Public-Private Collaboration to Re-engage Out-of-Care Persons into HIV Care

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BACKGROUND
Linkage to Care and Viral Suppression
New York City, 2016

Timely linkage to HIV care among newly diagnosed people

- Black: 68%
- Latino/Hispanic: 76%
- White: 75%
- API: 76%
- Other: 88%

Viral suppression among people in HIV medical care

- Black: 81%
- Latino/Hispanic: 85%
- White: 92%
- API: 91%
- Other: 84%

API=Asian/Pacific Islander
Timely linkage to care - HIV viral load (VL) or CD4 test drawn within 3 months (91 days) of HIV diagnosis, following a 7-day lag.
Viral suppression - Last HIV VL value in 2016 was ≤200 copies/mL.
In HIV medical care - At least one HIV VL/CD4 in 2016.

Data-to-Care (D2C)

• Identifying HIV-positive persons deemed to be out-of-care (OOC) for efforts to re-engagement and retention in care:

➢ Using public health HIV surveillance registry to identify persons lacking recent viral load, CD4 T cell count, or genotype reports

   NYC health department implemented D2C in 2007

➢ Using HIV clinic medical records to identify persons not retained in HIV care
## Challenges of D2C, “Routine D2C” (rD2C)

<table>
<thead>
<tr>
<th>Health Department</th>
<th>HIV Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misclassification of persons as OOC due to lag time from HIV test result to entry of report in HIV registry</td>
<td>Misclassification of persons as OOC due to patient’s self-transfer of care to another HIV clinic</td>
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<tr>
<td>Explaining to patients why health department know of, or is interested in their clinical care status</td>
<td>Patient attrition from routine clinical care</td>
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<tr>
<td>Time needed to negotiate and obtain clinic appointments for OOC persons agreeing to re-engage in care</td>
<td>Lack of capacity or limited resources to conduct extensive outreach (e.g., home visit, access to social services and internet-based databases) to OOC persons</td>
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Project Objectives

• Plan and implement “enhanced D2C” (eD2C) initiative:
  ➢ Integrate data from HIV surveillance registry and HIV clinic to identify OOC persons
  ➢ Focus on re-engaging non-Hispanic black OOC persons into care

• Reduce inefficiencies inherent in using lone surveillance or clinic records for rD2C
  ➢ Contact attempts to persons current-with-care misclassified as OOC
  ➢ Delays in obtaining clinic appointments by DOHMH disease intervention specialists (DIS)
NYC eD2C location by HIV Prevalence, NYC 2016

PLWHA as a percent of population* by ZIP code

- 0.1 - 0.5
- 0.6 - 1.0
- 1.1 - 1.7
- 1.8 - 3.3
- Non-residential zones


PLWHA=People living with HIV/AIDS

1Rates calculated using the intercensal 2015 NYC population.

2Age-adjusted to the NYC Census 2010 population. People newly diagnosed with HIV at death were excluded from the numerator.
Project Framework

• 2014 amendment to New York State HIV-related law:
  ➢ Permitting the sharing of patient-specific data from the HIV registry with a patient’s treating provider
  ➢ Data exchange for the purposes of linkage and retention in care

• Joint operational protocol endorsed by DOHMH and HIV clinic leadership delineating processes
  ➢ Data integration
  ➢ Responsibilities of project staff

• Pilot project from March 2016-October 2017
Eligibility

Patient ever received HIV care from the collaborating HIV clinic, then met following definitions:

- Patient had no CD4 or viral load test report in the HIV surveillance registry ≥9 months
- Patient had no clinic visit ≥9 months
- Regardless of time since OOC, patient deemed high priority by clinic providers, e.g., pregnant women
IMPLEMENTATION
Project Staff

• Existing collaboration:
  ➢ DOHMH DIS assist clinic new diagnosed with partner services
  ➢ Field visits to locate non-adherent newly diagnosed
  ➢ Existing DOHMH and HIV Clinic staff implemented eD2C project

• DOHMH:
  ➢ Field operations manager and supervisor
  ➢ Disease intervention specialist
  ➢ Data analyst

• HIV clinic:
  ➢ Clinic administrator
  ➢ Clinic medical director
  ➢ Patient navigator
Routine Data-to-Care (rD2C)

Health Department (HD)
Identifies patients presumed Out-of-Care using HIV surveillance registry

HD contacts provider to schedule appointment for patients

HIV Clinical Provider

Patient attends scheduled clinic appointment

Patient

HD contacts patients for re-engagement in care
Enhanced Data-to-Care (eD2C)

Health Department (HD)
Identifies persons presumed Out-of-Care using HIV surveillance registry

Clinical provider and HD exchange patient care status and locating information
Diweekly case management meetings between HD and clinic staff

HD re-approached patients for re-engagement in care
Referred patients who refused or preferring to attend another clinic

Clinical provider contacts patients for re-engagement assistance

HIV Clinical Provider

Patient attends scheduled clinic appointment

Patient
Patient Outreach

Telephone calls, text messages, letters, in-person visits
Comparison of eD2C and rD2C
March 2016-October 2017

• Patient demographics
• Accurate classification of care status: Presumed-OOC persons found to be current-with-care
• Outcomes of re-engagement in care efforts
• Timeliness of re-engagement in care efforts
**Race/ethnicity and Gender: eD2C versus rD2C**

*Excluded persons found to be HIV-uninfected*  
**All p<0.001**
HIV-related Characteristics of eD2C and rD2C Groups, March 2016-October 2017

*Excluded persons found to be HIV-uninfected

**All p<0.001
Proportions found Current-with-Care, March 2016-October 2017

- eD2C (N=187)
- rD2C (N=3417)

*p<0.05
Proportions Refusing Re-engagement in Care, March 2016-October 2017

Refused linkage*

- eD2C (N=187)
- rD2C (N=3417)

*p<0.05
Timeliness of Re-engagement Efforts from Initiation March 2016-October 2017

Days to first contact* | Days to clinic appointment
---|---
eD2C (N=187) | 17 | 25
rD2C (N=3417) | 7 | 35

*p<0.05
LESSONS LEARNED
Summary

• Surveillance data can be used to micro-target populations with poor care engagement to address HIV care disparities.

• Health department and HIV clinic collaboration to improve re-engagement of OOC patients in care using existing structures was feasible and acceptable.

• Reducing misclassification of persons as OOC through the eD2C model can improve the efficacy of efforts to re-engage OOC persons in care.
Next Steps

• Ongoing collaboration between the health department and HIV clinic to re-engage OOC persons in care

• NYC health department is exploring similar collaborative schemes with other NYC HIV clinic providers to address unique concerns with engagement of populations in HIV care, e.g., persons ≤30 years of age

• Conduct long-term evaluation to assess if persons re-engaged in care were retained and achieved viral suppression
Thank you

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