Welcome!

Learning Series for HIV Prevention-Surveillance Integration - Data to Care (August 6, 2019)

• We’ll get started in a few minutes
• Please:
  • Complete the survey
  • Mute your phone/computer
  • Enter your name/jurisdiction in the Group Chat
• Having IT issues? Use the Q&A box to submit a question. HealthHIV staff will follow-up with you individually.
CSTE/HealthHIV Learning Series for Prevention-Surveillance Integration

Data to Care
August 6, 2019
Welcome!

• This webinar is being recorded.

• Please remember to
  • Complete the survey
  • Mute your phone
  • Enter your name/jurisdiction in the Group Chat

• Having IT issues? Please use the Q&A box to submit a question. HealthHIV staff will follow-up with you individually.
• Orientation to On24
• Icebreaker
• Data to Care Evidence and Seattle-King County Experience
  • Julie Dombrowski, MD MPH
  • Q&A and discussion
• Beyond Linkage to Care: Lessons Learned Implementing Data to Care in Louisiana
  • Debbie Wendell, PhD MPH and Jacky Bickham, MPA
  • Q&A and discussion
• Closing
Using On24

• Webinar PPT/Recording
  ▪ Links sent after webinar

• Q&A
  ▪ Technical issues and content/speaker questions

• Group Chat
  ▪ Chat with peers, comments

• Survey
  ▪ Submit before webinar starts
• Only do icebreaker with the prevention/surveillance colleagues from your health department
  • If not there in person, share by email
• Come up with a list of **five of anything**. The list can literally be anything. Share the list with your colleagues.
• 5 min
Data to Care: Evidence to Date & the Seattle-King County Experience

August 6, 2019

Julie Dombrowski, MD, MPH
Associate Professor, Department of Medicine, UW
Deputy Director, HIV/STD Program, Public Health – Seattle & King County
Co-Director, UW Public Health Capacity Building Center
Outline

• Brief Background
• Data to Care evolution in King County
• Findings from other jurisdictions
• Summary of themes and future directions
Data to Care (D2C)

- Use of surveillance data to identify out-of-care persons & re-link them to care
- Distinguish re-linkage/re-engagement from linkage to care (first visit)

![Diagnosis-based HIV Care Continuum, U.S., 2016](image)

- Receipt Of Care: ≥1 visit in 2016
- Retained In Care: ≥2 visits ≥3 mo. apart
- Viral Suppression: VL <200 at last report

Example D2C Strategies

Health Department

Data sharing

HIV Clinic

Patient

Data sharing

HIV Clinic

Patient

Health Department
Prior to Data to Care: “Cleaning” the Surveillance Data

Estimated % of PLWHA out of care (no CD4 or VL ≥ 12 mo.) in King County, WA

N=2573

Key Finding #1 – Most people who appear to be out of care are not actually out of care

Buskin SB et al, STD 2014
Key Finding #1: Most PLWH who appear to be out of care are not actually out of care

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of cases investigated</th>
<th>% with alternate explanation* upon investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-state collaborative (WA, WY, AK, MT, ID, OR)</td>
<td>3866</td>
<td>72%</td>
</tr>
<tr>
<td>Maryland</td>
<td>2488</td>
<td>88%</td>
</tr>
<tr>
<td>New York</td>
<td>985</td>
<td>76%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>9308</td>
<td>53%</td>
</tr>
<tr>
<td>Seattle &amp; King County</td>
<td>2573</td>
<td>54%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>871</td>
<td>47%</td>
</tr>
</tbody>
</table>

*In care, deceased, moved out of area, labs not reported to surveillance, error
Sources: Dombrowski, JAIDS 2016; National HIV Prev. Conf (NHPC): Brantley #1910, Cassidy-Stewart #1650, Morrison #1503; Tesoriero J, JPMMP, 2017
King County Data to Care Program: Version 1.0

• Surveillance team identified cases
  • No CD4 or viral load in the past 12 months OR
  • VL>500 at time of last report, >6 months after HIV diagnosis

• Disease Intervention Specialists
  • Contacted last known provider
  • Contacted client
  • Conducted structured interview to assess barriers
  • Assisted with relinkage
    • Navigation
    • Referral to services
    • Brief counseling
    • Health education
King County Data to Care: Version 1.0 - Outcomes

997 cases identified

822 eligible cases

662 cases initiated

374 contacted (56%)

69 had viral suppression reported in 12 months (10% of initiated cases)

175 (18%) had moved or died*

162 (20%) had viral suppression reported before contact attempted

Key Finding #2 – In most cases, our Data to Care efforts do not lead to successful re-engagement in care

*After initial “cleaning” of 2573 cases with no labs in the past year in which 54% had moved or died
Key Finding #2: In most cases, our Data to Care efforts do not lead to successful re-engagement in HIV care.

Other Published Studies of Data to Care (v1.0) Programs

San Francisco
- 434 presumed OOC
- 282 cases prioritized for investigation
- 75 (27%) cases interviewed
- 15 (20%) re-initiated care

- 3-5% (15/434 or 15/282)

New York
- 1155 presumed OOC
- 233 (20%) located & confirmed
- 166 (71%) re-initiated care

- 14% (166/1155)

North Carolina
- 2099 cases referred
- 606 (29%) received services
- 279 (46%) re-initiated care

- 13% (279/2099)

Sources: Buchacz K, PLOS ONE 2015; Tesoriero J, JPHMP 2017; Sena A, JAIDS 2017;
Multisite Data to Care Evaluation*: Illinois±, Louisiana, Tennessee, Virginia

- Eligible cases (after full investigation): 5769
  - Unable to contact: 1605
  - Contacted: 4164
    - Confirmed out of care: 1479
      - Confirmed relinked to care: 694 (12% of initiated cases)
    - In care: 2586

General Themes:
- Many “out-of-care” can’t be contacted
- Success in only a small % of initiated cases

*Cases reported as in progress excluded from this figure
±Excluding Chicago
Sweeney P et al. Public Health Reports, 2018
Can we attribute the successful relinkages to our D2C efforts?
Implementation of Data to Care Program in Seattle-King County: Stepped Wedge Cluster Randomization

Order of provider clusters randomly assigned

Patients of Dr. A

Analysis Start Date

Dr. A

Dr. B

Dr. C

Dr. D

Analysis End Date

Time

Intervention Start Date = Doctor Contacted

Intervention Period

Control Period
Principal Finding of the Cluster RCT

Time to Viral Suppression According to Intervention vs. Control Period (excluding deaths and relocations, N=822)

About half of the individuals who achieved viral suppression did so before the Data to Care team attempted to contact them (N=161/301, 53%)

Key Finding #3: Many people re-engage in care independent of Data to Care Efforts

Source: Dombrowski JC, STD 2018
The Cooperative Re-Engagement Controlled Trial

• Data sharing between health department & healthcare providers
  - Connecticut (N=23 clinics; N=655 individuals)
  - Massachusetts (N=10 clinics; N=630 individuals)
  - Philadelphia (N=8 clinics; N=609 individuals)

• Randomized Data to Care intervention
  - Eligibility: no CD4 or viral load or no clinic visit for ≥6 months
  - Public health staff locate, contact and provide assistance to help out-of-care persons access HIV care

• Outcome #1: Re-engagement (visit within 90 days)

Fanfair, et al. CROI 2019
The Cooperative Re-Engagement Controlled Trial

Analyses of retention, viral suppression, cost ongoing

Fanfair, et al.  CROI 2019
Interpretation

• Goals of Data to Care:
  - ✔ Improving surveillance data quality
  - ✔ Re-linking PLWH to HIV care to one care appointment
  - ✗ Increasing viral suppression among PLWH

• The surveillance list recall strategy does not appear to have a substantial public health impact

• May improve with improvements in surveillance

• Main things we need to fix:
  - Identify out-of-care PLWH more efficiently
  - Identify PLWH earlier in course of care disengagement
  - More effective intervention to re-engage

Re-linking people to the same system of care that failed to engage them in the first place is not an effective strategy for most people who are out of care.
“Real-Time” Data to Care in Seattle & King County

- Data exchange with UW Medicine
  - Patients in ED or inpatient hospital
  - Previous HIV dx & VL >200 copies/mL
  - Alert to PHSKC relinkage team

- Data exchange with King County jails
  - Daily match between HIV surveillance data & jail booking
  - Weekly conference: Public Health relinkage team & jail release planners
# The Max Clinic: HIV Care for the “Hardest-to-Reach” Patients

## Components of the MAX Clinic (Evolved Over First 2 Years)

<table>
<thead>
<tr>
<th>Low-Threshold Care</th>
<th>Incentives</th>
<th>High Intensity Outreach Support</th>
<th>Coordinated Care &amp; Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in access to medical care</td>
<td>Snacks each visit, $10 meal vouchers 1x/wk</td>
<td>Non-medical case managers (Public Health)</td>
<td>Jails</td>
</tr>
<tr>
<td>- medical care 5 afternoons/wk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- case managers 5 days/wk</td>
<td>Cell phone</td>
<td>Medical case managers (Madison)</td>
<td>Housing &amp; mental health case management</td>
</tr>
<tr>
<td>Direct phone line to MAX case managers</td>
<td>Bus pass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Text message communication</td>
<td>$25 - visit + blood draw q 2 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm reduction approach</td>
<td>$50 – VL&lt;200 q 2 months (previously $100)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 95% have unstable housing, substance use disorders and/or untreated mental health disorders
Outcomes of Patients Enrolled in the Max Clinic (first 50) vs. Standard-of-Care Control (N=100) in the 12 months Pre- and Post-Baseline

### Viral Suppression (≥1 VL<200)

- **Max Patients:** 82%
- **Control Patients:** 65%

aRR* (95% CI): 3.2 (1.8–5.9)

### Engagement in Care (≥2 visits ≥ 60 days apart)

- **Control Patients:** 82%
- **Max Patients:** 90%

aRR* (95% CI): 1.3 (0.9–1.9)

*Adjusted for substance use, psychiatric dx, housing status
Other Examples of Care Tailored for High Need Patients with Complex Barriers to Care

<table>
<thead>
<tr>
<th>SHE Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wayne State University ID Clinic Homecare Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Link-Up Detroit (Data to Care program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vancouver Native Health Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximally Assisted Therapy Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Image]</td>
</tr>
</tbody>
</table>
Current King County D2C Approach

- Jail Booking
- ED/Hospital Alerts
- Provider & case manager referrals
- STD Clinic & Partner Services
- Surveillance list
- Case management - inactive case closures

Relinkage Team – assessment & triage by intervention intensity*

- **High**
  - Not virally suppressed; previous relinkage efforts unsuccessful
  - MAX clinic recruitment
- **Medium**
  - Not virally suppressed, but attending regular appointments
  - Care navigation, referral to support services, brief counseling, plan for follow-up
- **Low**
  - Not yet virally suppressed, but moving towards suppression
  - Appointment scheduling assistance
- **Minimal**
  - Last VL suppressed, but no labs in the past year
  - Appointment scheduling assistance
- **Investigation only**
  - Last VL suppressed, confirmed in care and on ART
  - No intervention

*criteria are for general guidance; case-by-case assessment still required
Summary

• We are still in the early stages of Data to Care
• Data more encouraging for one-time appointment completion than for viral suppression
• To date, D2C effectiveness limited by inaccuracies in surveillance data, difficulty contacting OOC individuals, and lack of effective interventions to re-engage people
• Improvements in surveillance data and “real-time” D2C approaches are promising
• We need to alter the medical system to meet the needs of the “hardest-to-reach” PLWH
Beyond Linkage to Care: Lessons Learned Implementing Data to Care in Louisiana

Jacky Bickham, MPA and Debbie Wendell, PhD, MPH
Louisiana Department of Health
STD/HIV Program

CSTE/HealthHIV Learning Series
August 6, 2019
LA Links: Data to care (D2C) in Louisiana

• Data to care (D2C) strategy implemented in Louisiana since Oct 2013
  – Originally funded by CDC as part of the CAPUS Demonstration Project at 3 sites: New Orleans, Baton Rouge and Shreveport
  – Expanded statewide in 2016 using Ryan White Part B and Minority AIDS Initiative funds

• Utilizes surveillance data to identify PLWH who are:
  – Newly diagnosed and not linked to care
  – Previously diagnosed and currently not engaged in care
  – In care, but experiencing high viral loads
LA Links: D2C in Louisiana

• Linkage to Care Coordinators (LCCs)
  – Locate and contact persons on D2C list
  – Help clients link to or reengage in HIV care
  – Provide extensive services to address social barriers to continual care engagement and viral suppression maintenance

• Louisiana currently has 9 LCCs
  – LCCs are Health Department employees
Overview of D2C in Louisiana

All HIV CD4 counts and viral load results for PLWH reported to surveillance

Persons added automatically to not-in-care list weekly, based on time since last CD4/viral load

Persons on list are contacted and assisted with linkage to care and other services

Clients discharged when they are linked to care and virally suppressed
Overview of LA Links D2C Process

Line Lists:
- Not in Care
- High Viral Load

Linkage to Care Coordinator

Client Outreach

Ryan-White Case Management
- HIV Medical Care
- Non-HIV Medical Care
- Supportive Services

Sustained:
- HIV Medical Care Engagement
- Viral Suppression Maintenance
D2C Case Management Application

- Homegrown user interface built in MS Access
  - Series of MS Access forms, queries, and some VB code
  - Linked to single master database
  - Script allows multiple users at one time with minimal stability issues

- Line list organization features
- Quick access to HIV lab database
- Search tools
- Alerts
- Quality control tools
D2C Case Management Application

• Links to contact event logs, intake forms, discharge forms, transportation assistance, referrals, etc.
Investigation Outcomes for Persons added to Louisiana Not-in-Care List
Sep 2013 - Sep 2018 (N=14,142)

- Located, Not Eligible: 71%
- Confirmed Not-in-Care: 10% (n=1,370)
- Unable to Locate: 8%
- In-Process: 11%
- Spontaneously Linked to Care: 49%
- Out of Jurisdiction: 10%
- Deceased: 3%
- Other: 9%
Results

LA Links Enrollment in Ryan White-funded vs. Non-Ryan White-funded Regions
Sept 2016 – Sept 2018

- RW-funded D2C: 274 clients, 58% enrolled in LA Links
- Non RW-funded D2C: 141 clients, 38% enrolled in LA Links
## Results

### Linkage to Care – 2018

<table>
<thead>
<tr>
<th></th>
<th>Confirmed as Not-in-Care and Offered Services by LCC</th>
<th>% Linked to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>318</td>
<td>74%</td>
</tr>
<tr>
<td><strong>Completed LA Links Enrollment</strong></td>
<td>167</td>
<td>89%</td>
</tr>
</tbody>
</table>
Results

Percent Virally Suppressed by Time Since Initial Enrollment
Sep 2013 - Sep 2017

% Virally Suppressed (of Persons in HIV Care)

Time Since Initial Enrollment

- Baseline
- 6-month
- 1 Year
- 1.5 Year
- 2 Years

All Clients
Black Males
Black Females
Transgender Females
White Males
White Females

Baseline: 14%
6-month: 21%
1 Year: 28%
1.5 Year: 47%
2 Years: 90%

Baseline: 64%
6-month: 86%
1 Year: 82%
1.5 Year: 86%
2 Years: 90%

Baseline: 0%
6-month: 10%
1 Year: 20%
1.5 Year: 30%
2 Years: 40%

Baseline: 10%
6-month: 20%
1 Year: 30%
1.5 Year: 40%
2 Years: 50%

Baseline: 20%
6-month: 30%
1 Year: 40%
1.5 Year: 50%
2 Years: 60%

Baseline: 30%
6-month: 40%
1 Year: 50%
1.5 Year: 60%
2 Years: 70%

Baseline: 40%
6-month: 50%
1 Year: 60%
1.5 Year: 70%
2 Years: 80%

Baseline: 50%
6-month: 60%
1 Year: 70%
1.5 Year: 80%
2 Years: 90%

Baseline: 60%
6-month: 70%
1 Year: 80%
1.5 Year: 90%
2 Years: 100%

Baseline: 70%
6-month: 80%
1 Year: 90%
1.5 Year: 100%
2 Years: 100%
Lessons Learned

• Importance of prevention/surveillance/services integration and collaboration

• D2C staff need to have access to current phone numbers/addresses
  – Louisiana LCC staff have access to eHARS, PRISM (STD database), Medicaid addresses, CAREWare (services database)
Lessons Learned

• Surveillance initiated D2C programs help find persons that the health care system has failed and links them to much needed, more appropriate medical care, services, and support
  – Much smaller population of persons in need of these services than expected

• During first year of enrollment
  – High care engagement rate (93%)
  – Large increase in viral suppression (25% to 64%)

• Long-term outcomes as of September 2018 (2-5 years of follow-up)
  – Care engagement decreased over time to level similar to state average
  – Viral suppression rate for clients engaged in care increased slightly over time (64% to 70%)
  – Viral suppression levels lower than state average

• Enrolled population faces immense ongoing social barriers
Barriers to HIV Care Engagement and Treatment Utilization

Barriers to HIV Care Engagement and Treatment in Louisiana:

- Stigma
- Mistrust of healthcare system
- Mistreatment in healthcare system
- Poverty
- Transportation
- Availability of HIV care providers
- Privatization of public hospitals
- Incarceration

- Gay, bisexual, other MSM
- Persons of color
- Transgender persons
- Rural communities
- Youth
Lessons Learned – Linkage Coordination

• Importance of choosing the right care provider based on client’s needs

• Some clients need more active referral for first appointment
  – Pre-planning and reminders
  – Attend first few appointments with client

• Create buy-in from Ryan White partners
  – Differentiate LA Links and traditional RW case management

• Partner with referral agencies and local Disease Intervention Specialists (DIS)

• LCCs can help facilitate interactions between provider and patient
Lessons Learned – Surveillance

• Updating the D2C lists frequently (daily/weekly) is essential for limiting amount of clients misclassified as out of care

• Number of persons on D2C lists that are confirmed out of care or with high VL decreases over time

• Client investigations can significantly increase quality of surveillance data
  – New addresses (e.g., moved out of state)
  – Identify missing lab data
  – Update names
  – Risk/gender information
Moving Forward: Long Term Follow-up and Addressing Structural Barriers

- Procedures and tools for longitudinal monitoring and follow-up
  - Routine client check-ins and monitoring after discharge
  - New features in LA Links Application
    - Up to date lab results compiled daily for enrolled and discharged clients
    - Low CD4 count, high viral load, and out-of-care alerts for enrolled and discharged clients
    - Ability to re-open previously discharged cases
    - Reappearance of discharged cases on LA Links list and assignment to previous LCC
    - Referrals from healthcare providers

- Addressing structural barriers
  - Compiling data on structural barriers
    - Client survey
    - Medicaid transportation
    - Clinic barriers

- Now following up on HIV/Hepatitis C co-infected clients to link them to Hepatitis C treatment
Thank you!!

Jacky Bickham, MPA
Prevention Manager
Jacky.Bickham@la.gov
(504) 568-7474

Debbie Wendell, PhD, MPH
Data Management/Analysis Unit Manager
Debbie.Wendell@la.gov
(504) 568-5504
What’s next?

- Resource document

- Next webinar
  - Late August on “Effectively Using Data to Support Programs” – Please respond to Doodle poll at: [https://doodle.com/poll/dp8gpyuakfrqc3b3](https://doodle.com/poll/dp8gpyuakfrqc3b3)

- Webinar Evaluation
  - [https://cste.co1.qualtrics.com/jfe/form/SV_6rjKyAjQtQp5Swl](https://cste.co1.qualtrics.com/jfe/form/SV_6rjKyAjQtQp5Swl)

- Complete pre-assessment
  - [https://cste.co1.qualtrics.com/jfe/form/SV_eIHZqp5UPLHQxq1](https://cste.co1.qualtrics.com/jfe/form/SV_eIHZqp5UPLHQxq1)
Thank you!

Evaluation:
https://cste.co1.qualtrics.com/jfe/form/SV_6rjKyAQtQp5Swl