



University of Washington
Public Health Capacity Building Center

Update from the 2015 National HIV Prevention Conference: Data to Care

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Common Themes



**2015 National HIV
Prevention Conference**
Accelerating Progress: Prevent Infections. Strengthen Care. Reduce Disparities.
Atlanta GA | December 6–9, 2015

- Reports from ≥ 15 states and 4 cities
 - Different definitions, methods, and outcome analyses
- Effectiveness of Data to Care strategy remains uncertain
 - Many or most persons who appear to be out of care are not actually out of care
 - Some presentations focused primarily on methodology
- New methods to improve Data to Care on the horizon

Synthesizing What we Know Now



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- What % of PLWH are truly out of care?
- How successful are we at contacting them?
- How successful are we at relinking them?

- How can we do better?
 - Data
 - Addressing complex psychosocial barriers to care

Cross-State Comparisons: Selected Presentations



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- **Louisiana**
 - Brantley, A., et al. *Expanding the Use of Surveillance Data to Improve HIV Medical Care Engagement and Viral Suppression.* [Abstract 1910]
- **Maryland**
 - Cassidy-Stewart, H., et al. *Maryland's PS12-1201 Demonstration Project: Improving the Health of Marylanders Living with HIV through Enhanced Linkage-to-Care Systems and Activities.* [Abstract 1650]
- **Massachusetts**
 - Nagavedu, K., et al. *Using HIV Laboratory Surveillance Data to Identify Out-of-Care Patients.* [Abstract 2231]
- **New York**
 - Tesoriero, J., et al. *Improving Retention in HIV Care through New York's Expanded Partner Services Pilot: Results of a 1 Year Pilot.* [Abstract 1484]
- **Tennessee**
 - Morrison, M., et al. *Partnering HIV Surveillance and Prevention to Identify and Provide Linkage to Care for Out of Care Diagnosed Positive Individuals.* [Abstract 1503]
- **Washington**
 - Heal, D., et al. *Using HIV Surveillance Data for Linkage and Re-engagement to HIV Care, the Washington State Experience.* [Abstract 2046]

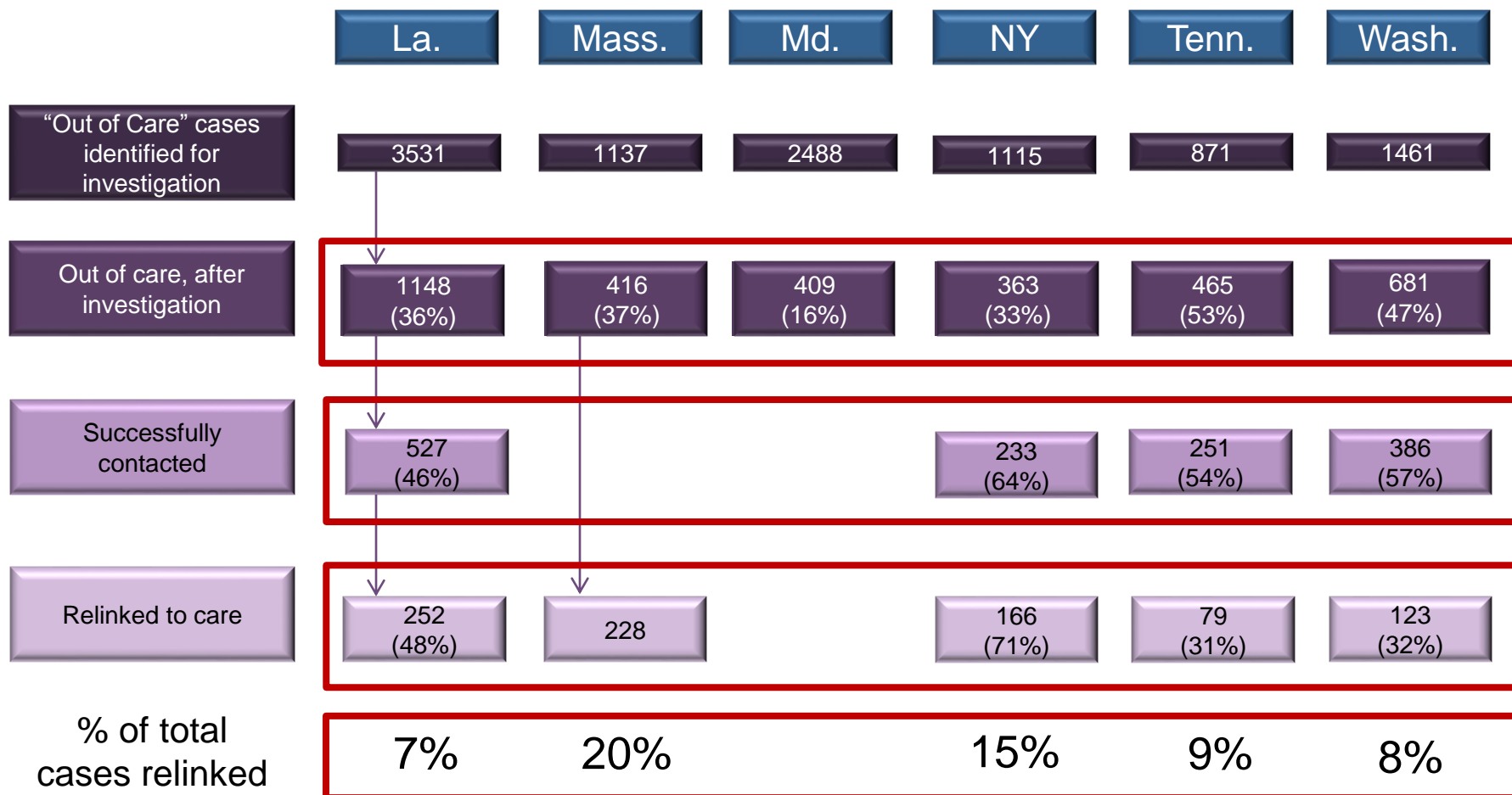
Cross-State Comparisons*



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*Projects used different definitions and methodologies. Above numbers are my attempt to synthesize the information and do not necessarily reflect the categories that author's used to describe each group

Synthesizing What we Know Now



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What % of PLWH are truly out of care?

- ~ 33 – 50% of those that *appear* to be out of care
- If applied to US continuum:
 - **54% of HIV-diagnosed → 18-27% of HIV-diagnosed**

How successful are we at contacting them?

- ~50% of attempts (17-25% of total cases)

How successful are we at relinking them?

- Remains unclear (varies)
- Not all projects account for “spontaneous” relinkage

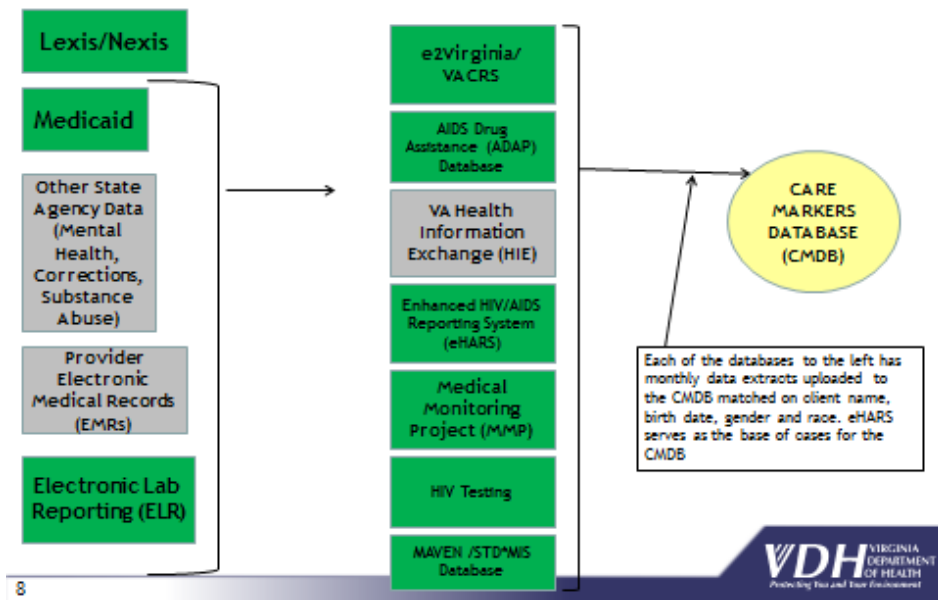
How can we do better?



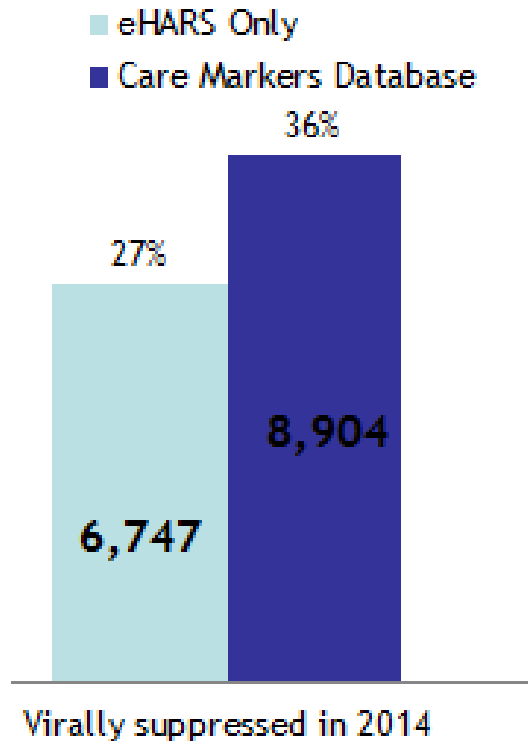
Virginia's Care Marker Database: Using Multiple Data Sources for HIV Care Linkage and Re-engagement (Abstract 1429)

Anne Rhodes et al., Virginia Dept. of Health

Care Markers Database



HIV Care Continuum Indicators: eHARS Only vs. Care Markers Database (CMDB)



Integrating internal databases increased viral suppression from 27 to 36%...

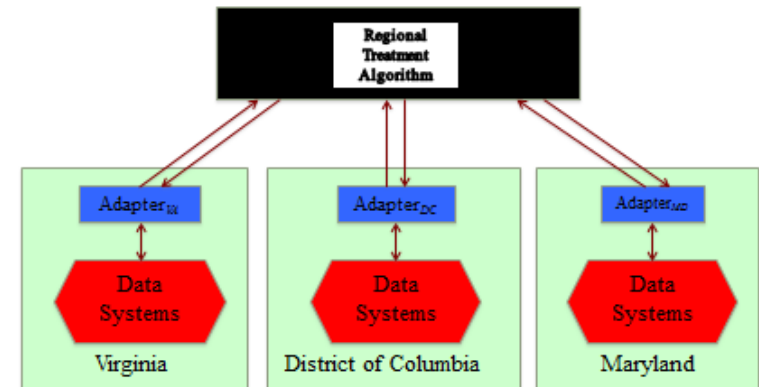
Quantifying the churn effect in the DC metropolitan region using a novel privacy and data sharing technology (Abstract 1999) *Anne Rhodes et al., Virginia Dept. of Health*

Next step: routinizing cross-jurisdictional data sharing

- “Black Box”: real time HIV surveillance
- Pilot project: NIH funding to Georgetown
- DC, MD, and VA departments of health
- Privacy technology used algorithm for matching
 - Results in varying strengths (Exact to Very Low)

NIH pilot study

Examination of HIV care “churn effect” across DC metropolitan region



Summary of the “Black Box” pilot

Output of person-matching across DC, MD, and VA eHARS databases:

Person matches across jurisdictions:	Exact	Very High	High	Medium High	Medium	Very Low	Total
DC-MD*	4013	5907	53	268	645	482	11 368
MD-VA*	856	2343	11	117	377	865	4569
VA-DC*	1064	3340	15	149	438	529	5535
Total	5933	11 590	79	534	1460	1876	21 472

*Bidirectional reporting results (i.e., DC-reported MD matches were equal to MD-reported DC-matches; etc.)

>90% validated by jurisdictional review

~50% not found through RIDR

Project Engage: An Innovative Program for Finding and Linking Marginalized Out of Care HIV-Infected Persons in Los Angeles County

Dierst-Davies., et al., LA County Dept. of Public Health

- 2 methods to recruit out-of-care
 - Social network
 - “Seeds” recruit “alters”
 - Direct
 - Flyers, field, word of mouth
- Confirm care disengagement with surveillance
- \$40 for each if truly out-of-care



Screening and Enrollment

Current Status

- Active (since October 2012)

Screened¹

- Seeds: 120
- Alters: 307

Enrolled

- Seeds: 62
- Alters: 104

Eligibility Criteria ²	n (%)
No HIV care visits in >12 months	36 (35%)
No HIV care for 7-12 months and most recent VL>200 copies/ml	12 (12%)
Newly-diagnosed and not linked within 3 months	14 (13%)
Recently released from jail with no identified primary HIV provider	50 (48%)
Other (inconsistent care, diagnosed in other country w/ no medical home)	13 (13%)

¹The majority of alters are not eligible because they are not HIV-infected or are in HIV care

²Categories are not mutually exclusive



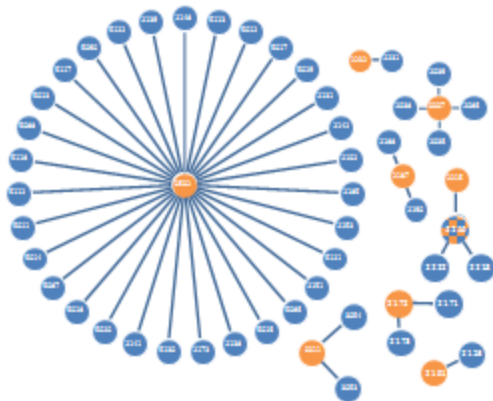
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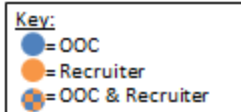
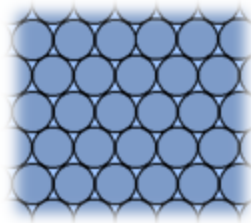


Project Engage Alter Recruitment (n=104)

Snowball Sample = 61 (59%)



Direct Recruitment = 43 (41%)



- Alters
 - 42% uninsured
 - 77% homeless
 - 60% recently incarcerated
 - 47% IDU
 - 31% engaged in sex work
 - Out of care: Mean 13 mo (SD: 21 mo)

- Social networks can bring in high priority patients if you find the “connector”



Improvements in Retention in Care & Viral Suppression: Results from the First Year of the Medical Care Coordination Program in Los Angeles County

Kulkarni, S., et al., LA County Dept. of Public Health

- Medical Care Coordination Program
- Multidisciplinary team
 - RN, MSW, case worker
- Screen clinic's HIV panel
- Assess & identify needs q6 months
- Link patients to support services or deliver brief interventions
- 25 Ryan White clinics managed by 19 agencies
- N=1204 patients in 2013



MCC Assessment and Patient Acuity

- Assessment identifies medical and psychosocial factors that may affect patient's health across 12 domains

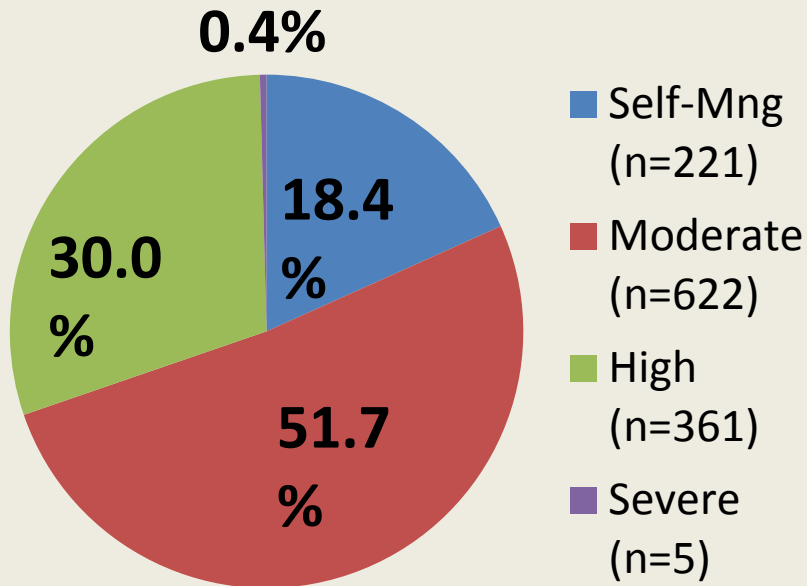
-Health status	- Quality of Life
-Adherence	- Access to Care
-Housing	- Financial
-Legal/End of Life	- Transportation
-Risk Behaviors	- Alcohol/Drug Use
-Mental health	- Support Systems



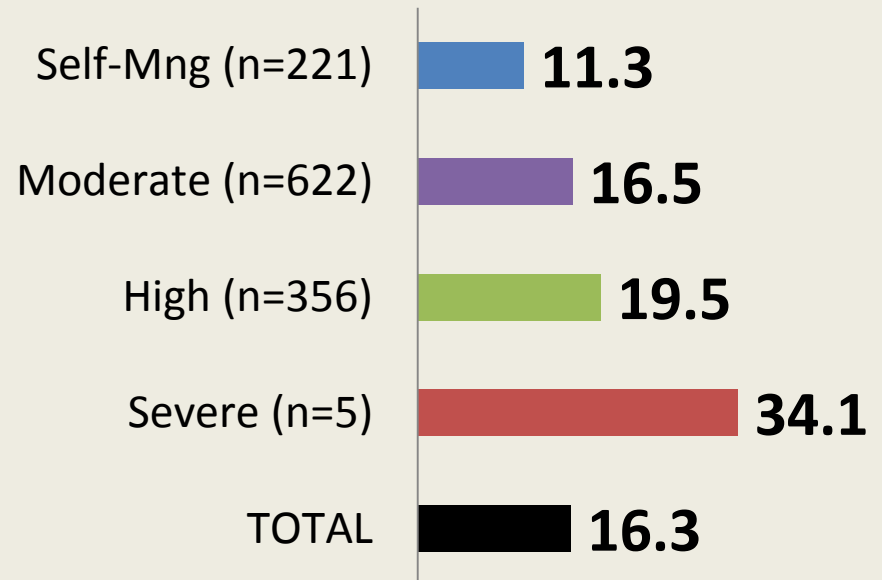
Systematically assessed acuity

Patient Acuity Level and Service Delivery Hours (n=1,204)

Patients by Acuity Level

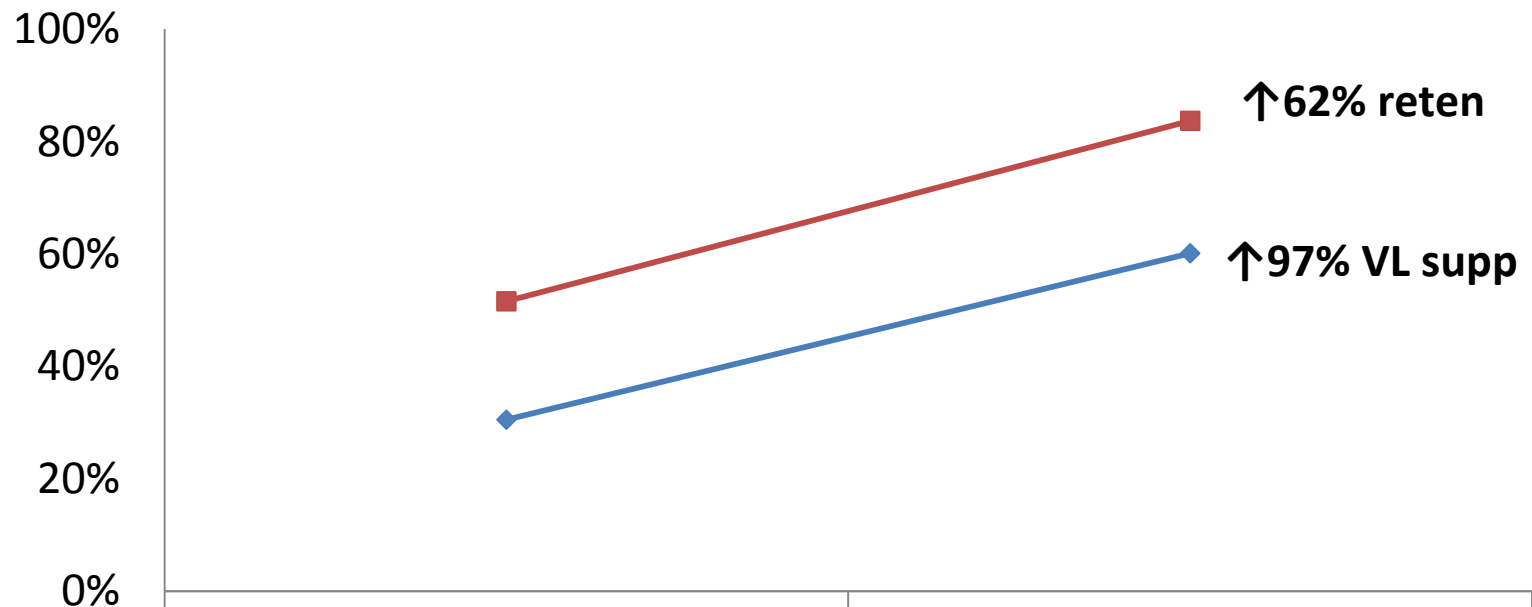


Median Service Hours per Patient by Acuity Level



12-Month Outcomes for All MCC Patients

Changes in Viral Suppression and Retention 12m Pre- and Post-MCC (N=1,204)



	12m Pre-MCC	12m Post-MCC*
◆ Viral Suppression	31%	60%
■ Retention in Care	52%	84%

Data source: DHSP, Casewatch, Years 22-24; DHSP, HIV Surveillance data 2012-2014, as of March 2015

*Significant difference from Pre- to Post-MCC ($p < 0.001$)

The Effects of Financial Incentives on Viral Load Suppression among Homeless PLWH

Ghose, T., et al. U. Penn & Housing Works (NYC)

- “The Undetectables Project”
- Clients receiving integrated HIV care at Housing Works
 - Medical provider, case manager, case coordinator
- Team adherence planning & support
- Assistance to meet subsistence needs
- \$100 q3 mo for undetectable VL
- CBT & support groups
- Pill boxes, texts, daily reminders
- DOT “formal & informal”

Viral Load	Baseline, Mar. 2004 (N=411)	Follow-up, Aug. 2015 (N=610)
Undetectable (<50 copies/mL)	54%	83%
Detectable	37%	15%
Unknown	9%	2%

Intensive support, housing & food assistance, & financial incentives might improve viral suppression among patients with complex barriers to care



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Thank you!