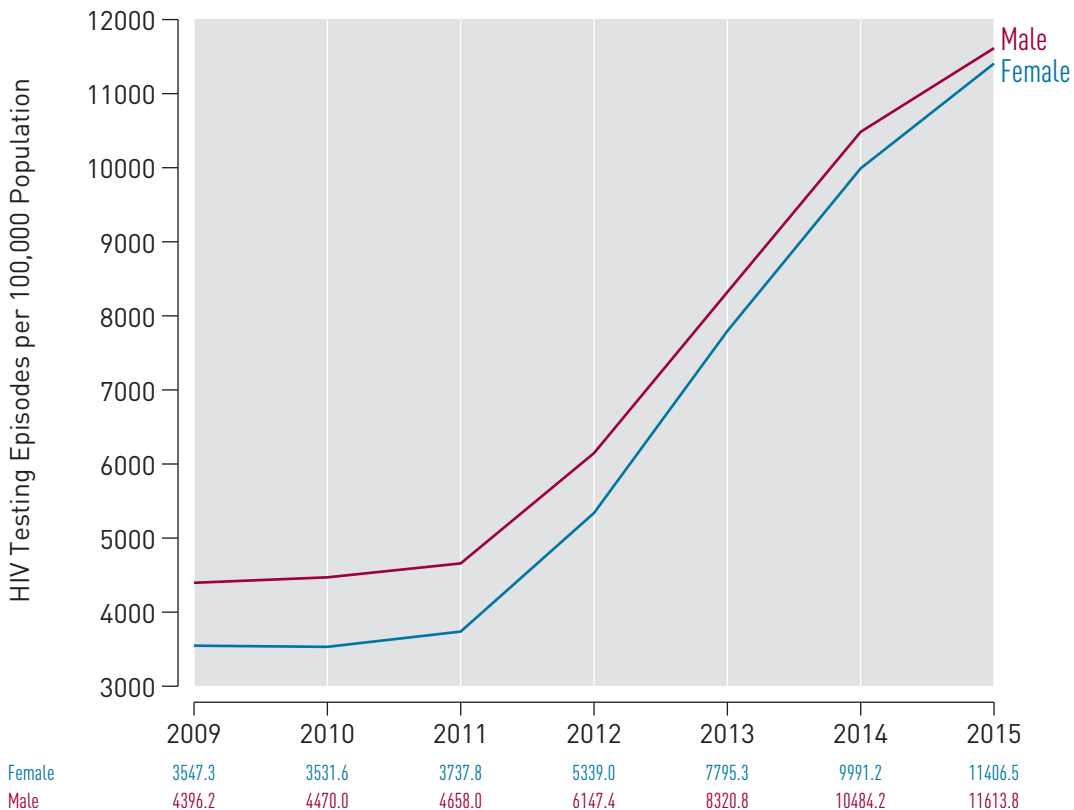
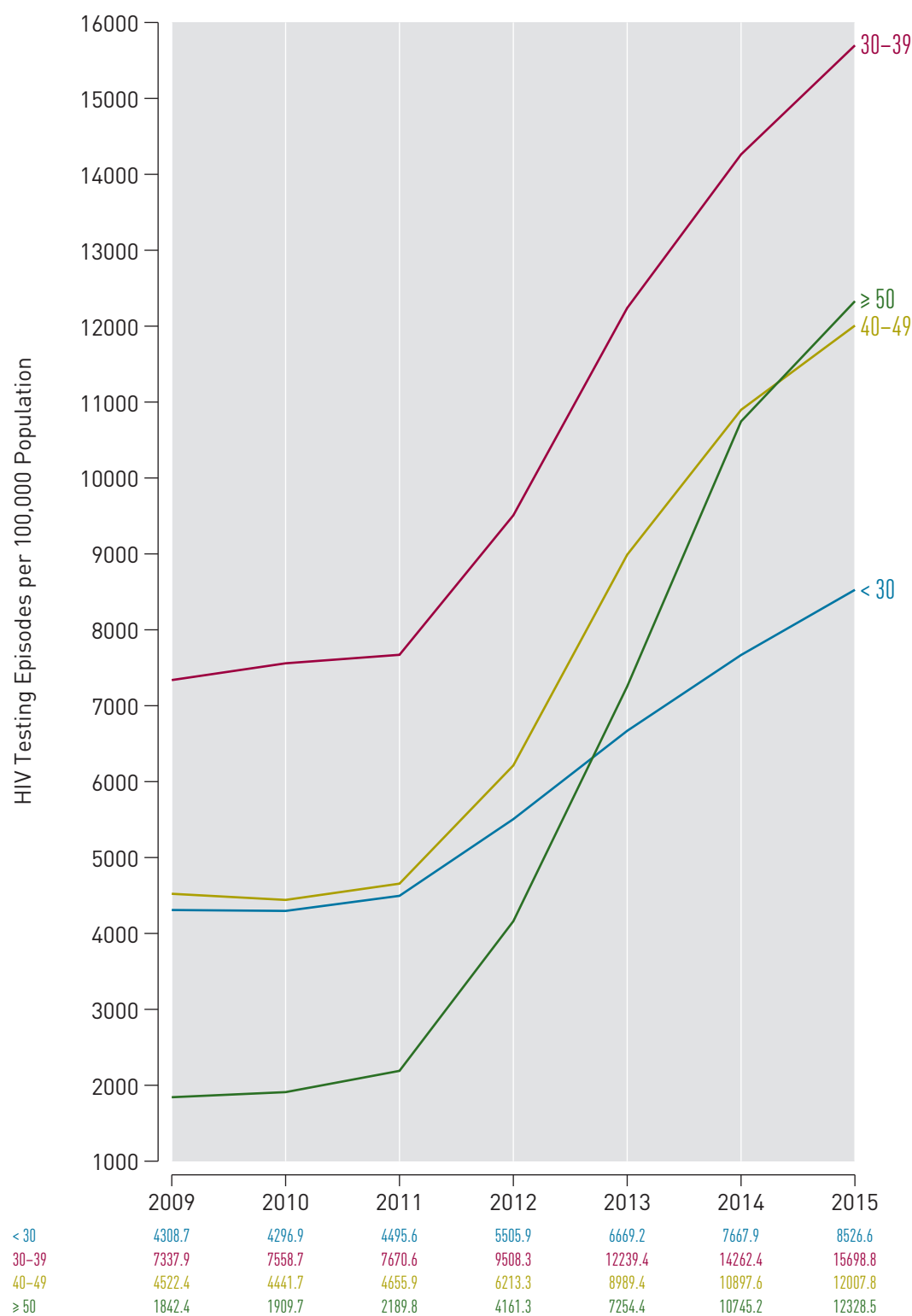


Figure 2.3 Rate of HIV Testing by Age Category for Vancouver Coastal Health ²



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 Vancouver Coastal Health ³

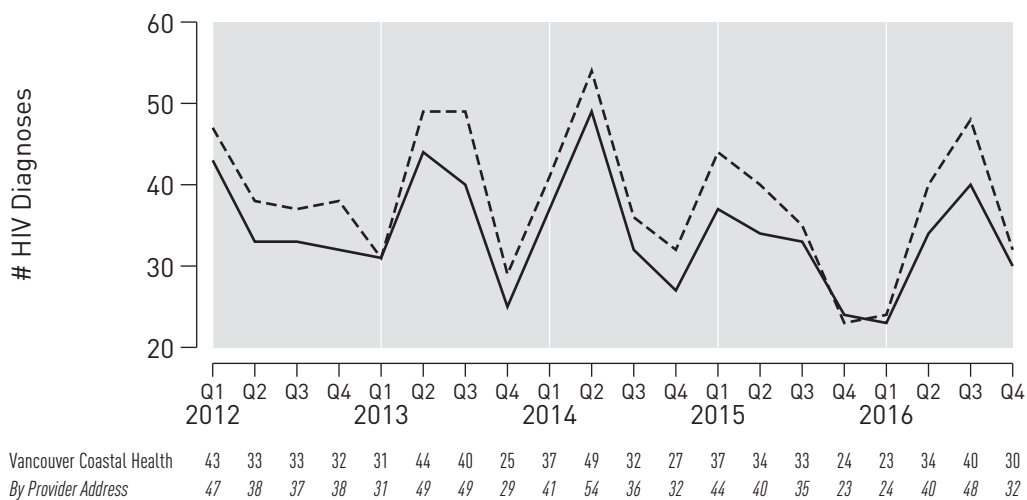
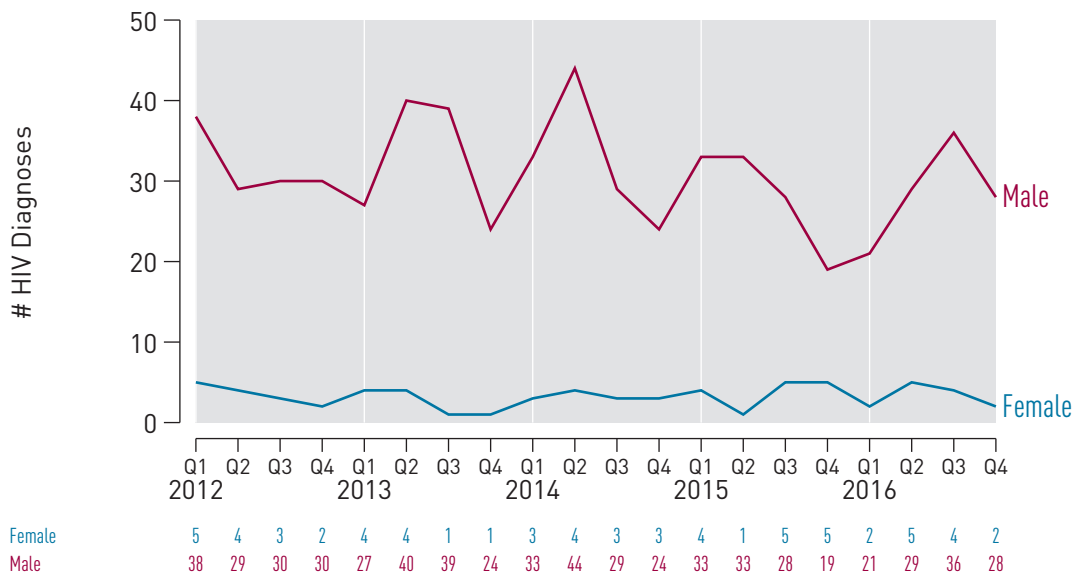


Figure 3.2 New HIV Diagnoses for Vancouver Coastal Health by Gender ³



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

Figure 3.3 New HIV Diagnoses for Vancouver Coastal Health by Age Category³

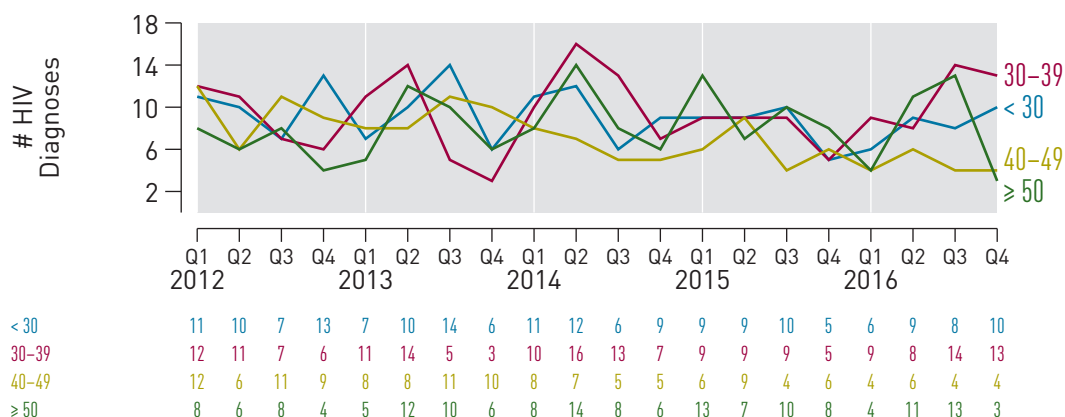
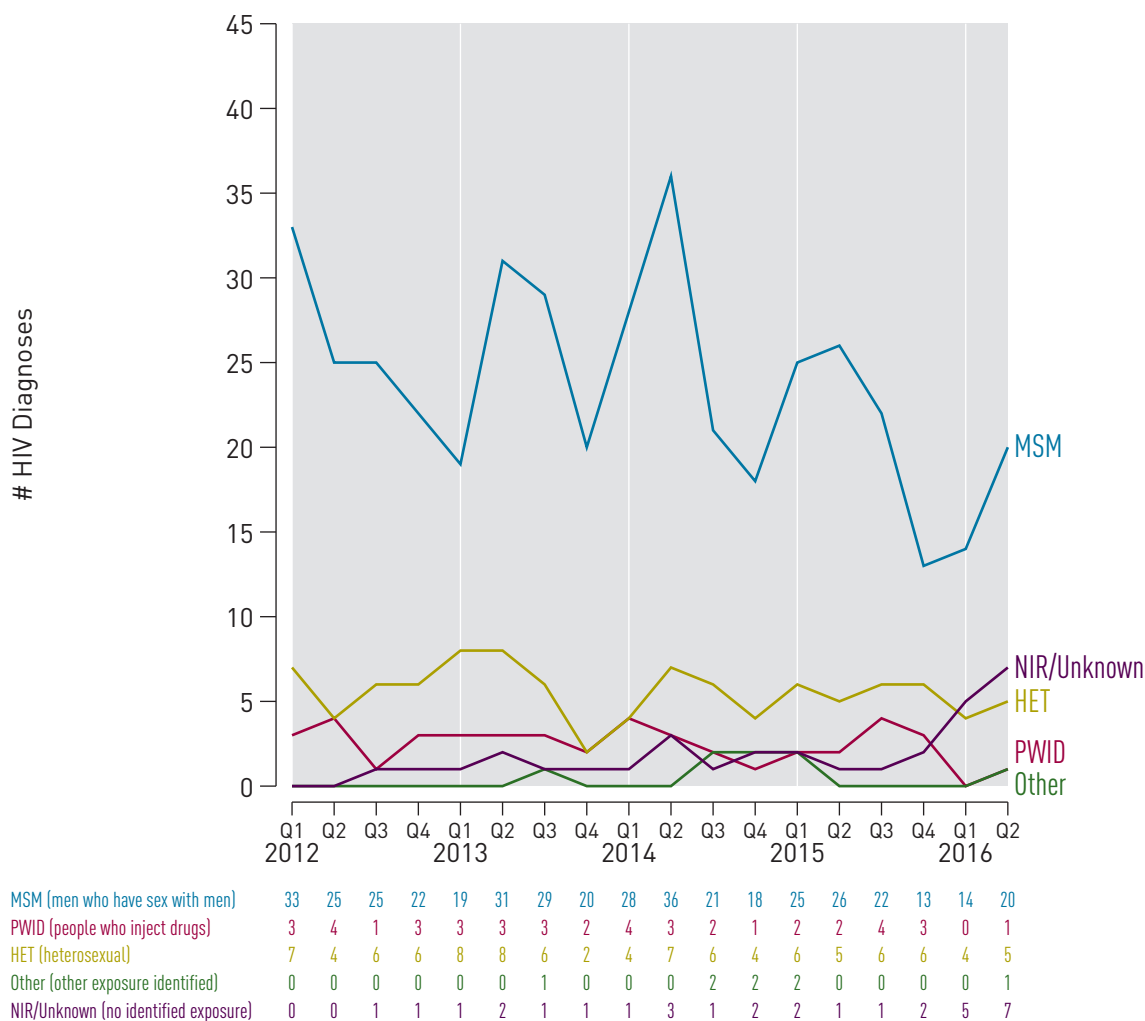


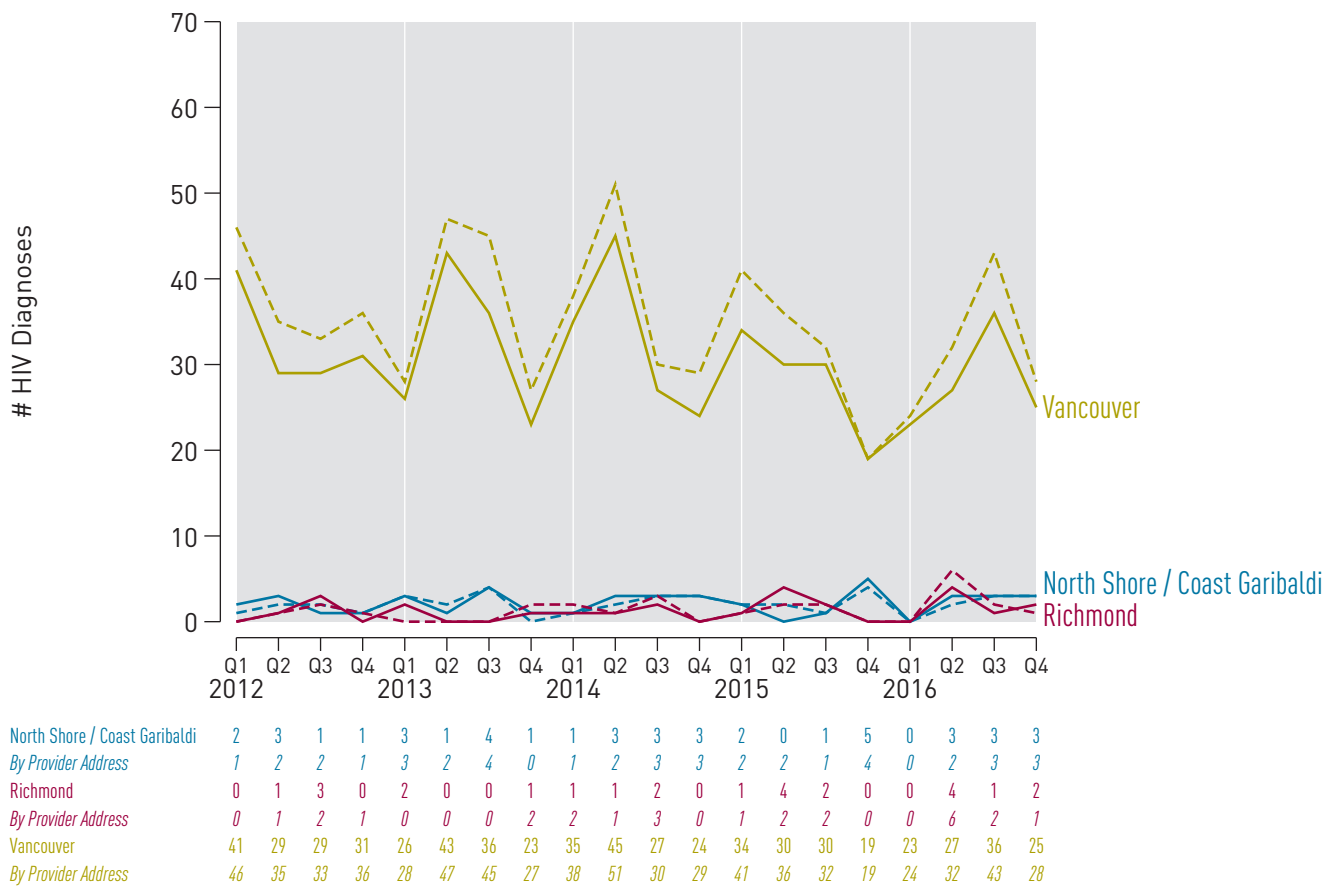
Figure 3.4 New HIV Diagnoses for Vancouver Coastal Health by Exposure Category^{3,4}



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.

Figure 3.5 New HIV Diagnoses for Vancouver Coastal Health by HSDA ³



³ Data Source: BCCDC. When present, "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 and laboratory results suggestive of acute HIV infection (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 and	CD4 ≥500
2a		CD4 350–499
2b		CD4 200–349
3		CD4 <200
Unknown	No available CD4	

Figure 4.1 Stage of HIV Infection at Diagnosis for Vancouver Coastal Health ⁵

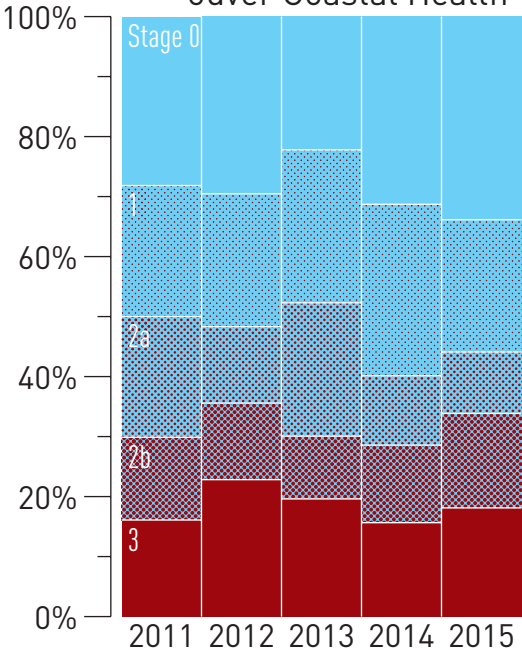
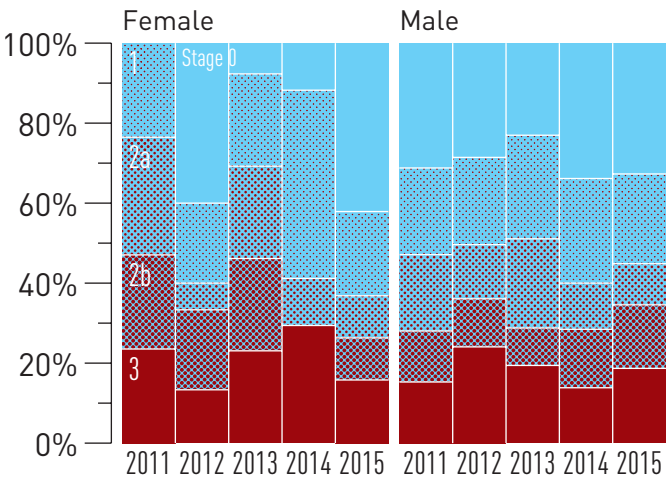


Figure 4.2 Stage of HIV Infection at Diagnosis by Gender for Vancouver Coastal Health ⁵



	Vancouver Coastal					Female					Male				
	2011	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15
Stage 0	49	44	34	46	43	0	6	1	2	8	49	38	32	44	35
Stage 1	38	33	39	42	28	4	3	3	8	4	34	29	36	34	24
Stage 2a	35	19	34	17	13	5	1	3	2	2	30	18	31	15	11
Stage 2b	24	19	16	19	20	4	3	3	0	2	20	16	13	19	17
Stage 3	28	34	30	23	23	4	2	3	5	3	24	32	27	18	20
Unknown	13	8	4	12	11	0	1	0	1	0	12	7	4	11	11
Total (n=)	187	157	157	159	138	17	16	13	18	19	169	140	143	141	118

5 Data Source: BCCDC

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

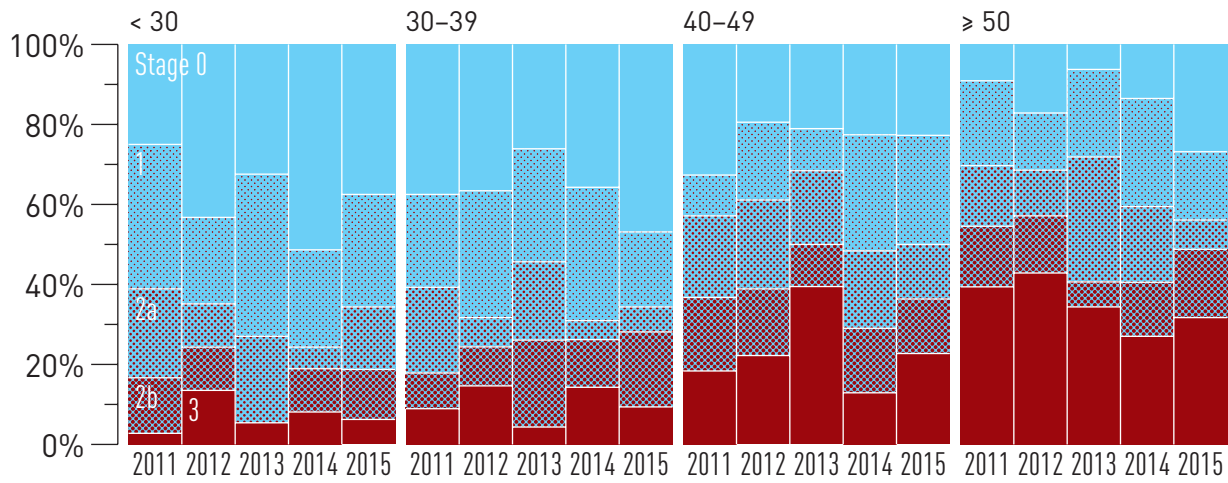
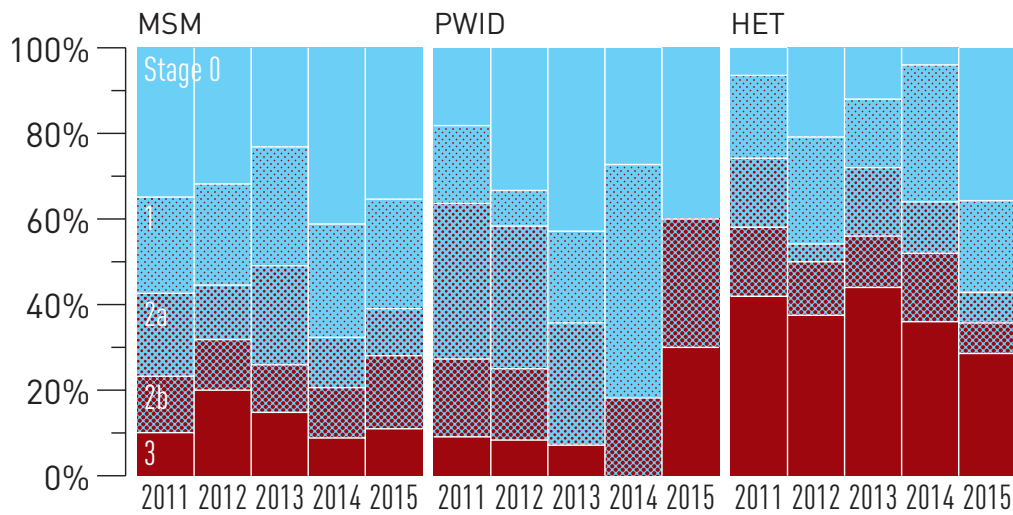


Figure 4.4 Stage of HIV Infection at Diagnosis by Exposure Category for Vancouver Coastal Health ^{5,6}



	< 30 years					30–39 years					40–49 years					≥ 50 years					MSM					PWID					Heterosexual					Other					NIR/Unknown				
	2011	12	13	14	15	11	12	13	14	15	11	12	13	14	15	11	12	13	14	15	11	12	13	14	15	11	12	13	14	15	11	12	13	14	15	11	12	13	14	15					
Stage 0	9	16	12	19	12	21	15	12	15	15	16	7	8	7	5	3	6	2	5	11	45	35	25	42	29	2	4	6	3	4	2	5	3	1	10	0	0	0	0	0	0	0	0		
Stage 1	13	8	15	9	9	13	13	13	14	6	5	7	4	9	6	7	5	7	10	7	29	26	30	27	21	2	1	3	6	0	6	6	4	8	6	1	0	0	1	0	0	0	2	0	1
Stage 2a	8	4	8	2	5	12	3	9	2	2	10	8	7	6	3	5	4	10	7	3	25	14	25	12	9	4	4	4	0	0	5	1	4	3	2	1	0	0	0	1	0	0	1	2	1
Stage 2b	5	4	0	4	4	5	4	10	5	6	9	6	4	5	3	5	5	2	5	7	17	13	12	12	14	2	2	0	2	3	5	3	3	4	2	0	0	0	0	1	0	1	1	1	0
Stage 3	1	5	2	3	2	5	6	2	6	3	9	8	15	4	5	13	15	11	10	13	13	22	16	9	9	1	1	1	0	3	13	9	11	9	8	1	0	0	3	0	0	2	2	2	3
Unknown	3	5	0	2	1	4	2	1	6	3	2	0	0	2	4	4	1	3	2	3	9	7	3	9	7	2	0	0	0	0	1	1	0	1	1	1	0	1	0	0	0	0	0	2	3
Total (n=)	39	42	37	39	33	60	43	47	48	35	51	36	38	33	26	37	36	35	39	44	381	171	117	111	89	13	12	14	11	10	32	25	25	26	29	4	0	1	4	2	0	3	6	7	8

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. Attrition 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 Q4–2016 Q3 in Vancouver Coastal Health and stratified by sex and age.

Figure 5.1 Estimated Cascade of Care for Vancouver Coastal Health, Year Ending 2016 Q4 ⁷

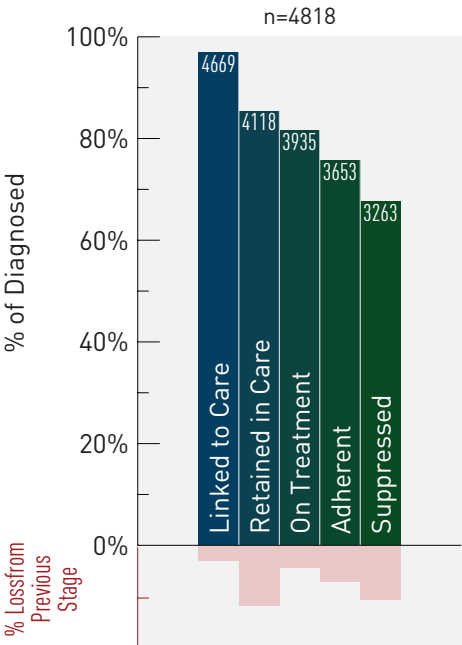
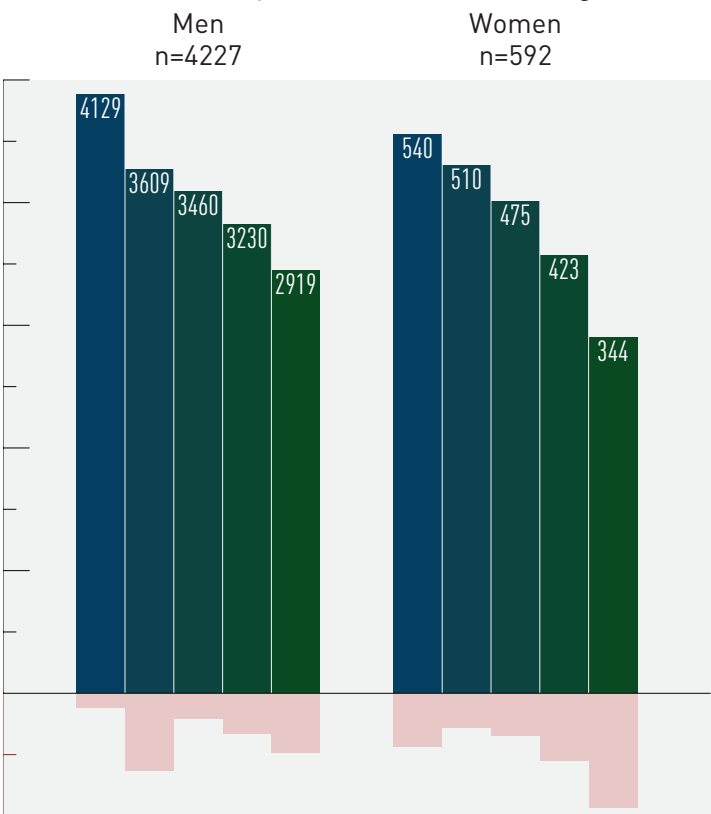


Figure 5.2 Estimated Cascade of Care for Vancouver Coastal Health by Gender, Year Ending 2016 Q4 ⁷



⁷ Data is for the period 2015 Q4–2016 Q3.

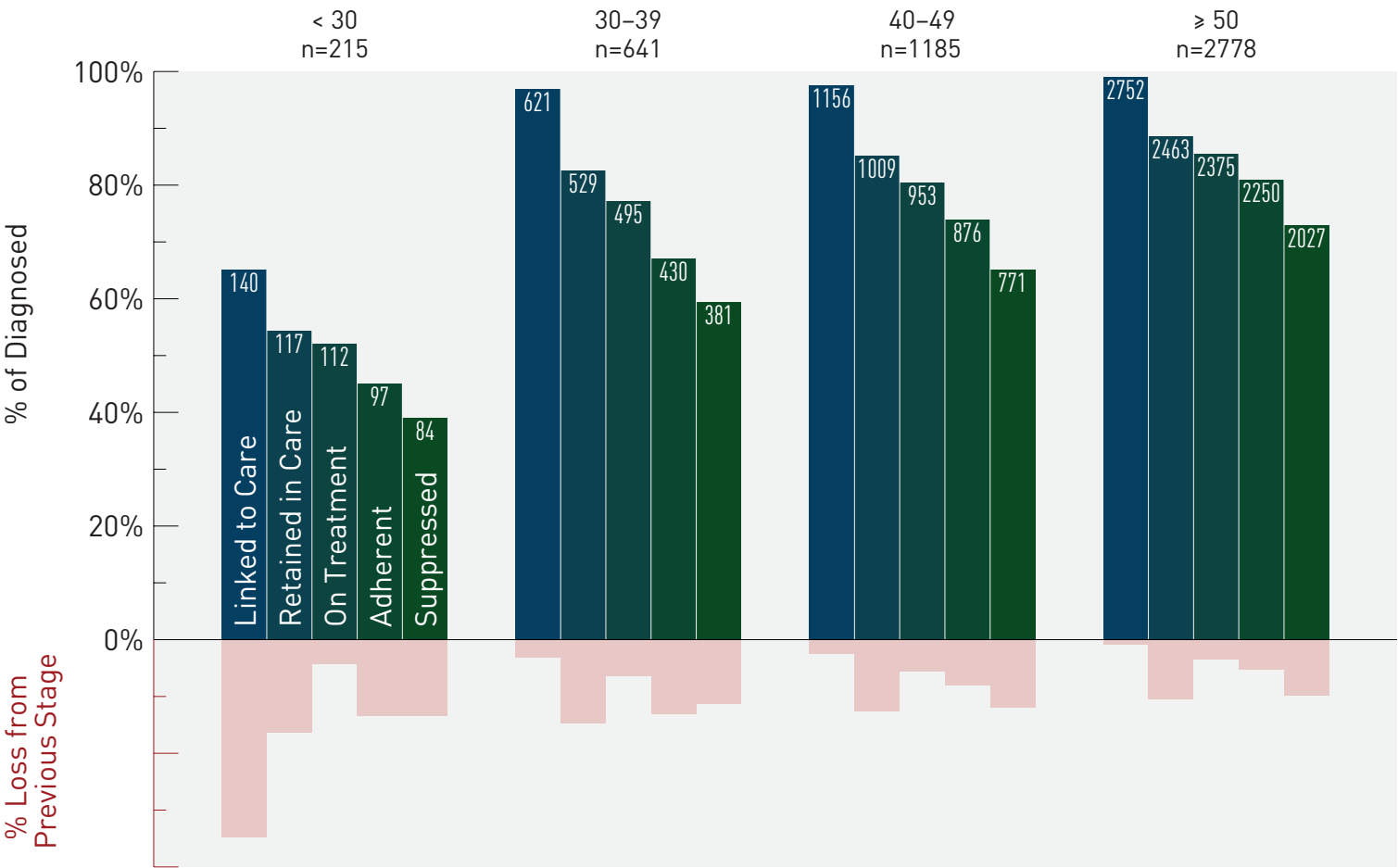
Data Sources:

- 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.

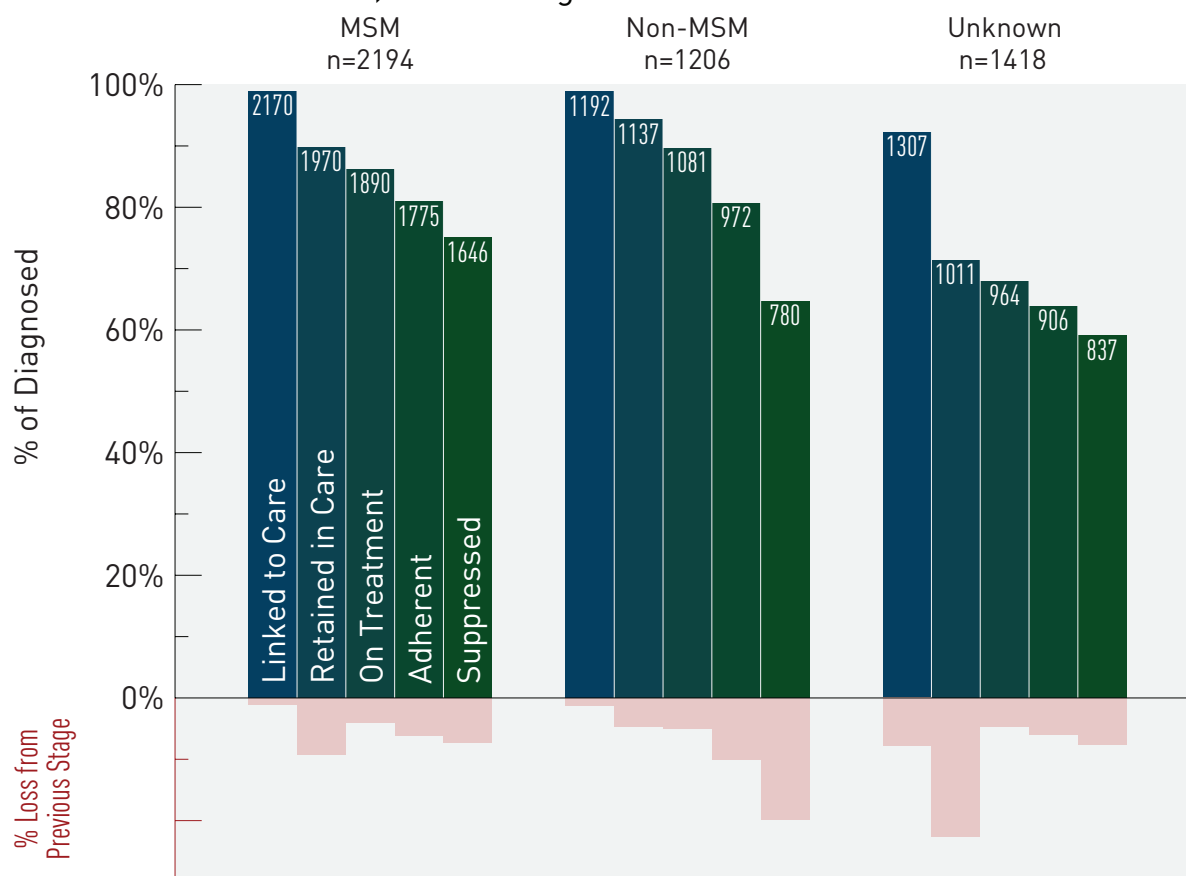
NB: Transgender have been assigned to their biological sex.

Figure 5.3 Estimated Cascade of Care for Vancouver Coastal Health by Age Category, Year Ending 2016 Q4 ⁸



⁸ Data is for the period 2015 Q4–2016 Q3.
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 Vancouver Coastal Health by MSM Status, Year Ending 2016 Q4 ⁹



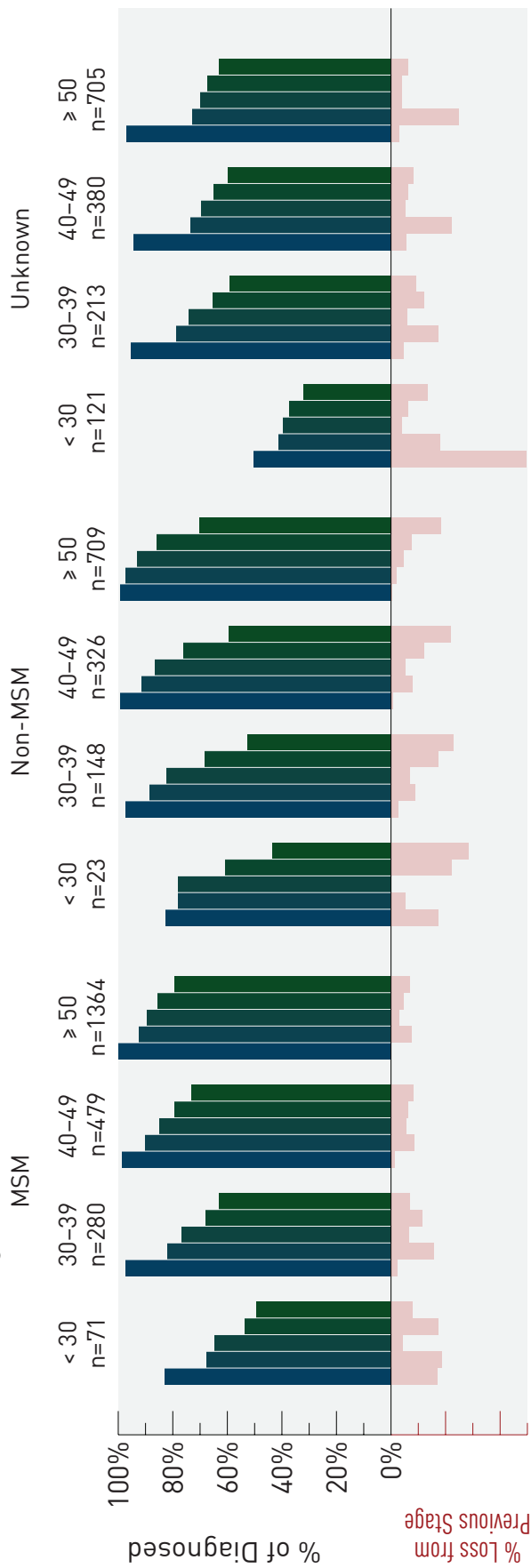
⁹ Data is for the period 2015 Q4–2016 Q3.

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 5.5 Estimated Cascade of Care for Vancouver Coastal Health by Age Category and MSM Status, Year Ending 2016 Q4⁹



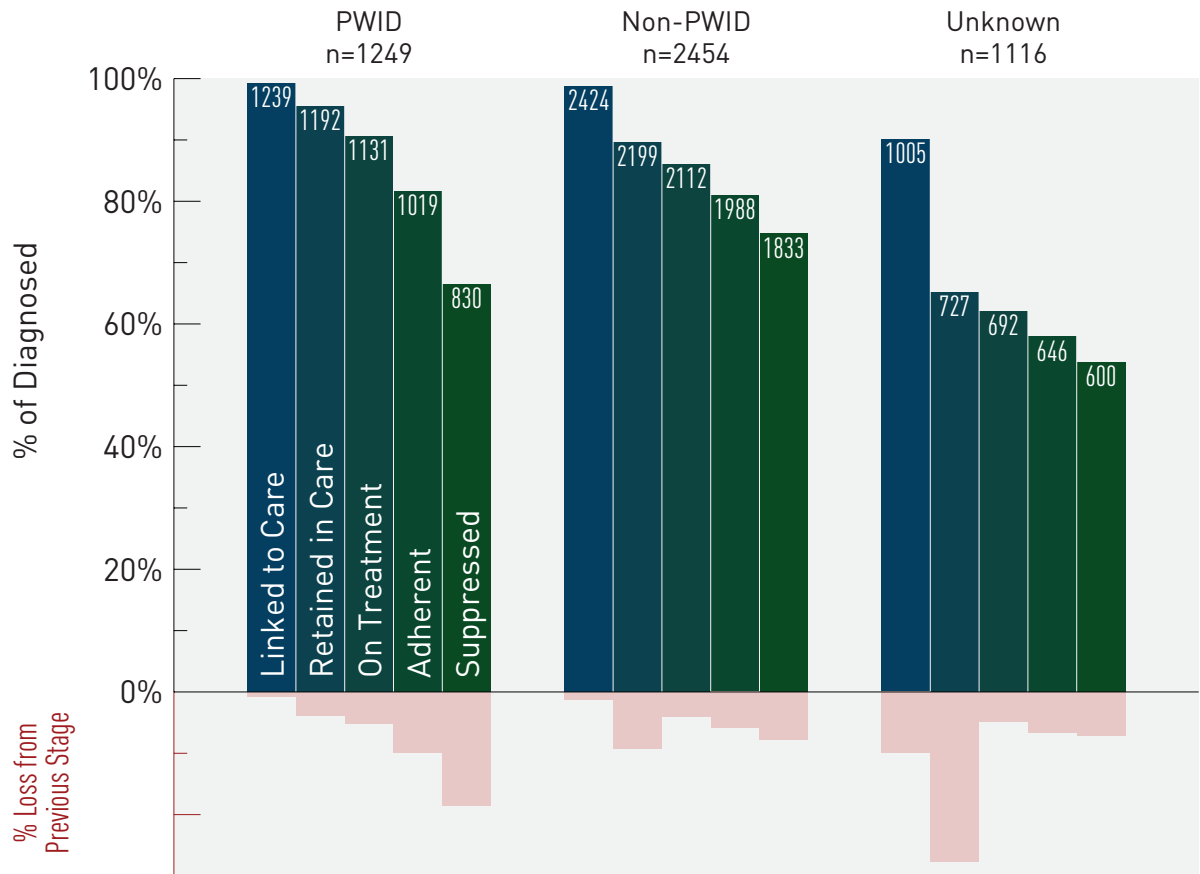
⁹ Data is for the period 2015 Q4–2016 Q3.

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 5.6 Estimated Cascade of Care for Vancouver Coastal Health by PWID Status, Year Ending 2016 Q4 ⁹



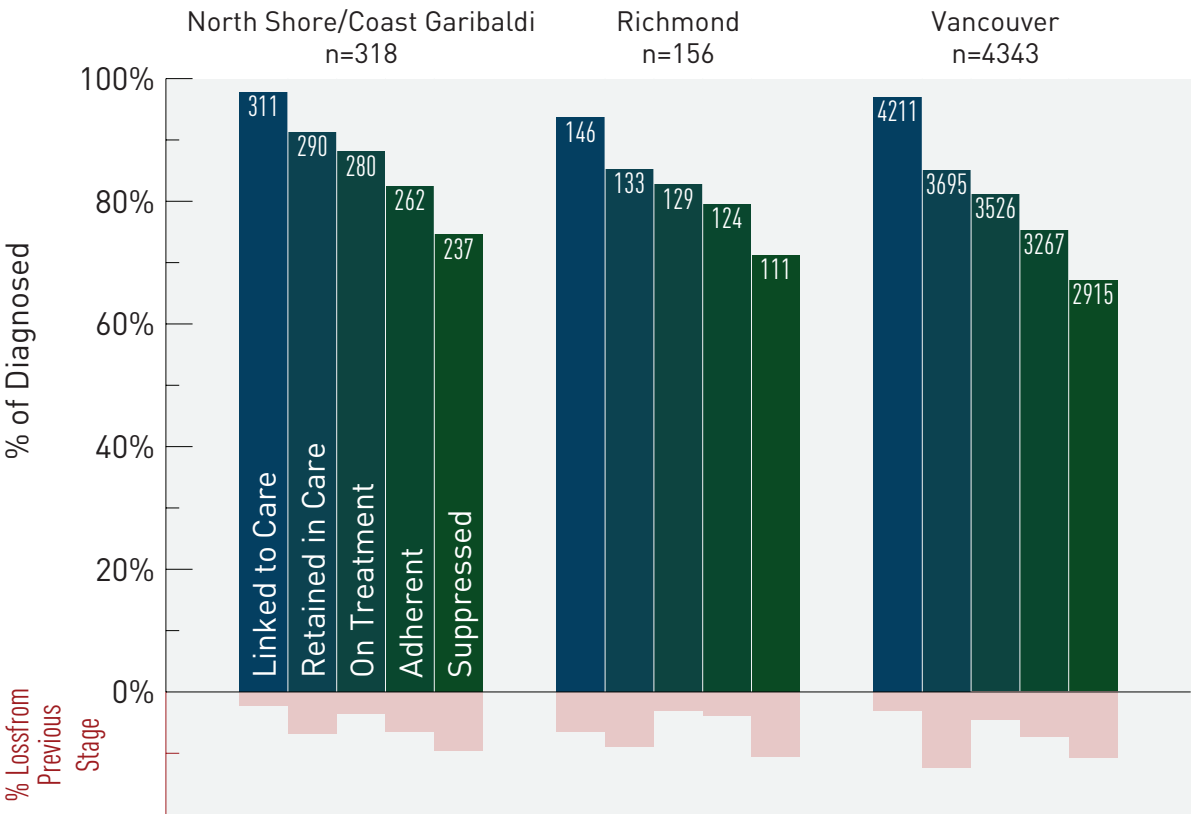
⁹ Data is for the period 2015 Q4–2016 Q3.

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 5.7 Estimated Cascade of Care for Vancouver Coastal Health by HSDA Year Ending 2016 Q4 ⁹



⁹ Data is for the period 2015 Q4–2016 Q3.

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.

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 2 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 Vancouver Coastal Health, 2015 Q1–2016 Q4 ¹⁰

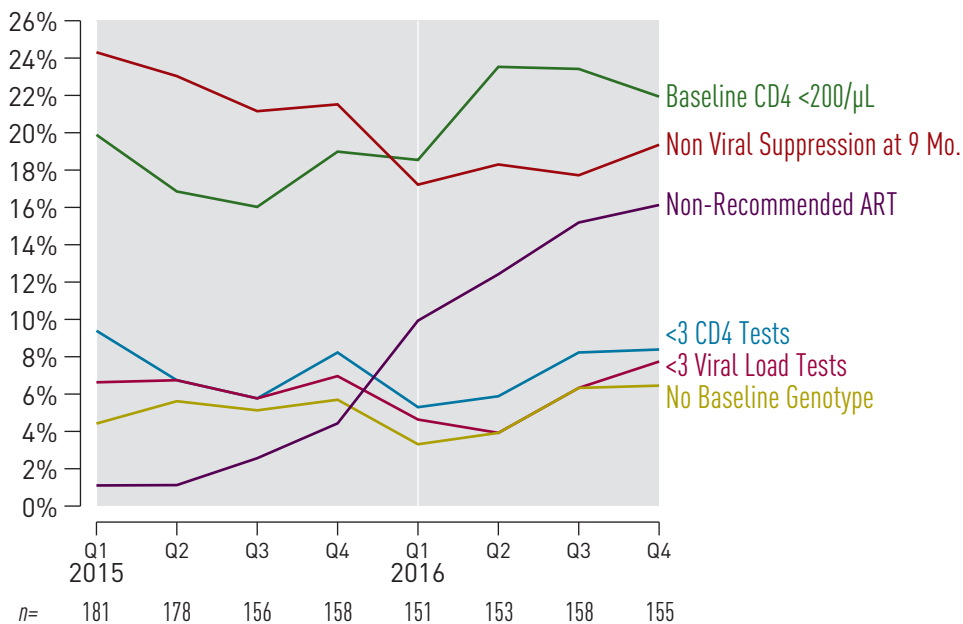
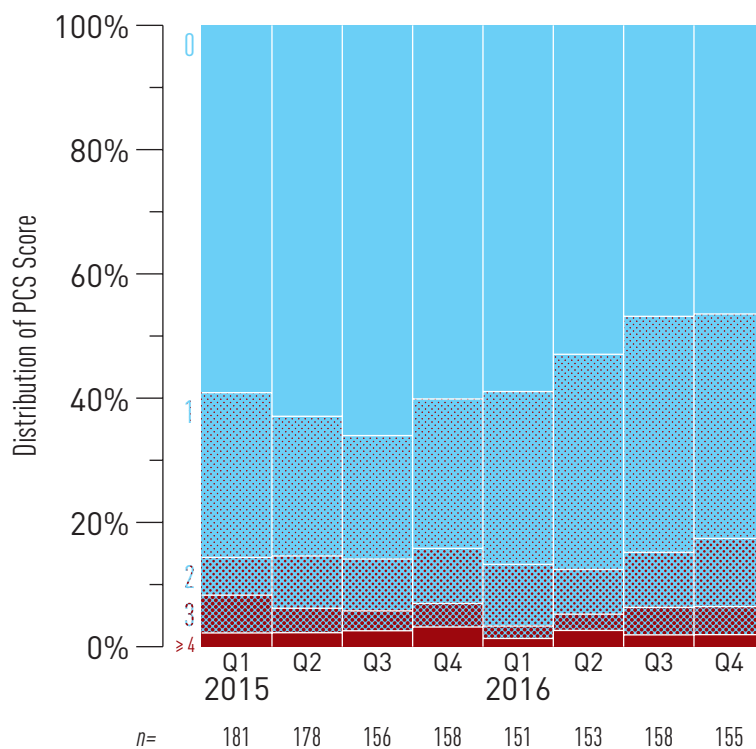


Figure 6.2 Historical Trends for PCS Score for Vancouver Coastal Health, 2015 Q1–2016 Q4 ^{10,11}



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

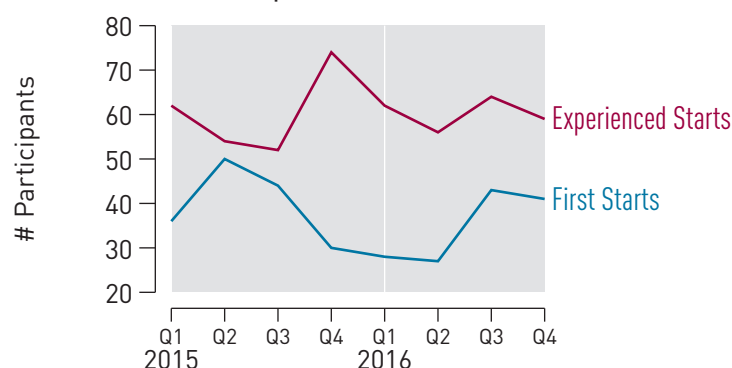
¹¹ Each quarter's data is calculated as the sum of the 4 quarters leading up to it. e.g. 2013 Q1 is calculated from 2012 Q2 – 2013 Q1. NB: A score of 0 is the best score and a score of 4 or more is the worst score.

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.

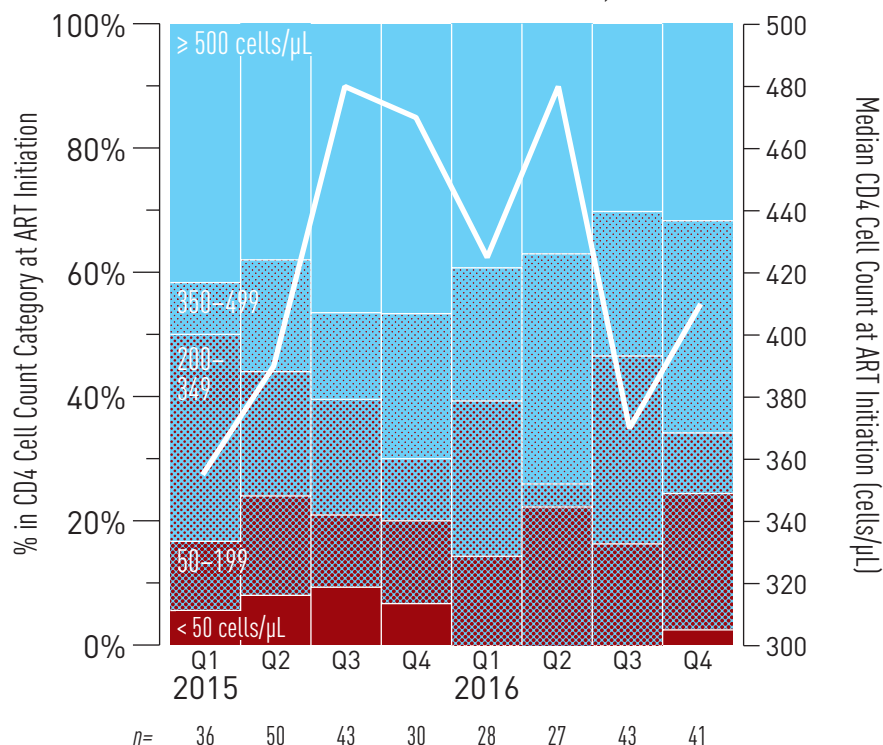
Indicator 7. New Antiretroviral Therapy Starts in Vancouver Coastal Health

Figure 7 BC-CfE Drug Treatment Program Enrollment: New ART Participants in Vancouver Coastal Health, 2015 Q1–2016 Q4 ¹²



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, 2015 Q1–2016 Q4 ¹³



¹² Data Source: Drug Treatment Program Database
Limitation: DTP participants are designated to an HA based on most current residence provided by the participant.

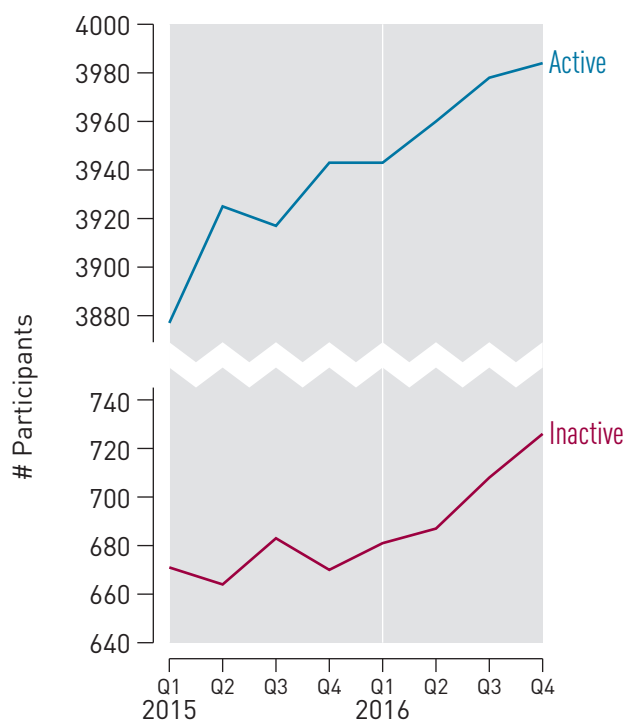
¹³ Data Source: Drug Treatment Program Database
Limitations: CD4 cell count data is approximately 80% complete.

Indicator 9. Active and Inactive DTP Participants

Table 3. Distribution of People on ART for Vancouver Coastal Health, 2016 Q4 ¹⁴

Age	< 30	138
	30–39	542
	40–49	1008
	≥ 50	2296
Gender	Male	3506
	Female	478
Exposure	MSM	1919
	PWID	1106
Total		3984

Figure 9 Active and Inactive DTP Participants in Vancouver Coastal Health, 2015 Q1–2016 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.

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.

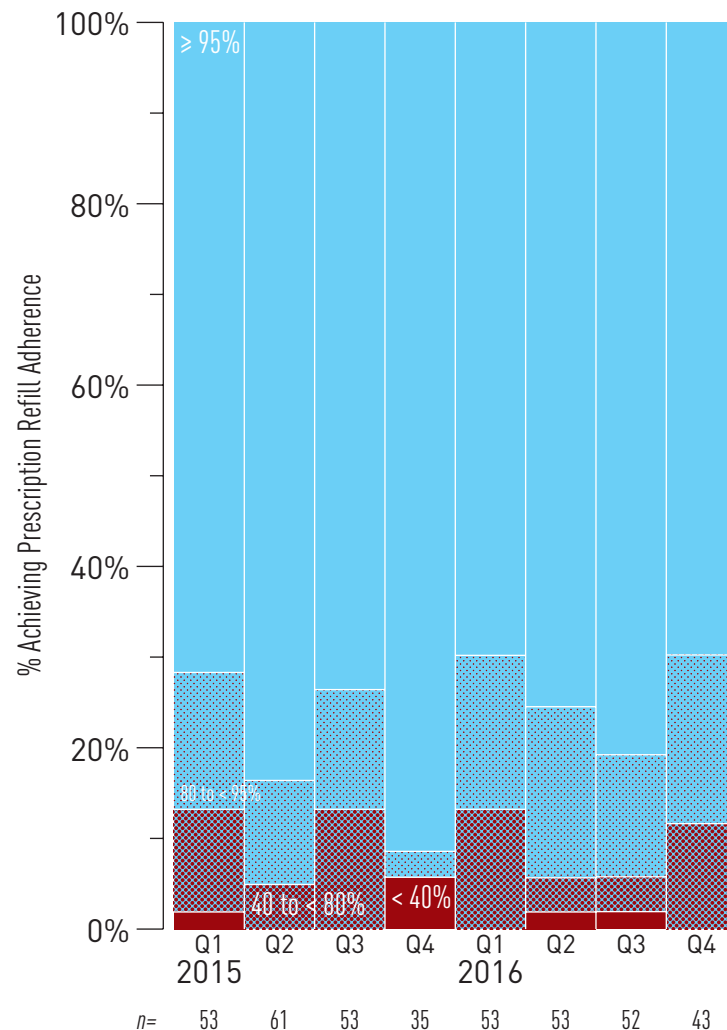
Inactive DTP participants: Persons no longer prescribed drugs through the HIV/AIDS Drug Treatment Program in the last quarter.

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 Vancouver Coastal Health, 2015 Q1–2016 Q4 ¹⁶



¹⁶ Data Source: Drug Treatment Program Database

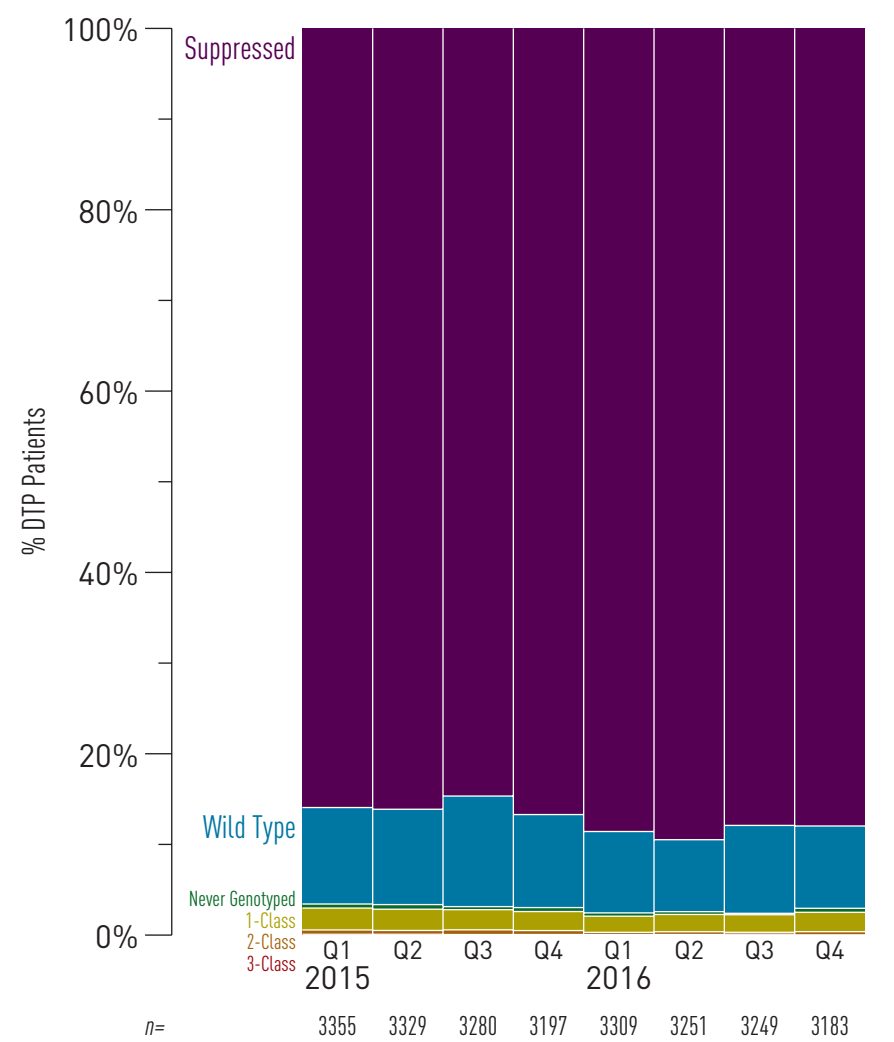
Limitation: Prescription refill adherence is used as a proxy for patient adherence.

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 Vancouver Coastal Health, 2015 Q1–2016 Q4 ¹⁷



¹⁷ Data Source: Drug Treatment Program Database

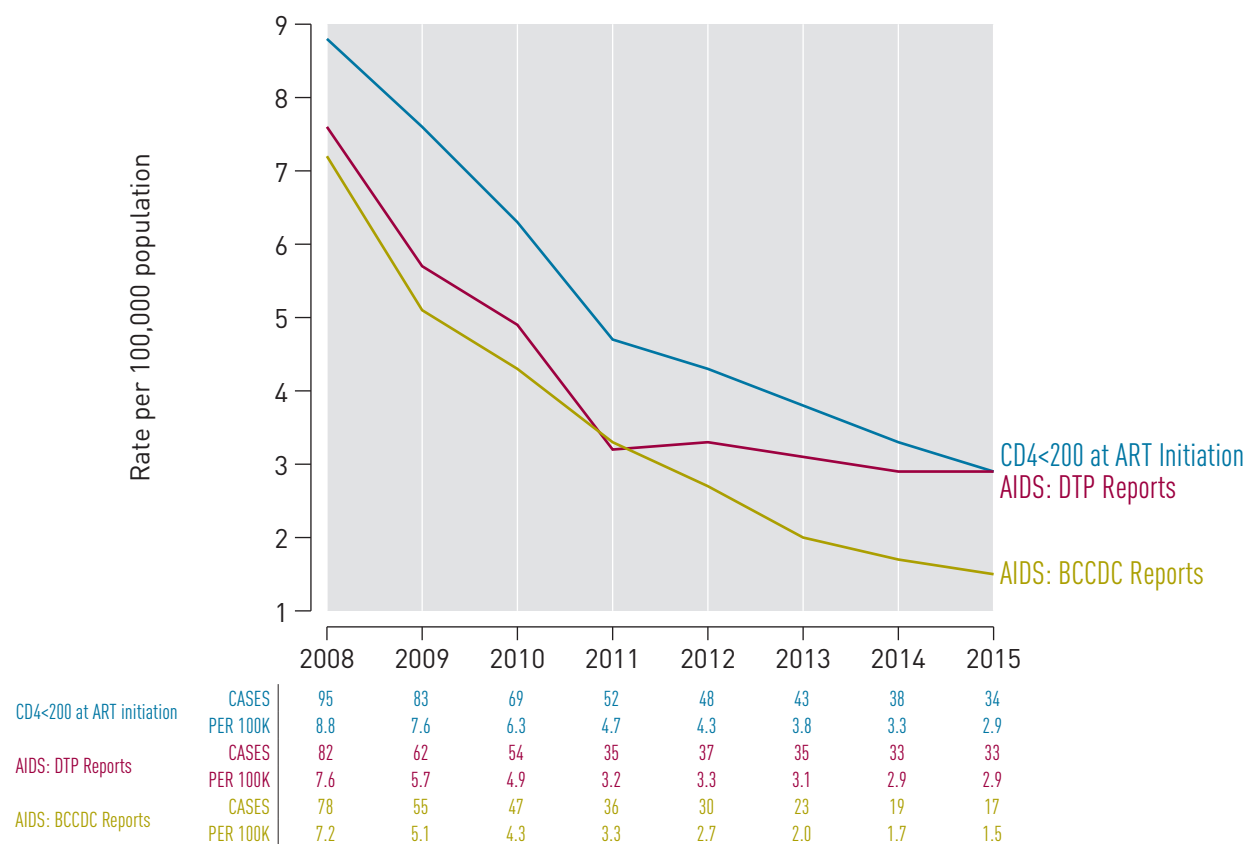
Limitation: DTP participants are designated to a HA based on most current residence provided by the participant.

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 Vancouver Coastal Health ¹⁸



¹⁸ 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. Indicator 12 also reflects information from BC Vital Statistics. As this information is made available to BC-CFE, we use it to inform the development and refinement of this indicator.

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

This indicator is currently under revision.

APPENDICES

Indicator 1: Test Episodes (thousands)		2012				2013				2014				2015				2016			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Vancouver Coastal Health		21.8	21.4	24.0	24.5	30.1	32.1	30.7	29.9	35.0	38.4	43.0	41.6	45.5	44.8	45.5	44.6	49.0	48.1	46.7	45.2
Gender	Female	9.0	9.0	10.3	10.7	13.6	14.8	14.0	13.6	15.8	17.9	20.0	19.6	21.8	21.6	21.8	21.2	23.0	23.1	22.2	21.0
	Male	10.5	10.3	11.4	11.9	14.3	15.3	14.4	14.3	16.8	18.3	20.4	19.9	21.8	21.4	21.9	21.7	24.1	23.4	22.7	22.3
	Other	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Age	< 30	6.4	6.2	7.1	7.1	7.7	8.2	8.3	8.1	8.8	9.0	10.2	9.9	10.2	10.3	11.4	11.1	11.1	11.3	11.6	11.1
	30–39	5.1	5.0	5.2	5.2	6.4	6.7	6.5	6.2	7.6	7.6	8.1	7.7	8.8	8.9	9.2	8.6	9.9	9.8	9.4	8.8
	40–49	3.4	3.4	3.5	3.8	4.8	5.1	4.6	4.6	5.4	5.7	6.1	5.9	6.5	6.4	6.5	6.3	7.1	6.9	6.4	6.2
	≥ 50	4.5	4.8	5.9	6.4	9.1	10.2	9.0	9.1	11.0	14.0	16.1	16.0	18.1	17.5	16.8	16.9	19.0	18.6	17.5	17.2
POC Tests		2.1	1.9	2.1	1.7	2.0	1.8	2.1	1.9	2.1	2.0	2.4	2.0	1.7	1.6	1.6	1.5	1.7	1.4	1.6	1.7
North Shore / Coast Garibaldi		2.1	2.0	2.1	2.3	2.5	2.6	2.6	2.7	3.1	4.3	4.8	5.3	5.8	5.6	6.1	6.0	6.2	6.1	6.4	6.3
	Female	1.1	1.0	1.1	1.2	1.3	1.4	1.3	1.3	1.6	2.2	2.5	2.8	3.1	3.0	3.3	3.2	3.2	3.2	3.3	3.3
	Male	1.0	1.0	1.0	1.1	1.2	1.3	1.3	1.3	1.5	2.1	2.2	2.5	2.7	2.6	2.8	2.8	3.0	2.9	3.0	3.0
Richmond		1.0	1.0	1.1	1.2	1.4	1.4	1.4	1.3	2.5	4.8	4.8	4.7	5.1	4.5	4.2	4.8	5.7	5.5	5.3	5.3
	Female	0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.7	1.3	2.6	2.6	2.4	2.7	2.5	2.2	2.6	3.0	3.1	2.9	2.8
	Male	0.5	0.5	0.5	0.6	0.7	0.7	0.7	0.7	1.2	2.2	2.3	2.2	2.4	2.0	2.0	2.2	2.7	2.4	2.4	2.5
Vancouver		18.7	18.5	20.9	21.1	26.2	28.1	26.7	25.8	29.4	29.2	33.3	31.6	34.6	34.7	35.1	33.9	37.1	36.5	35.0	33.5
	Female	7.4	7.5	8.7	8.8	11.6	12.7	12.0	11.5	12.9	13.1	15.0	14.3	16.0	16.2	16.3	15.5	16.8	16.8	16.0	14.8
	Male	9.0	8.9	9.9	10.3	12.4	13.4	12.4	12.3	14.1	14.1	15.9	15.1	16.7	16.8	17.1	16.7	18.4	18.1	17.3	16.8

Indicator 2: Rate of HIV Testing per 100,000		2009				2010				2011				2012				2013				2014				2015			
All Vancouver Coastal Health		4124.7				4140.0				4342.7				5822.1				8106.2				10292.3				11567.5			
North Shore / Coast Garibaldi		2668.8				2668.3				2773.8				3282.7				4085.4				6410.9				8204.2			
Richmond		1762.3				1840.3				1910.7				2441.4				3065.7				8124.7				8725.0			
Vancouver		5485.7				5494.2				5777.8				7957.9				11380.6				12633.5				13901.2			
Gender	Female	3547.3				3531.6				3737.8				5339.0				7795.3				9991.2				11406.5			
	Male	4396.2				4470.0				4658.0				6147.4				8320.8				10484.2				11613.8			
Age	< 30	4308.7				4296.9				4495.6				5505.9				6669.2				7667.9				8526.6			
	30–39	7337.9				7558.7				7670.6				9508.3				12239.4				14262.4				15698.8			
	40–49	4522.4				4441.7				4655.9				6213.3				8989.4				10897.6				12007.8			
	≥ 50	1842.4				1909.7				2189.8				4161.3				7254.4				10745.2				12328.5			

Indicator 3: New HIV Diagnoses		2012				2013				2014				2015				2016			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Vancouver Coastal Health	By Client Residence	43	33	33	32	31	44	40	25	37	49	32	27	37	34	33	24	23	34	40	30
	By Provider Address	47	38	37	38	31	49	49	29	41	54	36	32	44	40	35	23	24	40	48	32
Gender	Female	5	4	3	2	4	4	1	1	3	4	3	3	4	1	5	5	2	5	4	2
	Male	38	29	30	30	27	40	39	24	33	44	29	24	33	33	28	19	21	29	36	28
Age	< 30	11	10	7	13	7	10	14	6	11	12	6	9	9	9	10	5	6	9	8	10
	30–39	12	11	7	6	11	14	5	3	10	16	13	7	9	9	9	5	9	8	14	13
	40–49	12	6	11	9	8	8	11	10	8	7	5	5	6	9	4	6	4	6	4	4
	≥ 50	8	6	8	4	5	12	10	6	8	14	8	6	13	7	10	8	4	11	13	3
Exposure	MSM	33	25	25	22	19	31	29	20	28	36	21	18	25	26	22	13	14	20		
	PWID	3	4	1	3	3	3	3	2	4	3	2	1	2	2	4	3	0	1		
	HET	7	4	6	6	8	8	6	2	4	7	6	4	6	5	6	6	4	5		
	Other	0	0	0	0	0	0	1	0	0	0	2	2	2	0	0	0	0	1		
	NIR/Unknown	0	0	1	1	1	2	1	1	1	3	1	2	2	1	1	2	5	7		
North Shore / Coast Garibaldi	By Client Residence	2	3	1	1	3	1	4	1	1	3	3	3	2	0	1	5	0	3	3	3
	By Provider Address	1	2	2	1	3	2	4	0	1	2	3	3	2	2	1	4	0	2	3	3
Richmond	By Client Residence	0	1	3	0	2	0	0	1	1	1	2	0	1	4	2	0	0	4	1	2
	By Provider Address	0	1	2	1	0	0	0	2	2	1	3	0	1	2	2	0	0	6	2	1
Vancouver	By Client Residence	41	29	29	31	26	43	36	23	35	45	27	24	34	30	30	19	23	27	36	25
	By Provider Address	46	35	33	36	28	47	45	27	38	51	30	29	41	36	32	19	24	32	43	28

Indicator 4: Stage of HIV Infection at Baseline

	VCH					Female					Male					< 30 years					30-39 years					40-49 years				
	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15
Stage 0	49	44	34	46	43	0	6	1	2	8	49	38	32	44	35	9	16	12	19	12	21	15	12	15	15	16	7	8	7	5
1	38	33	39	42	28	4	3	3	8	4	34	29	36	34	24	13	8	15	9	9	13	13	13	14	6	5	7	4	9	6
2a	35	19	34	17	13	5	1	3	2	2	30	18	31	15	11	8	4	8	2	5	12	3	9	2	2	10	8	7	6	3
2b	24	19	16	19	20	4	3	3	0	2	20	16	13	19	17	5	4	0	4	4	5	4	10	5	6	9	6	4	5	3
3	28	34	30	23	23	4	2	3	5	3	24	32	27	18	20	1	5	2	3	2	5	6	2	6	3	9	8	15	4	5
Unknown	13	8	4	12	11	0	1	0	1	0	12	7	4	11	11	3	5	0	2	1	4	2	1	6	3	2	0	0	2	4
Total	187	157	157	159	138	17	16	13	18	19	169	140	143	141	118	39	42	37	39	33	60	43	47	48	35	51	36	38	33	26

	≥ 50 years					MSM					Heterosexual					PWID					Other Exposure					NIR/Unknown				
	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15	'11	'12	'13	'14	'15
Stage 0	3	6	2	5	11	45	35	25	42	29	2	4	6	3	4	2	5	3	1	10	0	0	0	0	0	0	0	0	0	0
1	7	5	7	10	7	29	26	30	27	21	2	1	3	6	0	6	6	4	8	6	1	0	0	1	0	0	0	2	0	1
2a	5	4	10	7	3	25	14	25	12	9	4	4	4	0	0	5	1	4	3	2	1	0	0	0	1	0	0	1	2	1
2b	5	5	2	5	7	17	13	12	12	14	2	2	0	2	3	5	3	3	4	2	0	0	0	0	1	0	1	1	1	0
3	13	15	11	10	13	13	22	16	9	9	1	1	1	0	3	13	9	11	9	8	1	0	0	3	0	0	2	2	2	3
Unknown	4	1	3	2	3	9	7	3	9	7	2	0	0	0	0	1	1	0	1	1	1	0	1	0	0	0	0	0	2	3
Total	37	36	35	39	44	138	117	111	111	89	13	12	14	11	10	32	25	25	26	29	4	0	1	4	2	0	3	6	7	8

Indicator 5: HIV Cascade of Care

Indicator 5: HIV Cascade of Care			Diagnosed	Linked	Retained	On ARVs	Adherent	Suppressed
Vancouver Coastal Health			4818	4669	4118	3935	3653	3263
Gender	Men		4227	4129	3609	3460	3230	2919
	Women		592	540	510	475	423	344
Age Category	< 30		215	140	117	112	97	84
	30-39		641	621	529	495	430	381
	40-49		1185	1156	1009	953	876	771
	≥ 50		2778	2752	2463	2375	2250	2027
MSM Status	MSM		2194	2170	1970	1890	1775	1646
	Non-MSM		1206	1192	1137	1081	972	780
	Unknown		1418	1307	1011	964	906	837
Age Category and MSM Status	MSM	< 30	71	59	48	46	38	35
		30-39	280	273	230	215	190	177
		40-49	479	473	432	407	381	350
		≥ 50	1364	1364	1260	1222	1166	1084
	Non-MSM	< 30	23	19	18	18	14	10
		30-39	148	144	131	122	101	78
		40-49	326	324	298	282	248	194
		≥ 50	709	705	690	659	609	498
	Unknown	< 30	121	61	50	48	45	39
		30-39	213	203	168	158	139	126
		40-49	380	359	279	264	247	227
		≥ 50	705	684	514	494	475	445
	PWID Status	PWID	1249	1239	1192	1131	1019	830
		Non-PWID	2454	2424	2199	2112	1988	1833
		Unknown	1116	1005	727	692	646	600
	HSDA	North Shore/Coast	318	311	290	280	262	237
Garibaldi								
Richmond		156	146	133	129	124	111	
Vancouver		4343	4211	3695	3526	3267	2915	

Indicator 6: Programmatic Compliance Score (PCS)	2015				2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
< 3 CD4 Tests	9.4%	6.7%	5.8%	8.2%	5.3%	5.9%	8.2%	8.4%
< 3 Viral Load Tests	6.6%	6.7%	5.8%	7.0%	4.6%	3.9%	6.3%	7.7%
No Baseline Genotype	4.4%	5.6%	5.1%	5.7%	3.3%	3.9%	6.3%	6.5%
Baseline CD4 < 200 cells/μL	19.9%	16.9%	16.0%	19.0%	18.5%	23.5%	23.4%	21.9%
Non-Recommended ART	1.1%	1.1%	2.6%	4.4%	9.9%	12.4%	15.2%	16.1%
Non Viral Suppression at 9 Mo.	24.3%	23.0%	21.2%	21.5%	17.2%	18.3%	17.7%	19.4%
PCS Score: 0	107	112	103	95	89	81	74	72
PCS Score: 1	48	40	31	38	42	53	60	56
PCS Score: 2	11	15	13	14	15	11	14	17
PCS Score: 3	11	7	5	6	3	4	7	7
PCS Score: 4 or more	4	4	4	5	2	4	3	3
Total (n=)	181	178	156	158	151	153	158	155

Indicator 7: **New DTP ARV Participants**

First Starts	36	50	44	30	28	27	43	41
Experienced Starts	62	54	52	74	62	56	64	59

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

CD4 ≥ 500	15	19	20	14	11	10	13	13
CD4 350-499	3	9	6	7	6	10	10	14
CD4 200-349	12	10	8	3	7	1	13	4
CD4 50-199	4	8	5	4	4	6	7	9
CD4 < 50	2	4	4	2	0	0	0	1
CD4 MED	355	390	480	470	425	480	370	410
Total (n=)	36	50	43	30	28	27	43	41

Indicator 9: **Active and Inactive DTP Participants**

Active DTP Participants	3877	3925	3917	3943	3943	3960	3978	3984
Inactive DTP Participants	671	664	683	670	681	687	708	726

Indicator 10: **Antiretroviral Adherence**

≥ 95%	38	51	39	32	37	40	42	30
80% to < 95%	8	7	7	1	9	10	7	8
40% to < 80%	6	3	7	0	7	2	2	5
< 40%	1	0	0	2	0	1	1	0
Total (n=)	53	61	53	35	53	53	52	43

Indicator 11: **Resistance Testing and Results**

Suppressed	2883	2867	2777	2772	2931	2909	2856	2800
Wild Type	357	350	400	328	297	258	315	289
Never Genotyped	15	17	11	14	12	10	5	14
1-Class	81	78	73	67	59	62	63	68
2-Class	16	14	17	14	8	10	7	11
3-Class	3	3	2	2	2	2	3	1
4-Class	0	0	0	0	0	0	0	0
Total (n=)	3355	3329	3280	3197	3309	3251	3249	3183

Indicator 12: **AIDS-Defining Illness**

	2008	2009	2010	2011	2012	2013	2014	2015
CD4 < 200 at Cases	95	83	69	52	48	43	38	34
ART initiation <i>Rate per 100,000</i>	8.8	7.6	6.3	4.7	4.3	3.8	3.3	2.9
AIDS Cases Cases	82	62	54	35	37	35	33	33
(DTP Reports) <i>Rate per 100,000</i>	7.6	5.7	4.9	3.2	3.3	3.1	2.9	2.9
AIDS Cases Cases	78	55	47	36	30	23	19	17
(BCCDC Reports) <i>Rate per 100,000</i>	7.2	5.1	4.3	3.3	2.7	2.0	1.7	1.5

Indicator 13: **HIV-Related Mortality**

	2004	2005	2006	2007	2008	2009	2010	2011
British Columbia	105	146	142	100	79	63	54	59
Per 100 HIV+ Population	1.03	1.40	1.34	0.93	0.72	0.56	0.47	0.50
Per 100,000 Population	2.50	3.43	3.29	2.28	1.80	1.41	1.19	1.29