Using Data to Optimize the HIV Care and Prevention Continua in San Francisco

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The views expressed herein do not necessarily reflect the official policies of the City and County of San Francisco; nor does mention of the San Francisco Department of Public Health imply its endorsement.
Disclosures

• I have been an investigator in studies for which Gilead has provided study drug
Roadmap

• Getting to Zero San Francisco

• Data on new HIV diagnoses and the HIV Care and PrEP Continua in SF
  – How data collected
  – Tracking progress
  – Identifying gaps and missed opportunities

• Strengthening HIV care and prevention through data
  – Data to Care
  – Data to PrEP
“Getting to Zero” in San Francisco Consortium

Zero new HIV infections
Zero HIV deaths
Zero stigma and discrimination

Photo by Jim Herd
Getting to Zero SF: What are we?

• Multi-sector independent consortium—operates under principles of collective impact:
  “Commitment of groups from different sectors to a common agenda to solve a specific problem.”

• Vision
  —Become the first municipal jurisdiction in the United States to achieve the UNAIDS vision of “Getting to Zero”

90% reduction in new HIV infections by 2020
Strategic Plan: Signature Initiatives

1. City wide coordinated PrEP program
2. Rapid ART start
3. Patient centered linkage, engagement, retention in care

Committee for each initiative + stigma committee has action plan, metrics and milestones. City of San Francisco provided additional funding 2015-6 for new initiatives
Data sources to inform HIV care and prevention efforts

### HIV Care Surveillance: Population-based cohort of living cases

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name-based HIV/AIDS case reporting</td>
<td>(medical providers/labs must report initial dx)</td>
</tr>
<tr>
<td>All HIV viral loads and CD4 (initial and f/u) reported to health dept</td>
<td></td>
</tr>
<tr>
<td>Every 12-18 months, medical chart review of living cases to collect:</td>
<td>- Treatment information, housing status (homeless), demographics, HCV status, relocation outside SF or change in med provider, vital status, OIs, CD4/VL results</td>
</tr>
</tbody>
</table>

### HIV Prevention: PrEP

<table>
<thead>
<tr>
<th>Description</th>
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<tr>
<td>STD clinic (SF City Clinic) and community-based (NHBS, STOP AIDS) surveys</td>
<td></td>
</tr>
<tr>
<td>EMR queries of SFDPH primary care clinics and other large PrEP practices</td>
<td>(e.g. Kaiser)</td>
</tr>
<tr>
<td>PrEP Demonstration Project</td>
<td></td>
</tr>
<tr>
<td>Interviews with new HIV diagnoses</td>
<td>(missed opportunities for PrEP)</td>
</tr>
</tbody>
</table>
New HIV diagnoses & deaths, San Francisco

New diagnoses:
- 75% MSM
- 11% MSM/IDU
- 55% people of color
- 13% under 25, 17% over 50
- 11% homeless

Deaths
- Declining HIV deaths
- Increasing drug overdoses and suicides
Total # new HIV diagnoses by race/ethnicity, San Francisco

**Disparities remain**
Annual male dx’es per 100,000:
- White: 69
- Black: 127
- Latino: 107
- Other: 33

*Significant decline*
Improving Trends in HIV Care Indicators

- **HIV testing**
  - Late testers: 27% (2010) → 16% (2014)

- **Linked to care** within 3 mo of new dx
  - 84% (2010) → 92% (2014)

- **Treatment initiation** within 12 mo of new dx
  - 77% (2010) → 97% (2014)

- **Time to VL suppression**
Continuum of HIV care among persons diagnosed with HIV, 2010-2013, San Francisco

### New diagnoses*

<table>
<thead>
<tr>
<th>Year</th>
<th>2010 Diagnoses</th>
<th>2011 Diagnoses</th>
<th>2012 Diagnoses</th>
<th>2013 Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td>84%</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>71%</td>
<td>73%</td>
<td>72%</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td>57%</td>
<td>59%</td>
<td>67%</td>
</tr>
</tbody>
</table>

### Linked to care within 3 months of diagnosis (1)

- 2010: 100%
- 2011: 84%
- 2012: 71%
- 2013: 57%

### Retained in care for 3-9 months after linkage (2)

- 2010: 100%
- 2011: 86%
- 2012: 73%
- 2013: 59%

### Viral suppression^ within 12 months among all new diagnoses (3)

- 2010: 100%
- 2011: 88%
- 2012: 72%
- 2013: 67%

*Number of new diagnoses shown each year is based on 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 $\leq 200$ copies/mL.
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.

New diagnoses*

Linked to care within 3 months of diagnosis (1)

Retained in care for 3-9 months after linkage (2)

Viral suppression^ within 12 months among all new diagnoses (3)

*Number of new diagnoses shown each year is based on 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.
Crude, preliminary PrEP cascade for MSM in SF

Data from NHBS, PrEP Demo, STOP AIDS, SFCC
Crude, preliminary PrEP cascade for MSM in SF

GAPS: Lower PrEP knowledge and/or use:
- African American, Latino MSM
- Women, including transwomen
- Youth (under 25)
- People who inject drugs

Data from NHBS, PrEP Demo, STOP AIDS, SFCC
Goals of Data to Care in SF

• Utilize routine data collected as part of HIV Surveillance to inform programmatic activities along the continuum of care
  – Combined Health Dept/Healthcare Provider Model
• Improve workflow
  – Focus PS/linkage on truly "new" positives
  – Focus contact tracing on named partners on HIV-negative
  – Focus HIV navigation services on people truly not-in-care
  – Prioritize navigation for those who are most likely to transmit

Importance of Triangulation of Data
LINCS Navigation

Goal: Provide appropriate HIV–related medical and social services to optimize individual health and prevent HIV transmission

1. Out of care HIV+ patients referred
2. Located patients are offered Navigation services
3. Navigators work to locate patients
4. Enrolled patients provided assistance to re-engage in care
Using surveillance data for program evaluation

LINCS Navigation 2012-2013

Enrolled (n=116)

Re-linked: 73% (n=85)

Not Re-linked: 26% (n=31)

<table>
<thead>
<tr>
<th>Re-linkage</th>
<th>Total</th>
<th>% VLS 12 months pre-LINCS</th>
<th>% VLS 12 months post-LINCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-Linked</td>
<td>85</td>
<td>24%</td>
<td>64%</td>
</tr>
<tr>
<td>Not Re-Linked</td>
<td>31</td>
<td>26%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Sachdev, Antunez et al IAPAC 2015

www.GettingToZeroSF.org
Data to PrEP

• **Focus PrEP outreach efforts** on those with lower PrEP knowledge / uptake
  – PrEP ambassadors
  – Social marketing campaigns
  – PrEP Demo Project for youth, transgender people

• **Identify at-risk pts** in DPH primary care who have rectal STIs or syphilis, not on PrEP
  – Consider adding PrEP to CMR forms

• Need **better data** on **PrEP cascade**
  – Offered PrEP, uptake when offered, access/coverage

• Need **better data** on **PrEP retention**
  – Missed visits, pts lost to f/u
  – Compare PrEP outcomes for different models of delivery
What’s the “secret sauce” to the Consortium?

- Engagement of multiple sectors:
  - Activists
  - Clinicians
  - Health Department, Mayor
  - Researchers
  - Foundations, others
- Passion for the outcomes
- Data, data, data
Summary

• **Significant progress in SF**
  – Declining HIV cases and HIV-related deaths
  – Improvements in HIV care indicators

• **Significant disparities remain** in new diagnoses, linkage to care, treatment initiation, retention, and viral suppression

• **Local data** can be used to **measure progress** towards Getting to Zero and **identify gaps**

• Ongoing **collaboration and communication** between Surveillance and Programmatic efforts are key
Thank you

- **HIV Surveillance**: Susan Scheer
- **Disease Control and Prevention**: Darpun Sachdev, Stephanie Cohen
- **Research**: Susan Buchbinder, Hyman Scott
- **Getting to Zero SF**
  - PrEP: Brad Hare
  - RAPID: Oliver Bacon
  - Retention: Edwin Charlebois, Andy Scheer
  - Stigma: Wayne Steward, Austin Padilla, Mark Ryle
  - Shannon Weber, all committee members
Thank you