University of Washington
Public Health Capacity Building Center

Public Health
Seattle & King County

National Center for Innovation in HIV Care, 3/11/2015

Data to Care: Improving Treatment Outcomes & Addressing Disparities

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Outline

- “Data to Care” background
- Re-linkage to care in Seattle – King County
  - History
  - Procedures
  - Outcomes
- Innovative models from around the U.S.
- My perspective on the role of CBOs & ASOs (for discussion)
- Mark Fleming’s front-line experience

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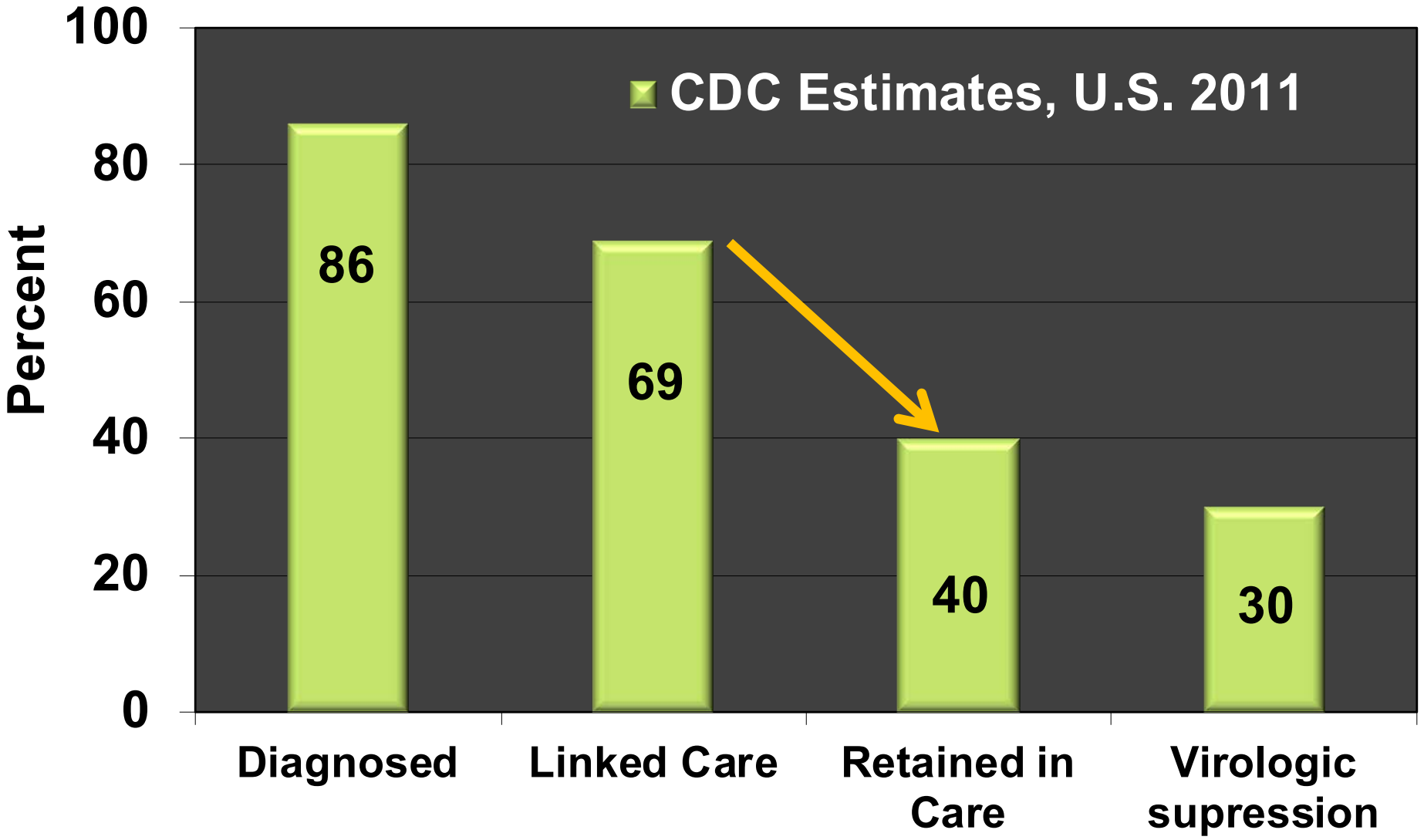
Retention in Care is a Point of Steep Drop-Off



Many Models of Programs to Improve Retention in HIV Care

- HIV Clinics
  - Orientation for new patients
  - Clinic-wide messaging
  - Patient tracing programs
- ASOs and CBOs
  - Patient navigator programs
  - Case management
  - Client tracing programs
- Health Departments
  - Funding programs of community organizations, clinics
  - Interventions guided by HIV surveillance data

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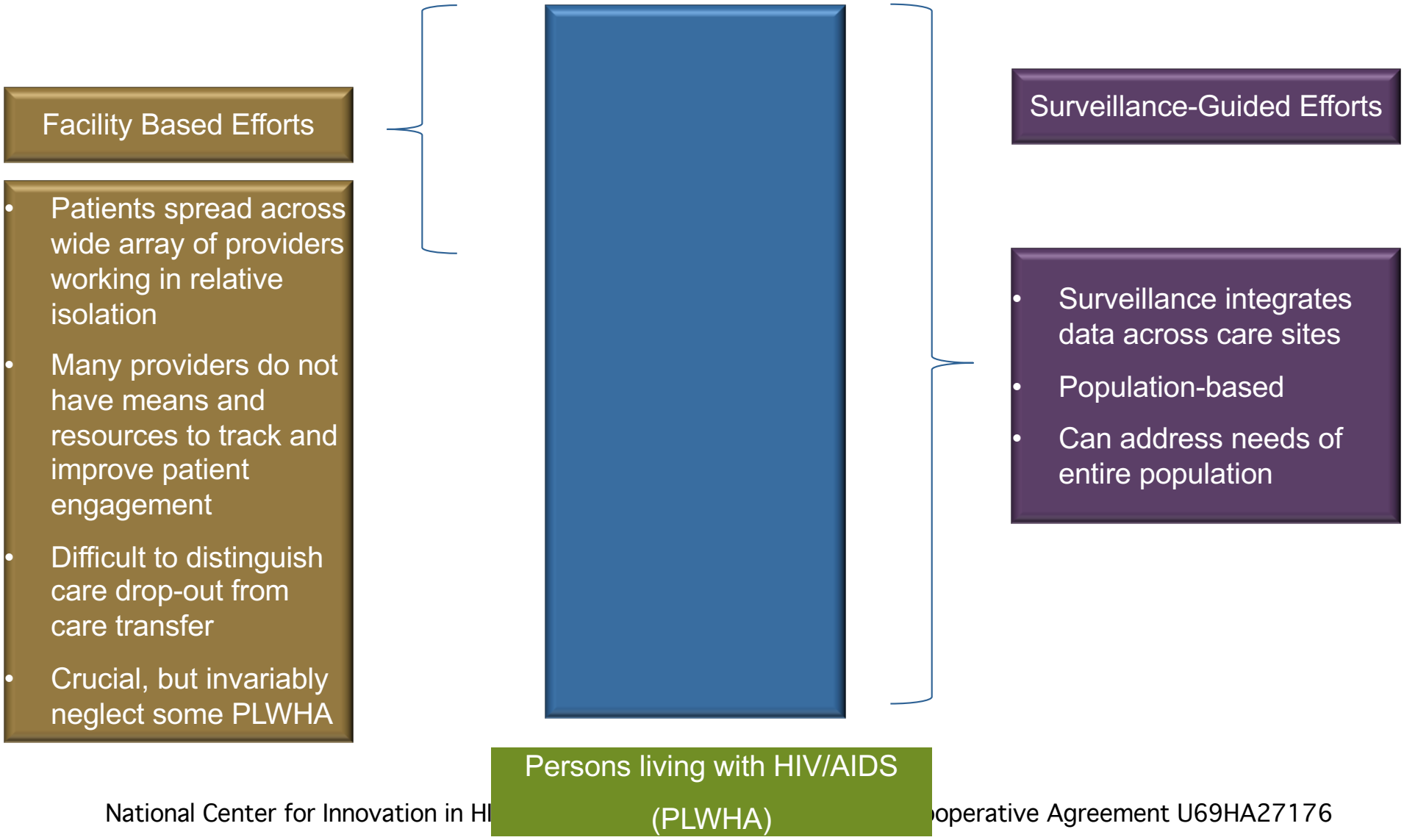
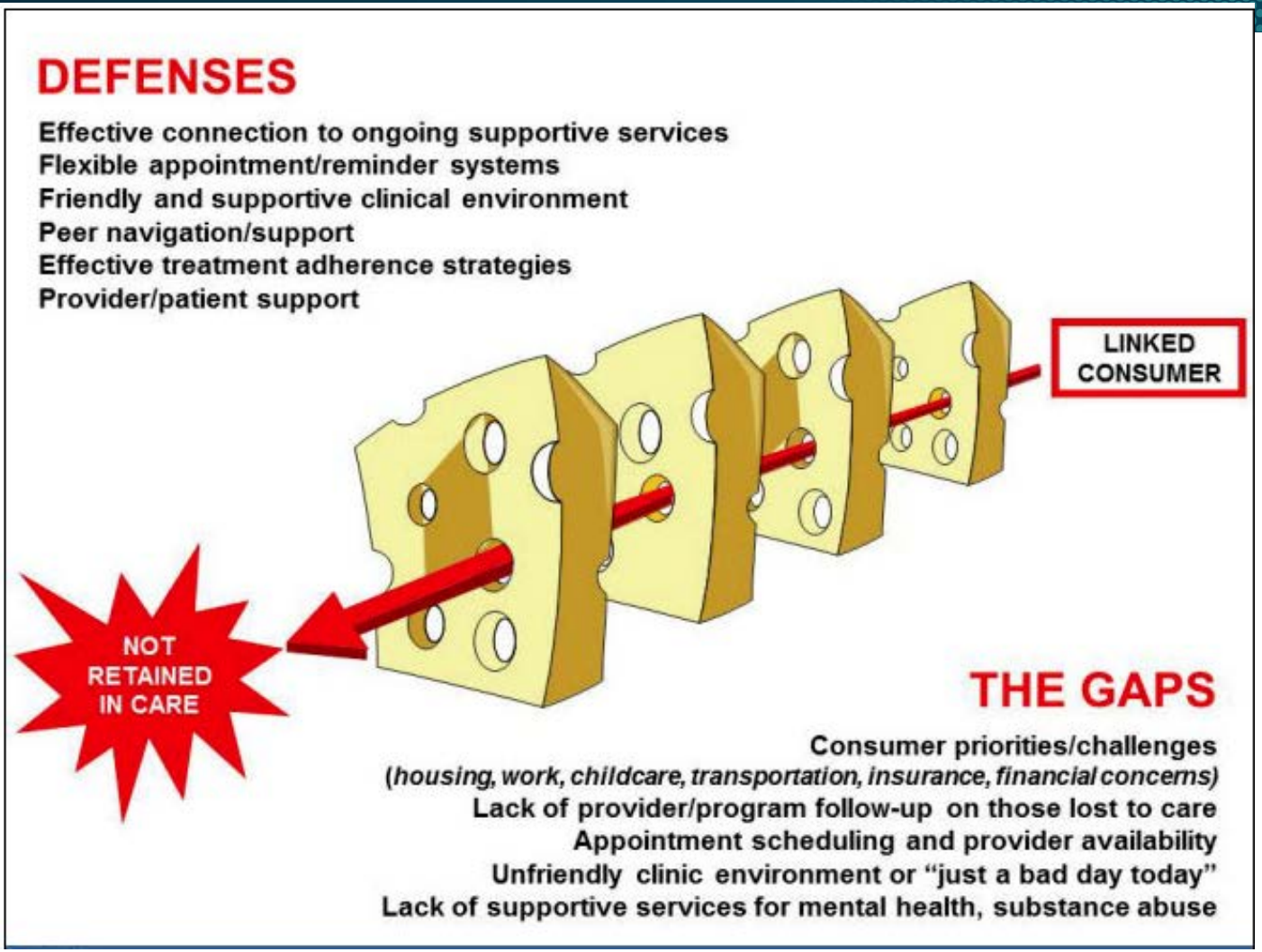
The Rationale for Surveillance-Based Re-linkage to HIV Care



The Need for Redundancy in Systems



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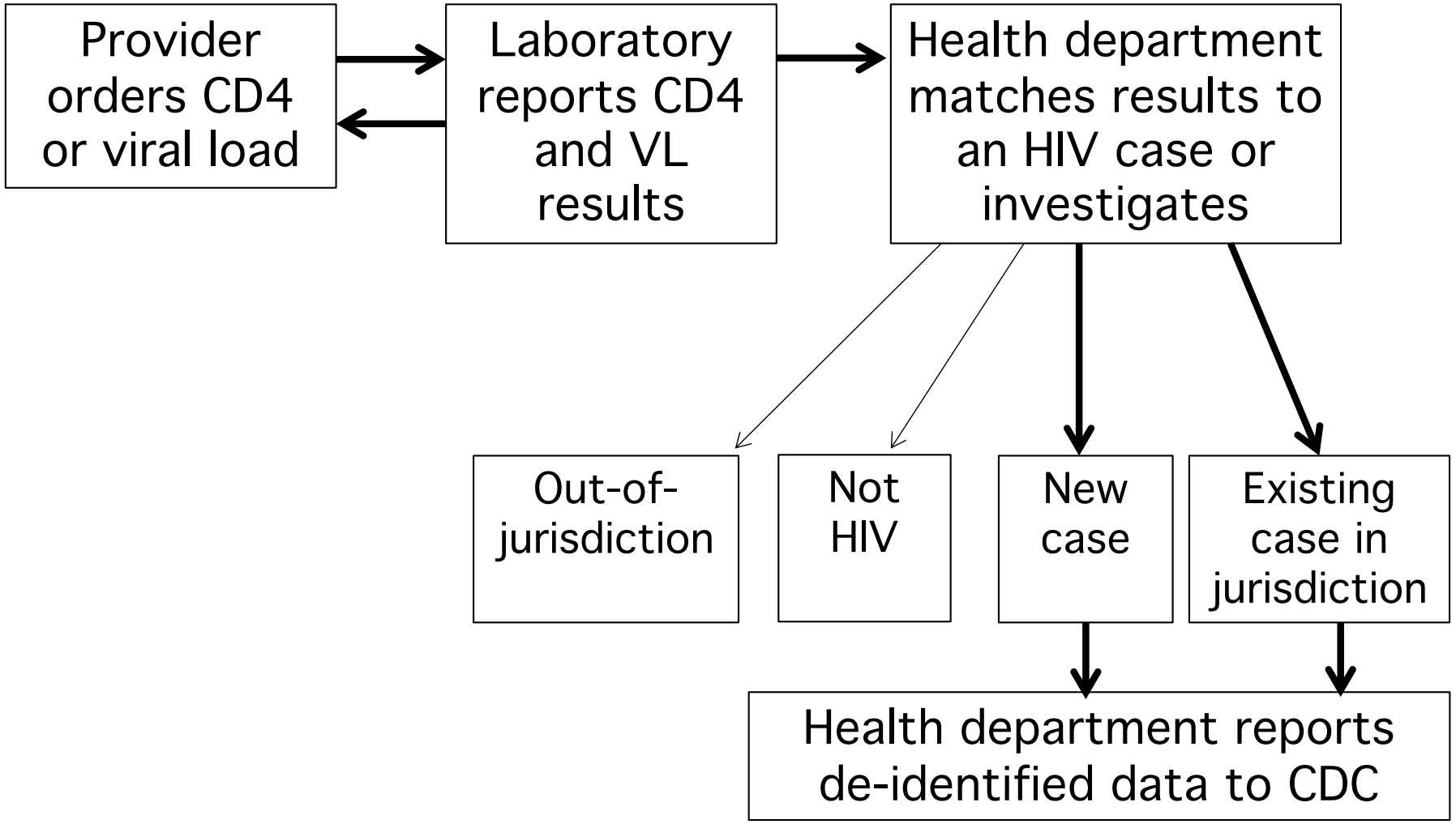
HIV Laboratory Surveillance in the US



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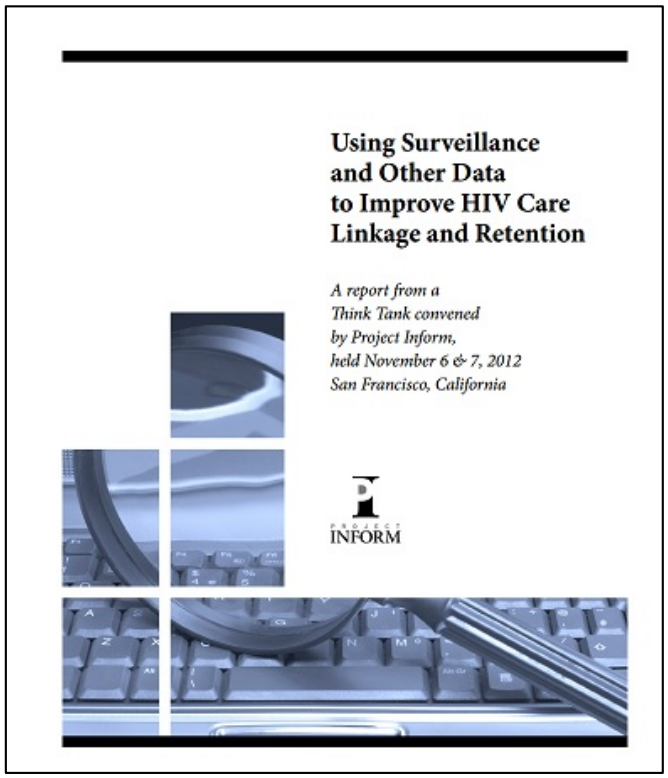
Community & Advocate Perspectives

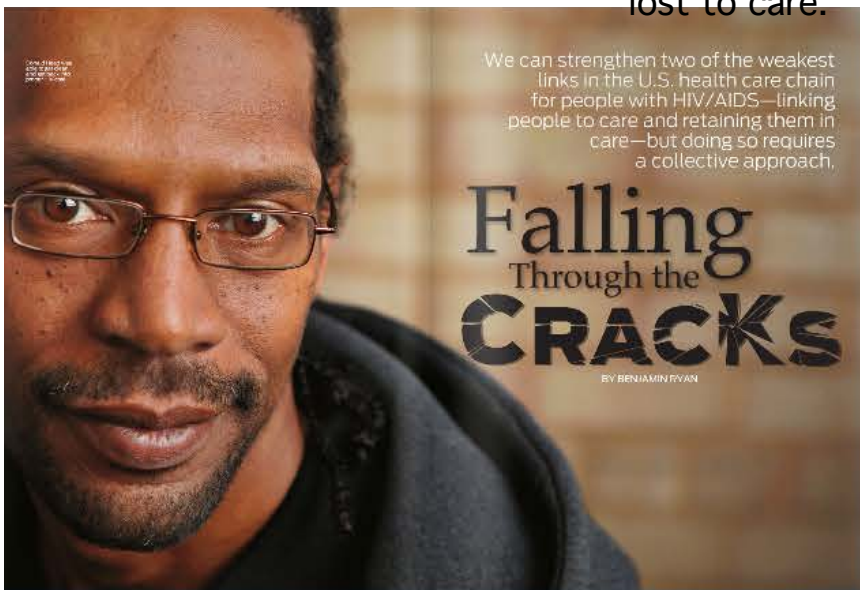


Consensus Statement:

"The benefits [to more active uses of collected data] potentially outweigh the risks so that we encourage local jurisdictions to actively engage stakeholders in considering the use of surveillance data along with other tools to systematically increase access to care, ensure better linkages to services, and improve retention in care."

POZ, March 2013

"Another effort that's gaining steam around the country is the use of local surveillance data to help providers determine which of their patients have been lost to care."



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"Data to Care"

- CDC Effective Intervention (effectiveinterventions.org)
- Coequal goals: to improve the health of individual PLWHA and prevent HIV transmission
- Three models
  - Health Department Model
  - Healthcare Provider Model
  - Combination Health Department/Healthcare Provider Model

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How could this address disparities?

- Key disparities:
  - Racial & ethnic minorities
  - Economic (not just low-income)
  - Foreign born
  - Drug use
  - Disparities in quality of healthcare
- Population-based approach can address the needs of the entire population
- Collaboration between organizations is required to do this effectively
- Impact on disparities likely to depend
  - Healthcare payer resources in the region
  - Adequacy of HIV clinical capacity

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History of Program Development

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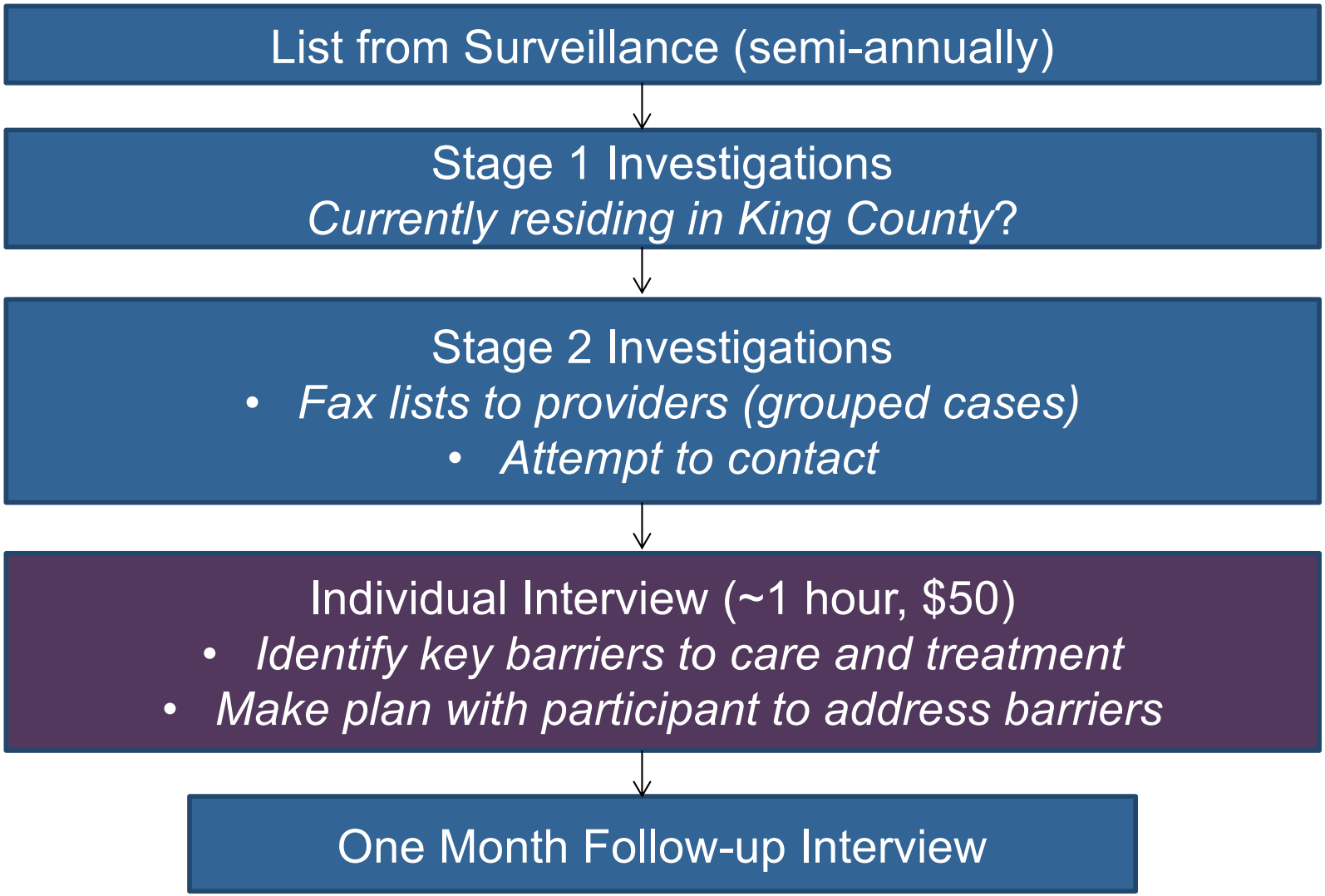
The Care & Antiretroviral Promotion Program (CAPP): Seattle – King County HIV Care Relinkage Program



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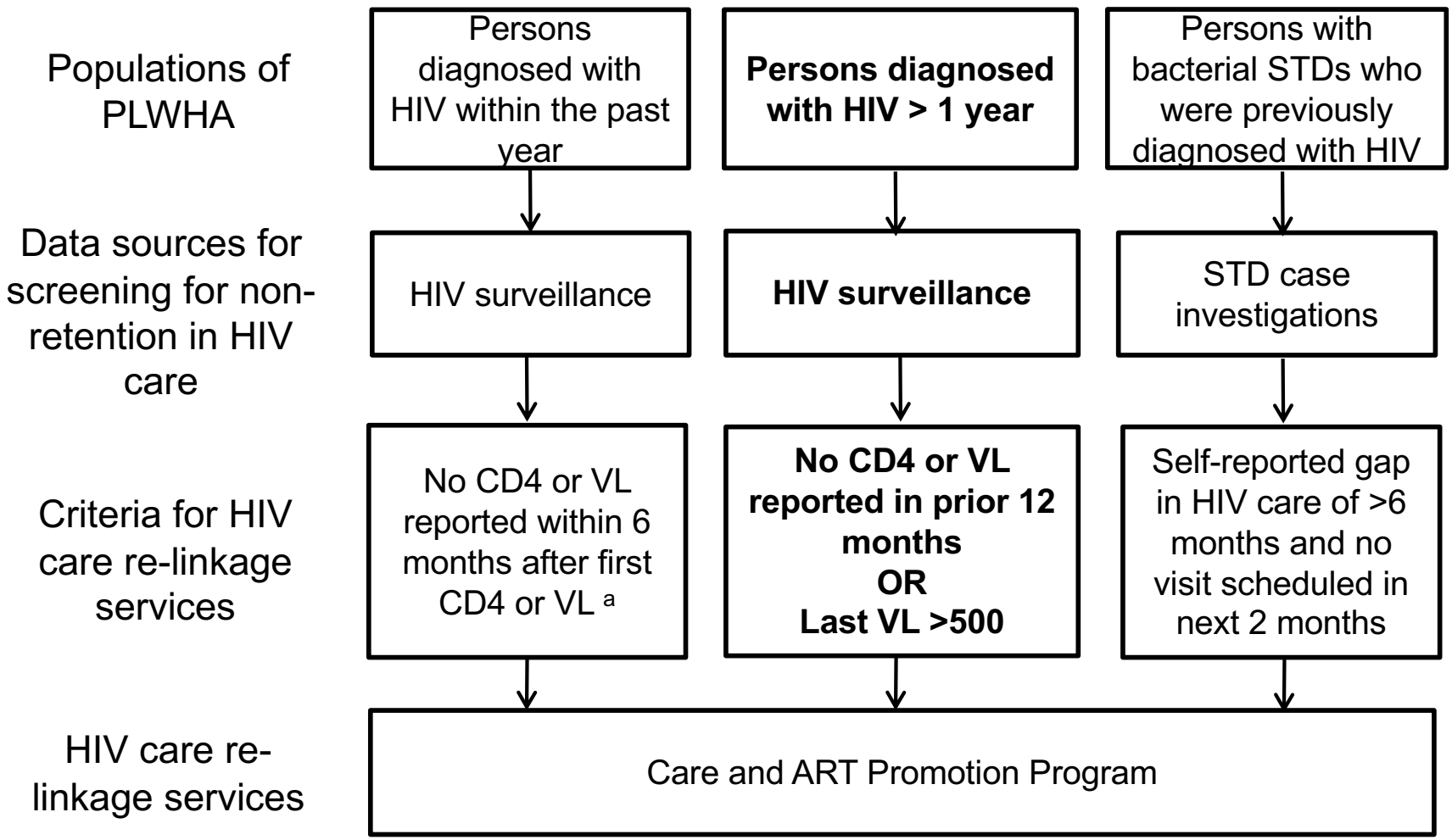
Multiple Referral Sources



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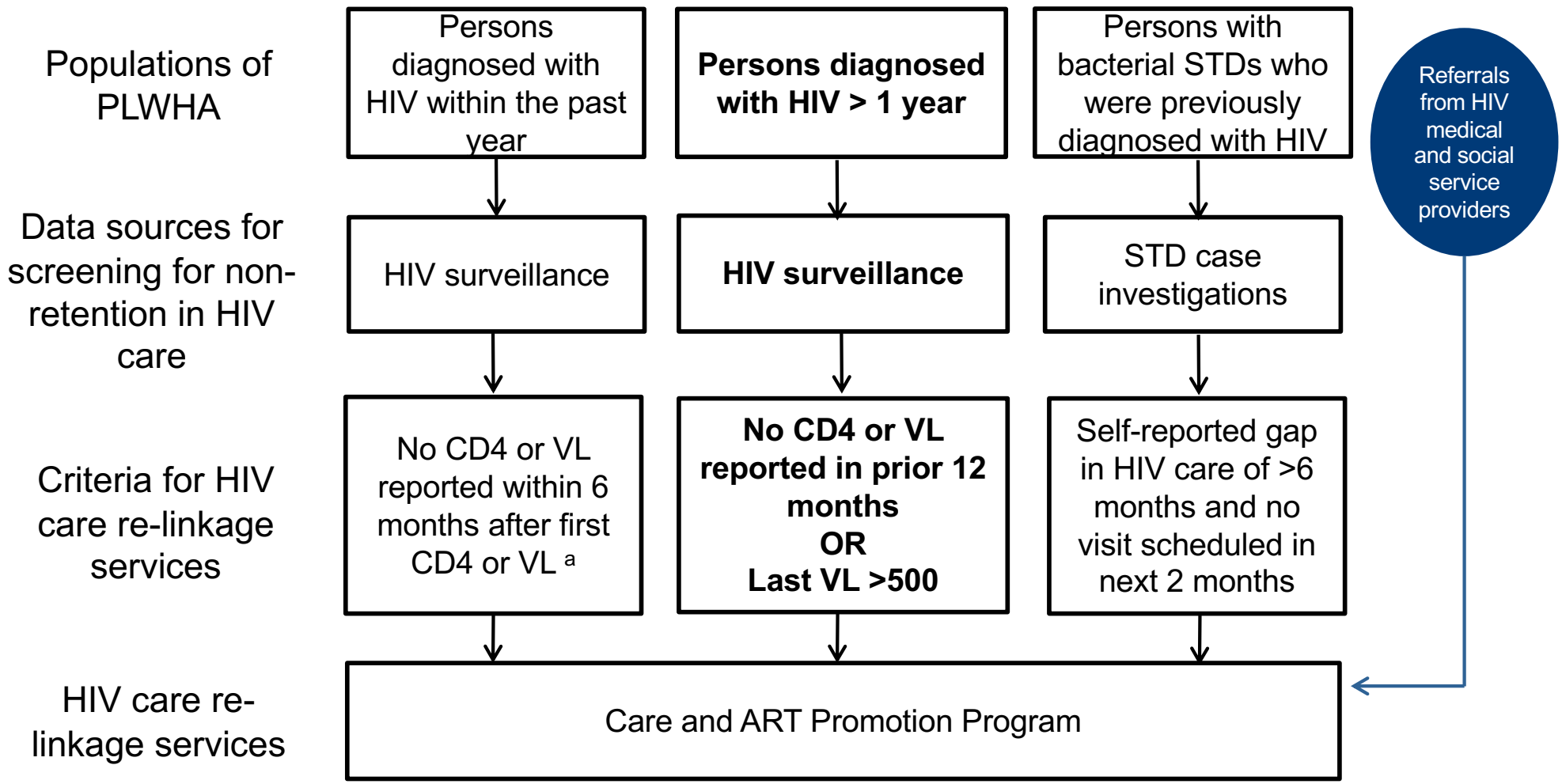

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Program Development (2008-2012)

- Calls to PLWHA identified through surveillance to survey acceptability
- Qualitative individual interviews with PLWHA (N=20) & medical providers (N=15)
- Pilot testing of intervention
- Group meeting with community HIV providers
- Additional meetings with high-volume medical providers
- Presentation to HIV Planning Council & Community Action Board
- Development and vetting of educational materials
- Rollout & evaluation

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Program Methods & Outcomes to Date

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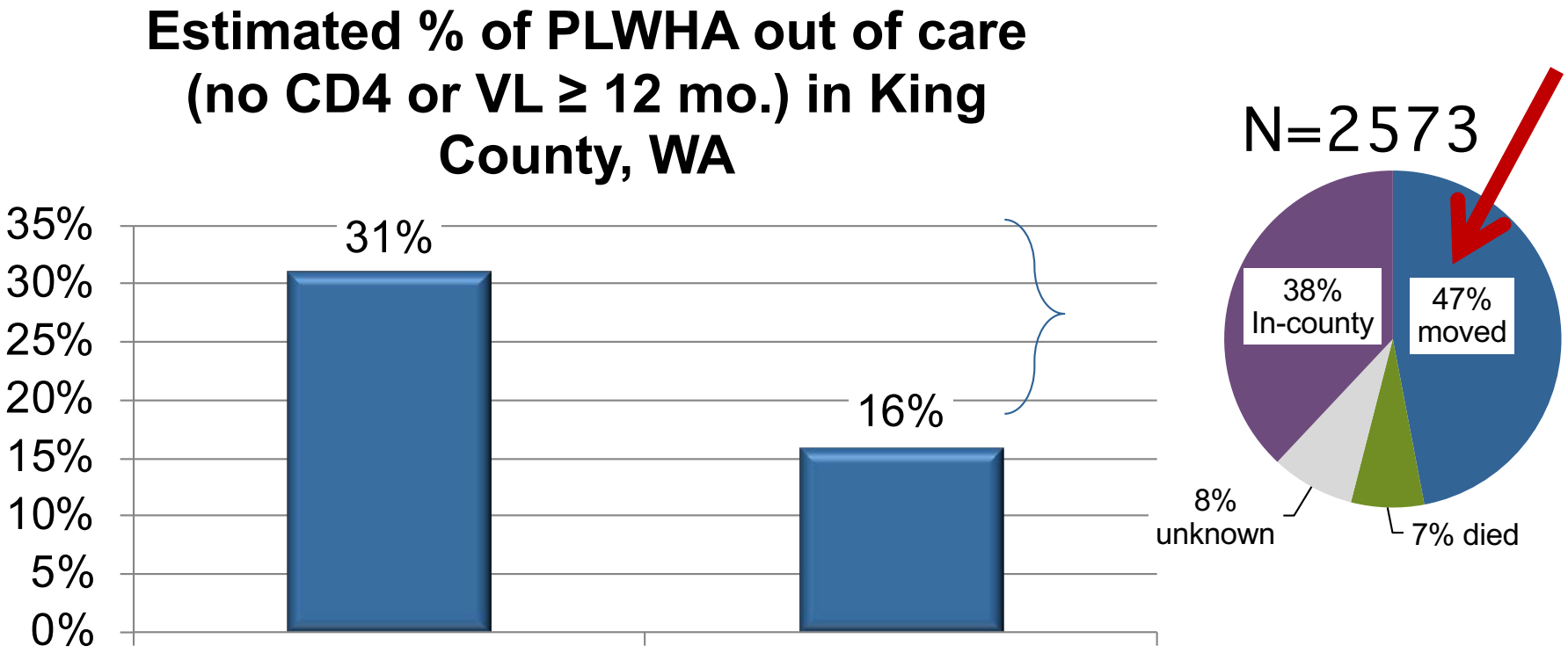
First, We Cleared Out the Backlog



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Buskin SB et al, STD 2014

Percentage of PLWHA Who Had Migrated Out of Area or Died Among Persons Appearing to be Out Of Care in HIV Surveillance

	King County, WA	Alaska	Multnomah CO, OR	San Francisco	Denver, CO
Population*	Surveillance-Based	Surveillance-Based	Surveillance-Based	Surveillance-based	New HIV Diagnosis Denver PH
Years	2006-10	1985-2012	1985-2013	2012	2005-7
Definition Out of Care	≥12 months no labs	≥12 months no labs	≥18 months no labs	No lab for 9-15 months	≥6 months no labs or visits
Number (%) Out of Care prior to Investigation	2573 (35%)	341 (54%)	756 (20%)	NA	145 (42%)
Percent Out of Care Who Migrated or Died	**54%**	**36%**	**72%**	**32%**	**27%**
Percent Presumed Out of Care	16%	37%	4%	NA	35%

* Surveillance-based efforts defined out-of-care persons using the entire population of PLWHA reported in the area as the population-at risk

Sources: Buskin S. STD 2014:41:35. Harvill J. AK DOH (unpublished), Toevs K. Multnomah CO DOH (unpublished). Buchacz K. CROI 2013.
Gardner E. J Inter Assoc Prov AIDS Care 2013:12:384.

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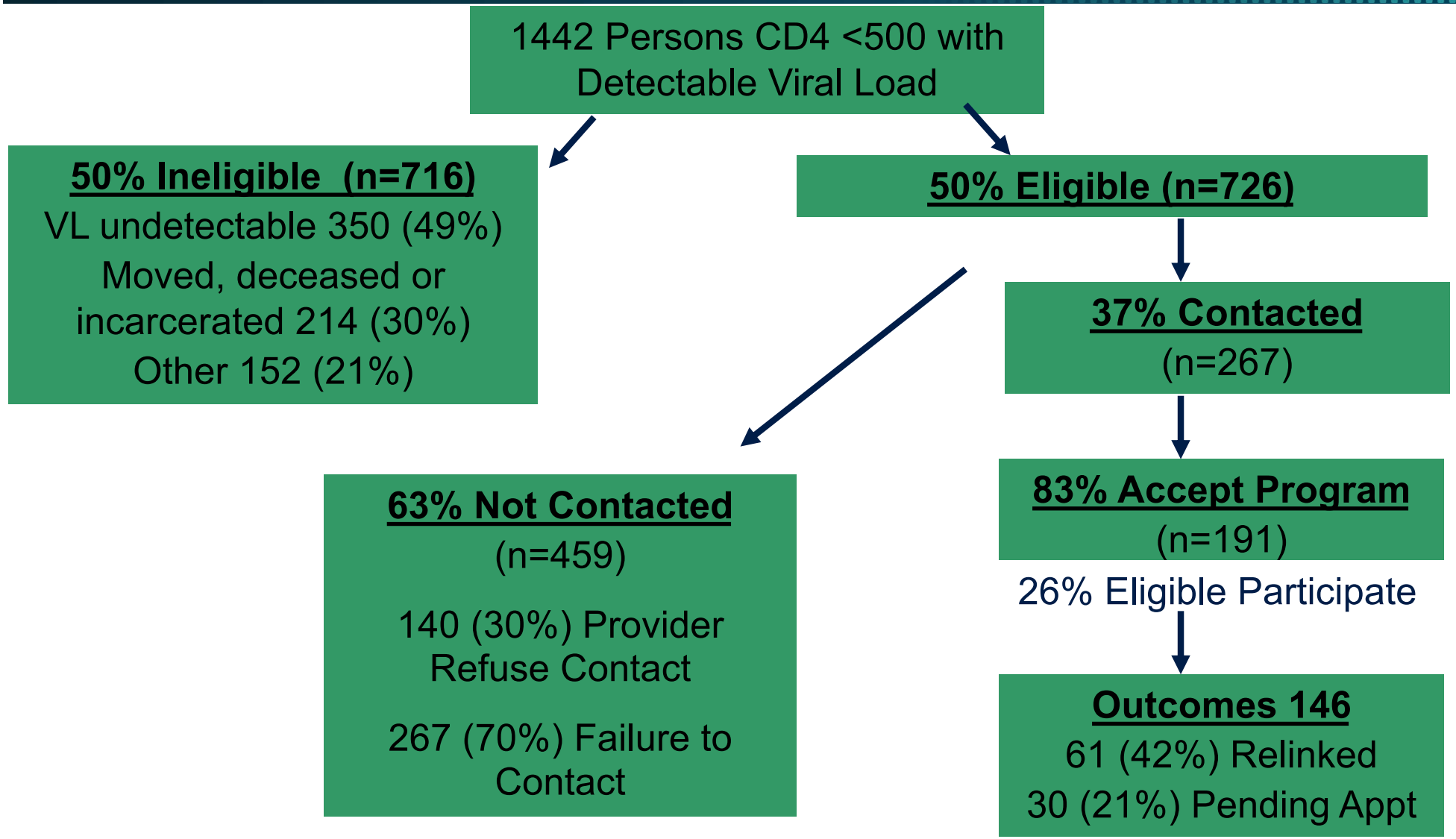
CAPP Outcomes (as of May 2014)



Source: Dombrowski J. Work in progress

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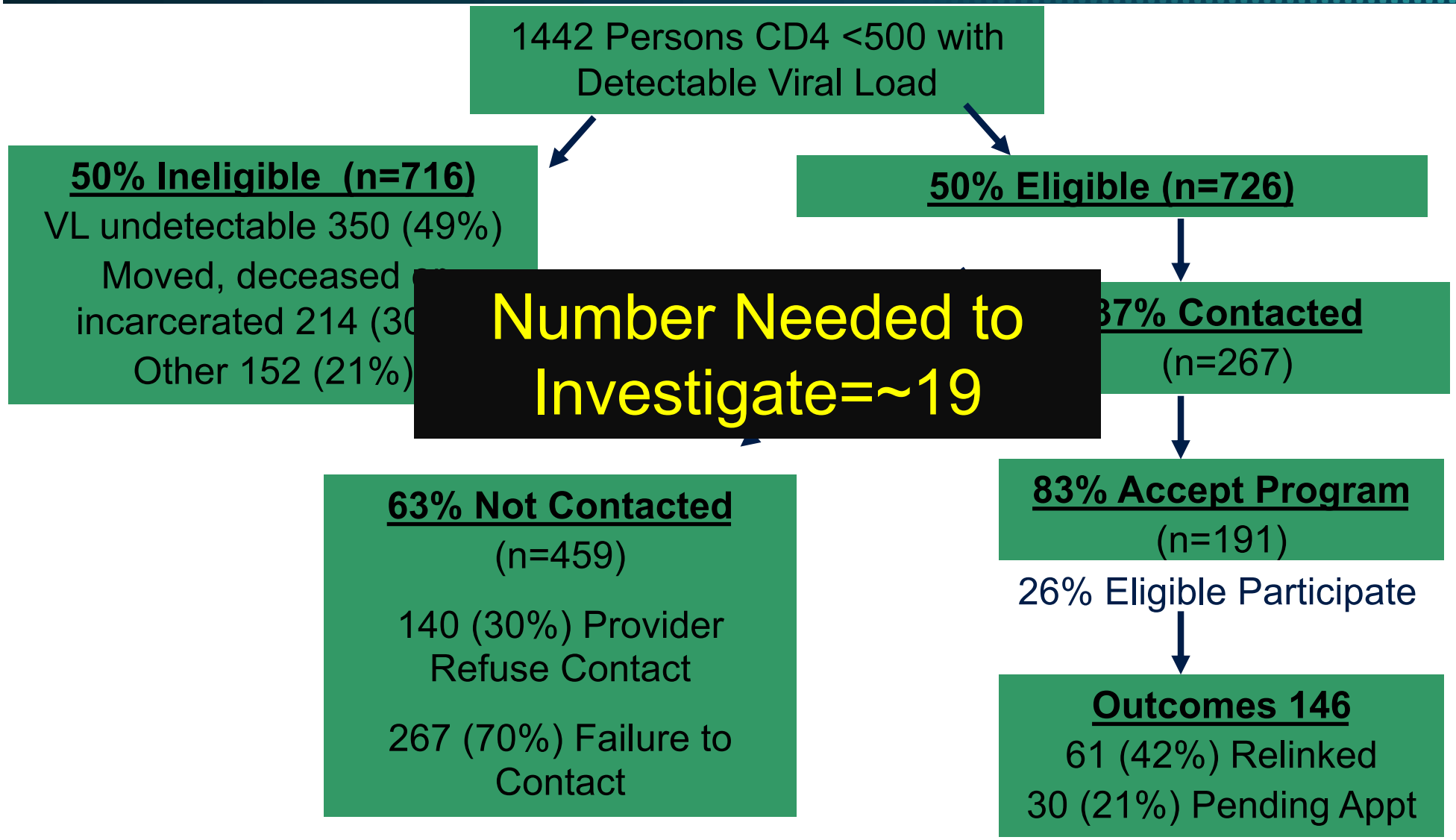
CAPP Outcomes (as of May 2014)



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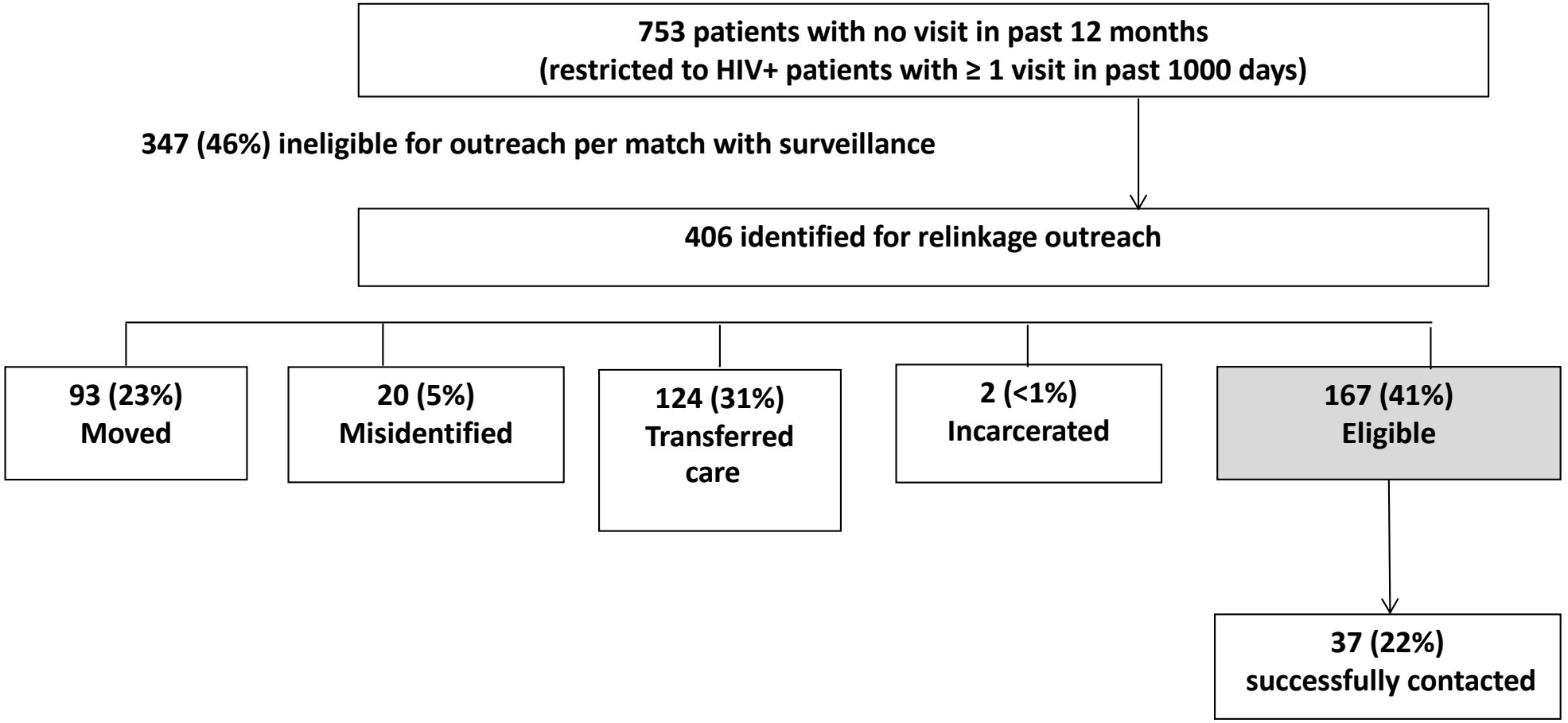
Clinic-Based Relinkage



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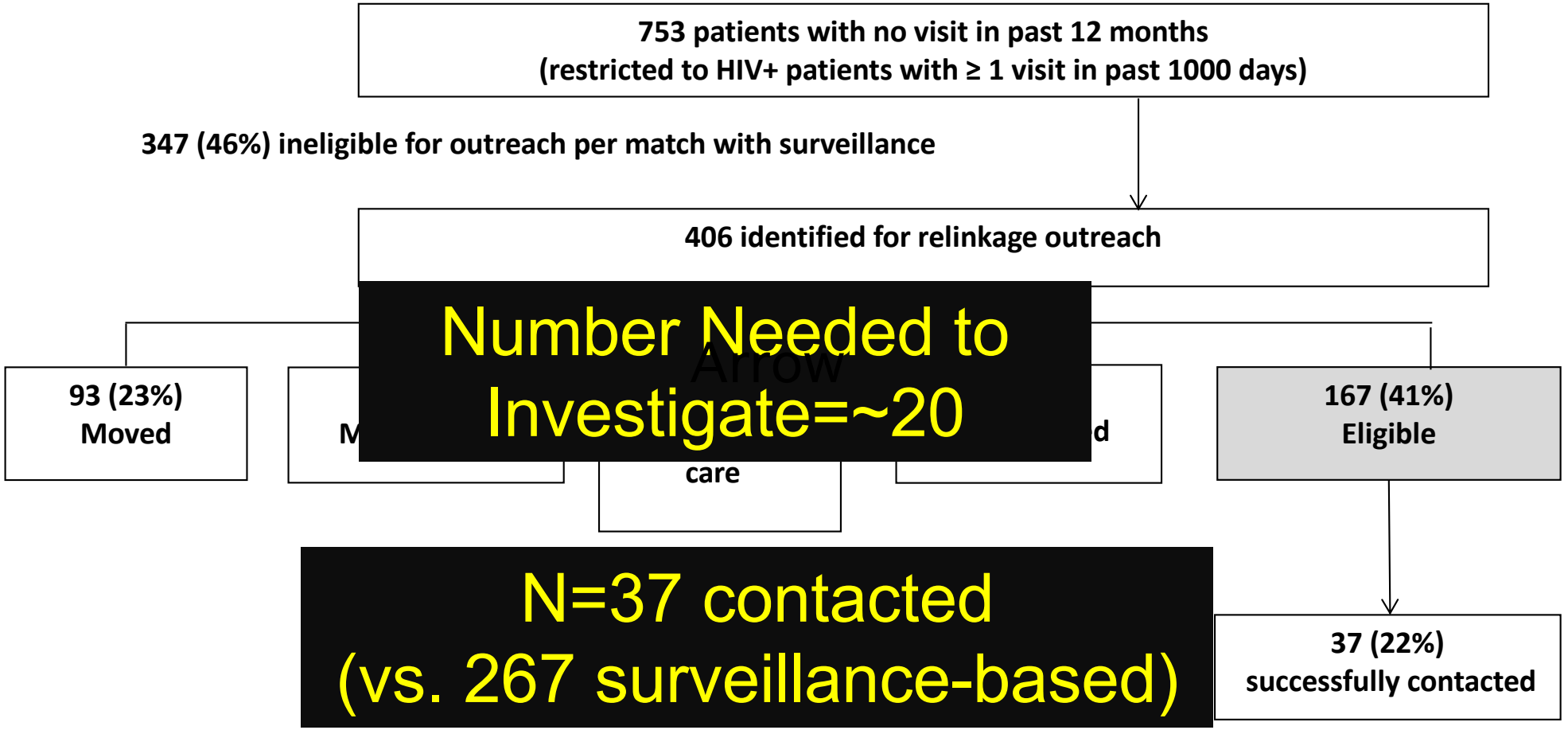

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Factors CAPP participants identified as "important" barriers to care (not mutually exclusive)

Barriers to HIV Care (N=248)	
No insurance	123 (52%)
Forget appointments	88 (35%)
Trouble getting appointments	83 (32%)
No transportation	77 (31%)
Don't know how to find doctor	69 (27%)
Poor relationship with doctor	67 (26%)

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CAPP Effect (N=257 in first analysis)

- One-month follow-up interviews
  - 50% reported having seen medical provider
  - 26% reported having a future appointment
  - 23% no appointment completed or scheduled
- Outcomes from surveillance
  - 69% had labs within 3 months of interview
  - 39% achieved VL <200 within 6 months
  - 47% achieved VL <200 within 12 months

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Progress to Date

- 1,960 cases closed
- 320 completed baseline interviews
  - 240 from surveillance
  - 62 from referrals (including STD Clinic)
  - 16 from STD partner services

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Cross-Institutional Collaborations: Seattle & King County

- Madison Clinic Relinkage Program
  - Ryan White Part C - funded
  - Clinic list matched to surveillance
  - Communication between outreach worker & CAPP counselors

Cross-Institutional Collaborations: Seattle & King County

- CBOs providing HIV case management
- Coordination of data collection
- Can submit list to be matched against surveillance
  - “Outreach indicated” = surveillance indicates client may be out of care
  - “Outreach not indicated” = surveillance indicates that client transferred care, is incarcerated or has moved out of the area
  - “Unmatched” = no record in surveillance (usually residing in neighboring county)

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Potential Roles for CBOs & ASOs in HIV Care Relinkage Programs

- Tracing of lost clients (Data source: CBO/ASO client records)
  - Interface with surveillance increases efficiency
- Assessment of retention in care and treatment among all clients receiving any service
  - "Are you in care?" not enough
- Collaboration with health departments and clinics to accept referrals for more intensive support
  - Relying on referral alone – less likely to be successful & does not proactively address the problem

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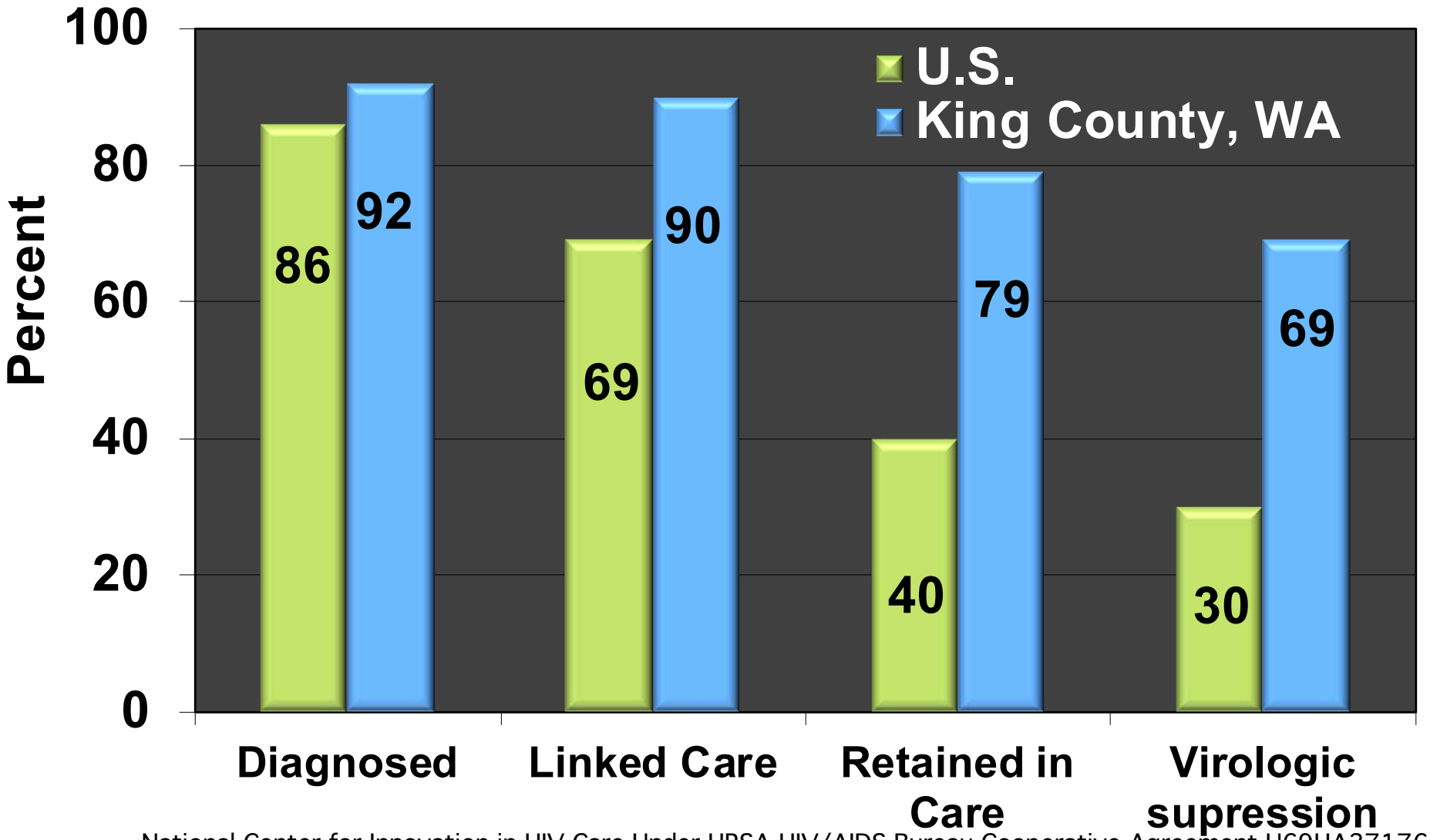
HIV Care Continuum U.S. & King County, WA



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Sources: Bradley H. MMWR 2014. PHSKC surveillance report

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Key Considerations for Data to Care Programs

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Key Considerations for a Data to Care Program

- Role of HIV medical providers in re-linkage
- Who does the work
- Maximizing efficiency
  - theoretical concerns vs. realities in practice

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Role of HIV Medical Providers

- Do the HIV providers have the *right* to decline outreach on behalf of their patients?
  - Doctors don't own patients

- Providers have more up-to-date and complete contact info than surveillance
- The relinkage workers need to make friends with the support & scheduling staff

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Who Does the Work?

- How will clients perceive the relinkage counselor?

- Client perception is very important, but counselor also **MUST** have
  1. Advanced case investigations skills
  2. Diplomacy with patients and providers – ability to change communication styles as needed
  3. A gentle, but firm hand to guide people back into care
     - Willing to do the bureaucratic, nitty-gritty, occasionally mind-numbing work of navigating the healthcare systems

Key Training for a Re-linkage Counselor

- Understanding of *contemporary* HIV medical care
- Knowledge of insurance & ADAP qualifications
- Extensive knowledge of how to efficiently navigate healthcare systems ("red carpet"; no phone trees)
- When to hand-off to more intensive service

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Optimizing Efficiency

LESS

MORE

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UW PHCBC

Key Considerations for CBOs & ASOs

- Data sharing agreements between agencies
- Stakeholder input
- Established clients vs. wider target population
- Referral based vs. active seeking
- Efficiency
- Difference from a case manager
- Data instruments

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Innovative Models from Around the U.S.

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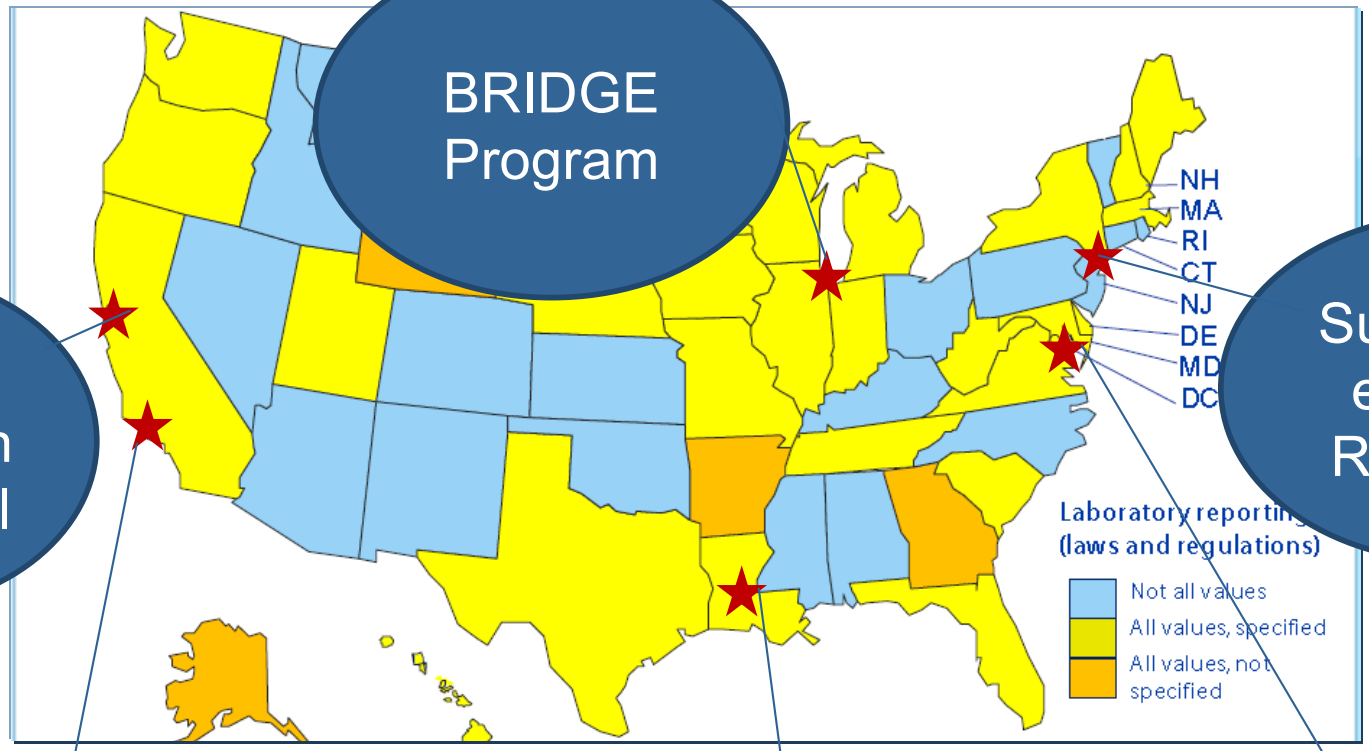
Examples of U.S. Health Department Interventions to Improve Retention in Care



BRIDGE Program

Patient navigation by referral

Surveillance-Based Relinkage

Social network utilization

Interface with electronic health records to generate alerts

Recapture blitzes

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Stories from the Front Line

Mark Fleming

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Acknowledgements

Funding

Ryan White Part A

CDC Category C Demonstration Grant

Collaborators

WA State Department of Health

HIV medical providers in Seattle – King County

Lifelong/Evergreen Wellness Advocates

Madison Clinic leaders, case managers, and outreach staff

Project NEON

UW CFAR and Madison Community Advisory/Action Boards

Ryan White Part A Planning Council

PHSKC Staff

Mark Fleming

Angela Nunez

Matthew Golden

HIV/STD Partner Services team

HIV Surveillance team

Ryan White Part A team

Frank Chaffee

Robert Marks

Elizabeth Barash

Linda Coomas

Jim Jorgenson

Shirley Zhang

STD Clinicians

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