Getting to Zero
What is the missing link?

Retention

Darpun Sachdev, MD and Erin Antunez, MA
What we will cover today?

- HIV epidemic in San Francisco
- What is LINCS
- Next Steps for LINCS
New HIV diagnoses, deaths, and prevalence, 2006-2014, San Francisco

Year | Living HIV cases | New HIV diagnoses | Deaths
---|---|---|---
2006 | 14,454 | 519 | 327
2007 | 14,657 | 527 | 324
2008 | 14,915 | 522 | 264
2009 | 15,128 | 467 | 254
2010 | 15,320 | 439 | 247
2011 | 15,499 | 413 | 234
2012 | 15,692 | 429 | 236
2013 | 15,854 | 371 | 209
2014 | 15,979 | 302 | 177
Continuum of HIV care among persons diagnosed with HIV, 2010-2013, San Francisco

GAPS

- Timely linkage to care, retention and viral suppression less likely among women and transwomen, African Americans and Latinos, and PWID
- Homeless persons less likely to be on treatment.

* Number of new diagnoses shown each year is based on the evidence of a confirmed HIV test and does not take into account patient self-report of HIV positive.

^ Defined as the latest viral load test during the specified period is <= 200 copies/mL.
What is SFDPH doing to improve the continuum of care in SF?
1. **Linkage to care** and **Partner Services** for newly diagnosed HIV+

2. **Navigation** for known HIV+
   - Goal: Provide appropriate HIV–related medical and social services to optimize individual health and prevent HIV transmission
Patient Navigation

• Drawn from a model implemented in the 1990s to help black and Latino patients navigate cancer care at Harlem Hospital
• Guide through pre-determined care plan
• Culturally similar to population served
• Can include “peer” navigators
CDC Antiretroviral Treatment and Access to Services (ARTAS) trial

• Strengths-based case management intervention (identify abilities, foster self-efficacy, set goals)
• 273 recently diagnosed individuals randomized to up to 5 sessions with a linkage facilitator in 90 days (mean # sessions = 2.6)
• 78% had a primary care visit by 6 months vs. 60% in control arm
• 64% had another visit by 12 months (vs. 49%)

Gardner et. al., AIDS 2005
• Systematic monitoring of entry into HIV care (IIA)
• Systematic monitoring of retention in HIV care (IIA)
• Brief, strengths-based case management for individuals with a new HIV diagnosis (IIB)
• Intensive outreach for individuals not engaged within 6 months of a new HIV diagnosis (III C)
• Use of peer or paraprofessional patient navigators (III C)

What is LINCS Navigation?

• Facilitate timely linkage to essential HIV-related medical and social services to optimize individual health and prevent HIV transmission

• Referrals from healthcare providers and HIV Surveillance

• Navigators help “navigate the system of care” by supporting the HIV+ patient in making, keeping track of, and attending medical appointments
  – Short term Navigation (~90 days)
  – Provide warm referrals to other resources to address varying barriers to care

• Goals: 1) Linkage to HIV primary care and 2) demonstration of self-efficacy
LINCS Navigation Prioritization Flow

1. Dx <6 months ago + missed 1 appt
2. Hospitalized with detectable viral load

3. Detectable viral load, not seen in 4 months (prioritize VL>100,000)

4. CD4<200 and history of poor medication adherence
LINCS Navigation Process

Out of care HIV+ patients referred

Located patients are offered Navigation services

Navigators work to locate patients

Enrolled patients provided assistance to re-engage in care
LINCS Locating Process

Receive patient information from healthcare provider (DPH clinic) or surveillance (city-wide)

Locate client and see if they are interested and eligible for navigation services

Jail
In care already
Out of jurisdiction

Eligible?

Yes

Unable to locate

Offer navigation services

Triangulation of Data
Program Description: Core Activities

- Benefits (Insurance) Navigation
- Strengths Based Case Management
- Appointment reminders and escorts
- Warm handoffs to medical case management and housing services
Waldo finds himself.
Does Navigation Work?
LINCS Navigation Referrals, 2012-2014 (N=444)

- 10% Patient located, enrolled in Navigation
- 5% Unable to contact
- [VALUE] 3%
- [VALUE] 2%
- [VALUE] 1%
- [VALUE] 0%

Primarily referred from DPH clinics
Navigation Outcomes

- Enrolled (n=182)
  - Re-linked: 75% (n=137)
  - Not Re-linked: 25% (n=45)

Median time of navigation services: 3 months
# Client Characteristics and VLS status pre and post-LINCS

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total</th>
<th>% VLS 12 months pre-LINCS</th>
<th>% VLS 12 months post-LINCS</th>
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</thead>
<tbody>
<tr>
<td><strong>Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-24</td>
<td>7 (4%)</td>
<td>29%</td>
<td>57%</td>
</tr>
<tr>
<td>25-39</td>
<td>83 (46%)</td>
<td>28%</td>
<td>50%</td>
</tr>
<tr>
<td>40+</td>
<td>92 (50%)</td>
<td>29%</td>
<td>61%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>154 (85%)</td>
<td>30%</td>
<td>60%</td>
</tr>
<tr>
<td>Female</td>
<td>20 (11%)</td>
<td>25%</td>
<td>56%</td>
</tr>
<tr>
<td>Transgender</td>
<td>8 (4%)</td>
<td>13%</td>
<td>38%</td>
</tr>
<tr>
<td>MSM</td>
<td>115</td>
<td>27%</td>
<td>53%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>53 (29%)</td>
<td>21%</td>
<td>58%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>33 (28%)</td>
<td>30%</td>
<td>55%</td>
</tr>
<tr>
<td>White</td>
<td>89 (49%)</td>
<td>34%</td>
<td>56%</td>
</tr>
<tr>
<td>Other</td>
<td>7 (4%)</td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>Homeless</td>
<td>67</td>
<td>27%</td>
<td>55%</td>
</tr>
<tr>
<td>Drug Use</td>
<td>86</td>
<td>28%</td>
<td>57%</td>
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</table>

VLS improved regardless of age, race, housing status, or drug use.
Re-Linkage and viral load suppression pre-and post-LINCS

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<td>Re-Linkage</td>
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<tr>
<td>Re-Linked</td>
<td>137</td>
<td>30%</td>
<td>63%</td>
</tr>
<tr>
<td>Not Re-Linked</td>
<td>45</td>
<td>24%</td>
<td>33%</td>
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What’s next?: Clinic-based Navigators and Data to Care
# New Programmatic Activities

<table>
<thead>
<tr>
<th>Program</th>
<th>2012-2014</th>
<th>Oct 2015-current</th>
</tr>
</thead>
<tbody>
<tr>
<td># Navigators</td>
<td>1.5 FTE</td>
<td>6 FTE (4 placed at DPH clinics, 2 at City Clinic)</td>
</tr>
<tr>
<td># Contact Specialists</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Out of care &gt; 6 months</td>
<td>Detectable viral load and out of care &gt; 4 months</td>
</tr>
<tr>
<td>Referral</td>
<td>Healthcare provider</td>
<td>Health care provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surveillance identified</td>
</tr>
<tr>
<td>Training</td>
<td>Informal, shadowing</td>
<td>3 day comprehensive Navigator bootcamp with weekly LINCS meetings and monthly city-wide Navigator networking events</td>
</tr>
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## Navigation

- Images of boots, a hand knocking on a door, and a cell phone.

## Contact Specialist

- Images of a phone and a computer keyboard.
DPH Clinics with clinic-based LINCS Navigators

Ward 86
Mission

Tom Waddell
Tenderloin

Castro Mission
Castro
Goals of Data to Care in SF

• “Using surveillance data to identify HIV-diagnosed persons who are not in care, link them to care, and support the HIV care continuum”
  – Re-engaging persons who have fallen out of care

• CDC encourages all health departments to implement D2C
SF HIV Surveillance Background

- All HIV viral loads, confirmed HIV positive antibody tests and CD4 cell counts must be reported to the health department.
- **Follow up** case information is collected through routine lab-based reporting (VL, CD4) (not just the diagnostic or first report).
- ~every 12-18 months, medical chart review of living cases and collect:
  - treatment information
  - housing status (homeless), demographics, HCV
  - any patient re-location outside of SF or change in medical provider
  - vital status
  - subsequent OI’s, CD4, VL lab results

Data to Care: Target HIV+ patients with no or detectable VL?
Targeting Data to Care Efforts

- Large number of persons who are misclassified as out of care, who are unlocatable or uncontactable limits the utility of Data to Care
- Data to Care as just one component of efforts to improve engagement
- Targeting population for data to care is likely key to efficiency

<table>
<thead>
<tr>
<th>Priority Populations for Relinkage and improved viral suppression outcomes</th>
<th>Implementation effort</th>
</tr>
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<tbody>
<tr>
<td>Patients attending safety-net clinics</td>
<td>DPH clinic-based HIV Navigators</td>
</tr>
<tr>
<td>HIV+ clients named as partners to new HIV+ or syphilis cases</td>
<td>Linkage of HIV and STD surveillance data</td>
</tr>
<tr>
<td>STD clinic patients who are out of care</td>
<td>Routine ascertainment of care status at STD visits</td>
</tr>
<tr>
<td>Black and Latino MSM and transwomen</td>
<td>Development of lists of patients</td>
</tr>
</tbody>
</table>
Using surveillance data to support HIV care navigation and viral suppression

- DPH Clinic lists of not-in-care pts
- HIV+ named partners through syphilis or HIV partner services
- Referrals from STD clinics
- African-American and Latino MSM and transwomen not-in-care

LINCS
People • Care • Prevention
HIV Surveillance
Flowchart of program implementation from clinic-based list

Clinic generated list of HIV+ pts out of care (as of 10/15) (N=244)

Surveillance match (n=242)
- 12% in care new clinic
- 12% in care on own
- 11% moved
- 1% Incarcerated

63% Needs contact specialist (n=152)
- 36% in care on own
- 18% moved
- 9% Unable to locate
- 2% Incarcerated
- 1% Died

21% Enrolled in LINCS (n=52)

Contacted/Located (n=152)

Primary outcome: Viral suppression 12 months post-LINCS
Navigation Lessons learned

- Short-term navigation and re-linkage to care improves HIV suppression
- Working closely with HIV Surveillance helps clinics identify who have moved or transferred care
- Targeting navigation efforts is critical to identify individuals who are more likely to transmit HIV and reduce disparities
Case Studies
Navigation Case #1

- Pt History: 48 year-old MSM, undocumented male- Came here on a student visa that had expired
- Pt. housed in a SRO
- Active Meth use
- Medical hx:
  - Dx in 2008
  - No care for over a year (Since 2014)
  - Referred by PHAST RN and Social Worker-Met inpatient 10/15 at SFGH, pt was hospitalized with pneumonia
  - Labs: CD4 20 and Viral load of 76,489
  - No Insurance, Not on HIV meds for over a year
Navigation activities

- Visited pt at home to make contact (No Phone!) & build rapport
- Appt reminders, escorted to visits
- Reconnected to care team- PCP, RN, Social Worker
- Insurance- Big issue- Pt had fallen out of care because lost health insurance, helped re-access insurance (addressed legal status)
- Emotional support around starting ART- Pt got back on meds

# 11 home visits
# 3 escorts to appts
# 6 contacts with providers
Case #1 Outcomes

• Re-Engagement:
  – Pt now insured
  – Pt is fully re-engaged in HIV care, several appts with PCP
  – Pt adherent to ART, labs 1/19/16: CD4 count went up to 133 and Viral load went down to 126
  – Pt now comes in on his own
  – Helped pt get a phone, so can receive appt reminders from clinic
Navigation Case #2

• Patient History: A 30 year-old homeless male from PA
• Active meth use
• Socially isolated, reports walking to and from Fresno in recent months
• Medical History:
  – Dx HIV+ in 2013, never in care for HIV
  – Labs(9/23/15): CD4 124 and VL was 205,053
  – Not on meds, said he didn’t want to get on meds
  – Hospitalized at SFGH with a kidney infection
  – Referred via PHAST
Navigation Activities

- Met inpatient at hospital to build connection and trust
- ART education and support along with care team - discussed ART benefits, pt started taking meds
- Discussed options post discharge - pt was interested in substance use treatment
- Warm handoff to inpatient drug treatment program
- Completed detox, then went to longer term tx program where he had shingles outbreak - Pt was Re-hospitalized
- Post discharge from SFGH - escorted pt to Medical Respite since he needed more intensive medical care - He was also assessed to have higher, acute needs than LINCS could handle
Case #2 Outcomes

- Warm handoff to HHOME, intensive mobile HIV medical care team
- Medical Respite- long stay
- Labs: 2/24/16 pt has CD4 237 and an undetectable viral load
- Housed at SRO through HHOME, receiving mobile medical care at home, and intensive case management, and is attending PCP appts
- Vulnerable to LTFU (mental health, relapse, and reported non adherence at 3/23/16 PCP visit)
Navigation Key Points

- Each pt has their own history & their own barriers
- Harm reduction
- Recognize pt autonomy
- Set boundaries
- Navigation is short-term and focused on re-linkage and early re-engagement
- Warm handoffs to long-term case management is critical
Acknowledgements

Charles Fann
Stephanie Cohen
Susan Philip
Bob Kohn
Tracey Packer
Mac Mc Master
Sharon Penn
Gloria Calero
Rebecca Shaw
Mark O’Neil
Nora Anderson
Lanika Johnson
Max Ruben

SFDPH HIV Surveillance:
  – Sharon Pipkin
  – Viva Delgado
  – Ling Hsu
  – Susan Scheer

PHAST Team:
  – Sandra Torres
  – Fabi Calderon
  – Joe Pelletier
  – Diane Jones
  – Clarissa Ospina Norvell

All of the HIV+ patients and providers we work with in SFDPH clinics