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

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Common Themes

• 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

- 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

- **Louisiana**
  - Brantley, A., et al. *Expanding the Use of Surveillance Data to Improve HIV Medical Care Engagement and Viral Suppression.* [Abstract 1910]

- **Maryland**

- **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**

- **Washington**
### Cross-State Comparisons*

<table>
<thead>
<tr>
<th>State</th>
<th>&quot;Out of Care&quot; cases identified for investigation</th>
<th>Out of care, after investigation</th>
<th>Successfully contacted</th>
<th>Relinked to care</th>
<th>% of total cases relinked</th>
</tr>
</thead>
<tbody>
<tr>
<td>La.</td>
<td>3531</td>
<td>1148 (36%)</td>
<td>527 (46%)</td>
<td>252 (48%)</td>
<td>7%</td>
</tr>
<tr>
<td>Mass.</td>
<td>1137</td>
<td>416 (37%)</td>
<td>233 (64%)</td>
<td>166 (71%)</td>
<td>20%</td>
</tr>
<tr>
<td>Md.</td>
<td>2488</td>
<td>409 (16%)</td>
<td>251 (54%)</td>
<td>79 (31%)</td>
<td>15%</td>
</tr>
<tr>
<td>NY</td>
<td>1115</td>
<td>363 (33%)</td>
<td>386 (57%)</td>
<td>123 (32%)</td>
<td>9%</td>
</tr>
<tr>
<td>Tenn.</td>
<td>871</td>
<td>465 (53%)</td>
<td></td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Wash.</td>
<td>1461</td>
<td>681 (47%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

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?
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)
Summary of the “Black Box” pilot

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

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

*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

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

Note: Categories are not mutually exclusive.
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

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

Patients by Acuity Level

- Self-Mng (n=221): 18.4%
- Moderate (n=622): 51.7%
- High (n=361): 30.0%
- Severe (n=5): 0.4%

Median Service Hours per Patient by Acuity Level

- Self-Mng (n=221): 11.3 hours
- Moderate (n=622): 16.5 hours
- High (n=356): 19.5 hours
- Severe (n=5): 34.1 hours
- TOTAL: 16.3 hours

Data source: DHSP, Casewatch, Years 23-24 and MCC Assessment, Jan 2013-December 2013
12-Month Outcomes for All MCC Patients

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

<table>
<thead>
<tr>
<th></th>
<th>12m Pre-MCC</th>
<th>12m Post-MCC*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Suppression</td>
<td>31%</td>
<td>60%</td>
</tr>
<tr>
<td>Retention in Care</td>
<td>52%</td>
<td>84%</td>
</tr>
</tbody>
</table>

↑62% reten
↑97% VL supp

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”

<table>
<thead>
<tr>
<th>Viral Load</th>
<th>Baseline, Mar. 2004 (N=411)</th>
<th>Follow-up, Aug. 2015 (N=610)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undetectable (&lt;50 copies/mL)</td>
<td>54%</td>
<td>83%</td>
</tr>
<tr>
<td>Detectable</td>
<td>37%</td>
<td>15%</td>
</tr>
<tr>
<td>Unknown</td>
<td>9%</td>
<td>2%</td>
</tr>
</tbody>
</table>

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