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

Chi-Chi Udeagu, MPH

Jamie Huang, MPH

Lil Eason

Leonard Pickett

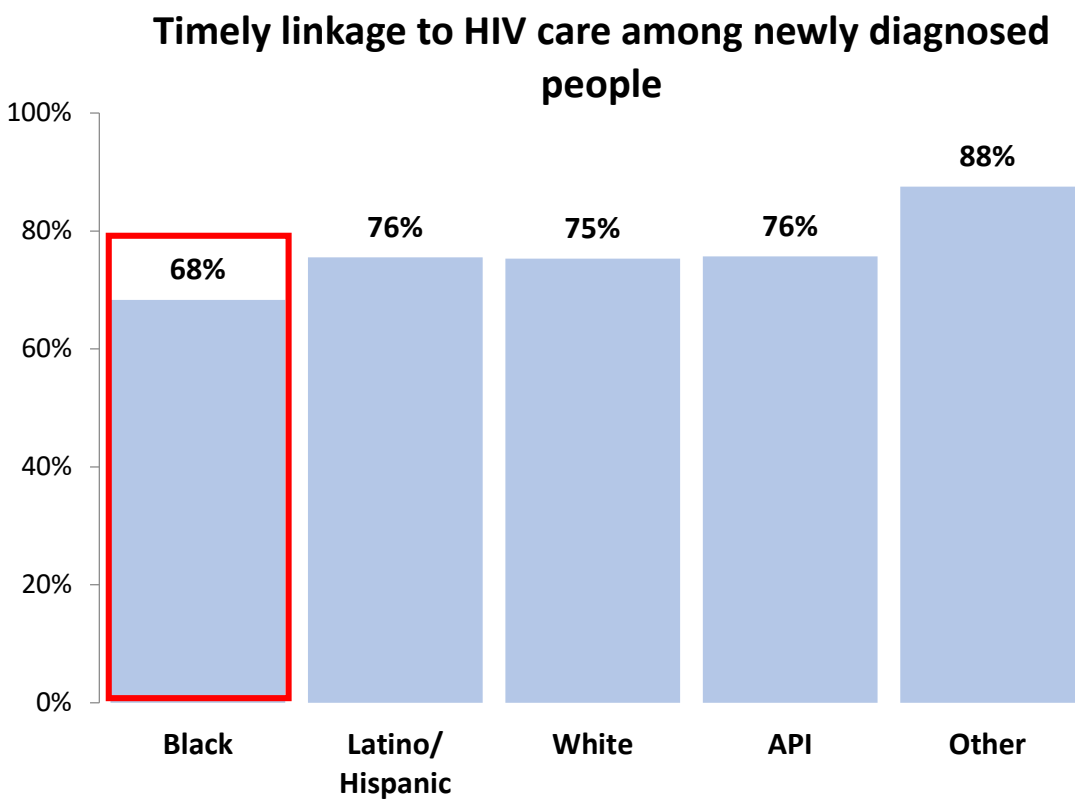
New York City Department of Health and Mental Hygiene

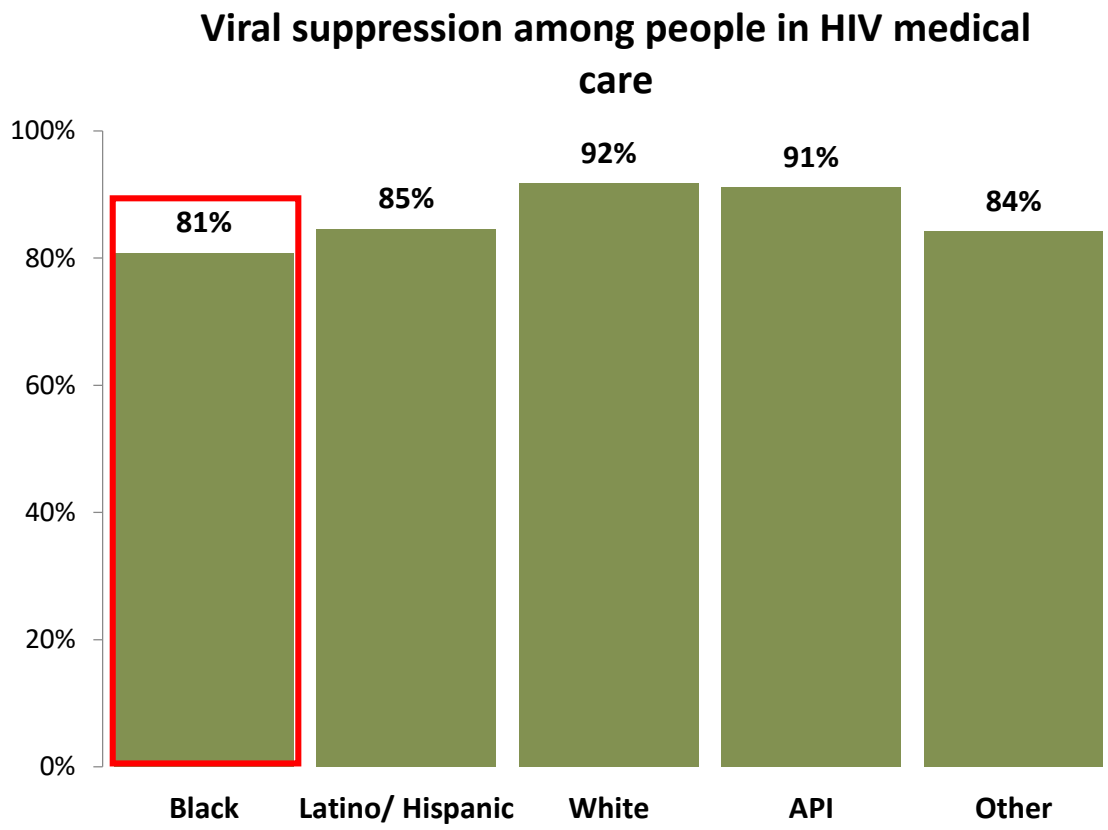
Adherence Conference 2018

NYC Health

BACKGROUND

Linkage to Care and Viral Suppression New York City, 2016





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.

HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2015*. New York City Department of Health and Mental Hygiene: New York, NY. December 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)

Health Department	HIV Clinic
Misclassification of persons as OOC due to lag time from HIV test result to entry of report in HIV registry	Misclassification of persons as OOC due to patient's self-transfer of care to another HIV clinic
Explaining to patients why health department know of, or is interested in their clinical care status	Patient attrition from routine clinical care
Time needed to negotiate and obtain clinic appointments for OOC persons agreeing to re-engage in care	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

INTERVENTION

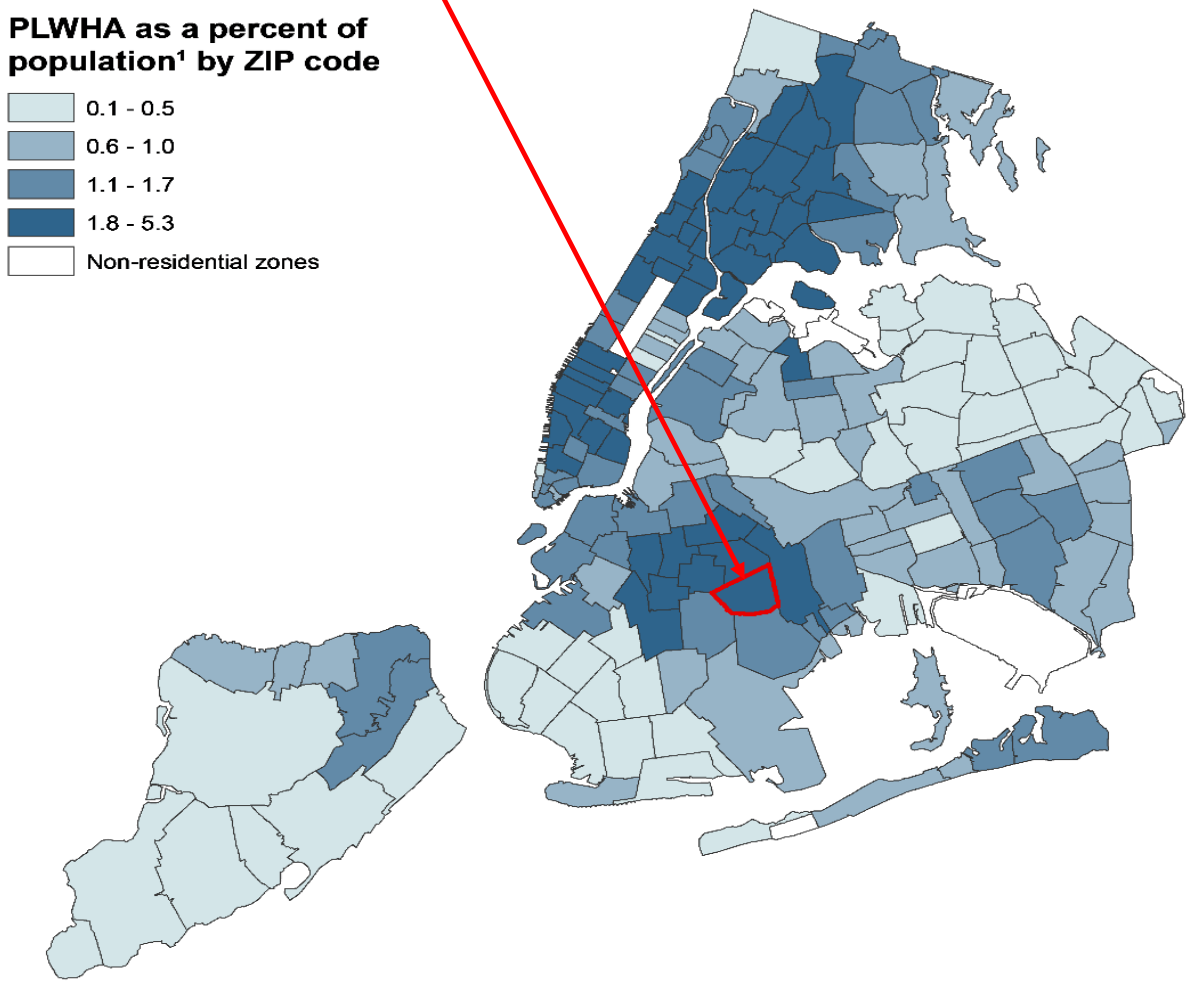
Project Objectives

- **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 Health

NYC eD2C location by HIV Prevalence, NYC 2016



HIV Epidemiology and Field Services Program. *HIV Surveillance Annual Report, 2015*. New York City Department of Health and Mental Hygiene: New York, NY. December 2016.

PLWHA=People living with HIV/AIDS

[1]Rates calculated using the intercensal 2015 NYC population.

[2]Age-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

NYC Health

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**

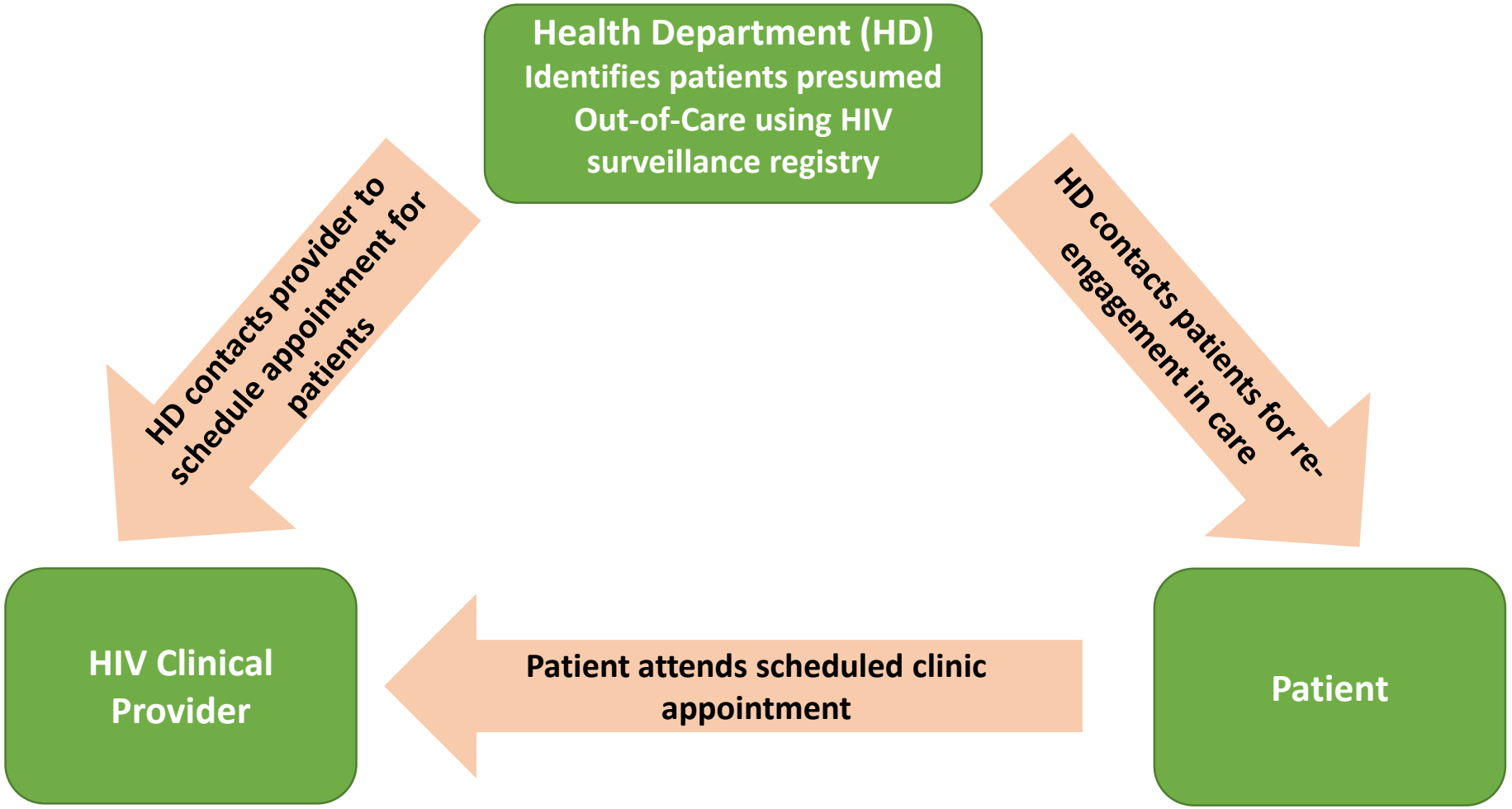
IMPLEMENTATION

Project Staff

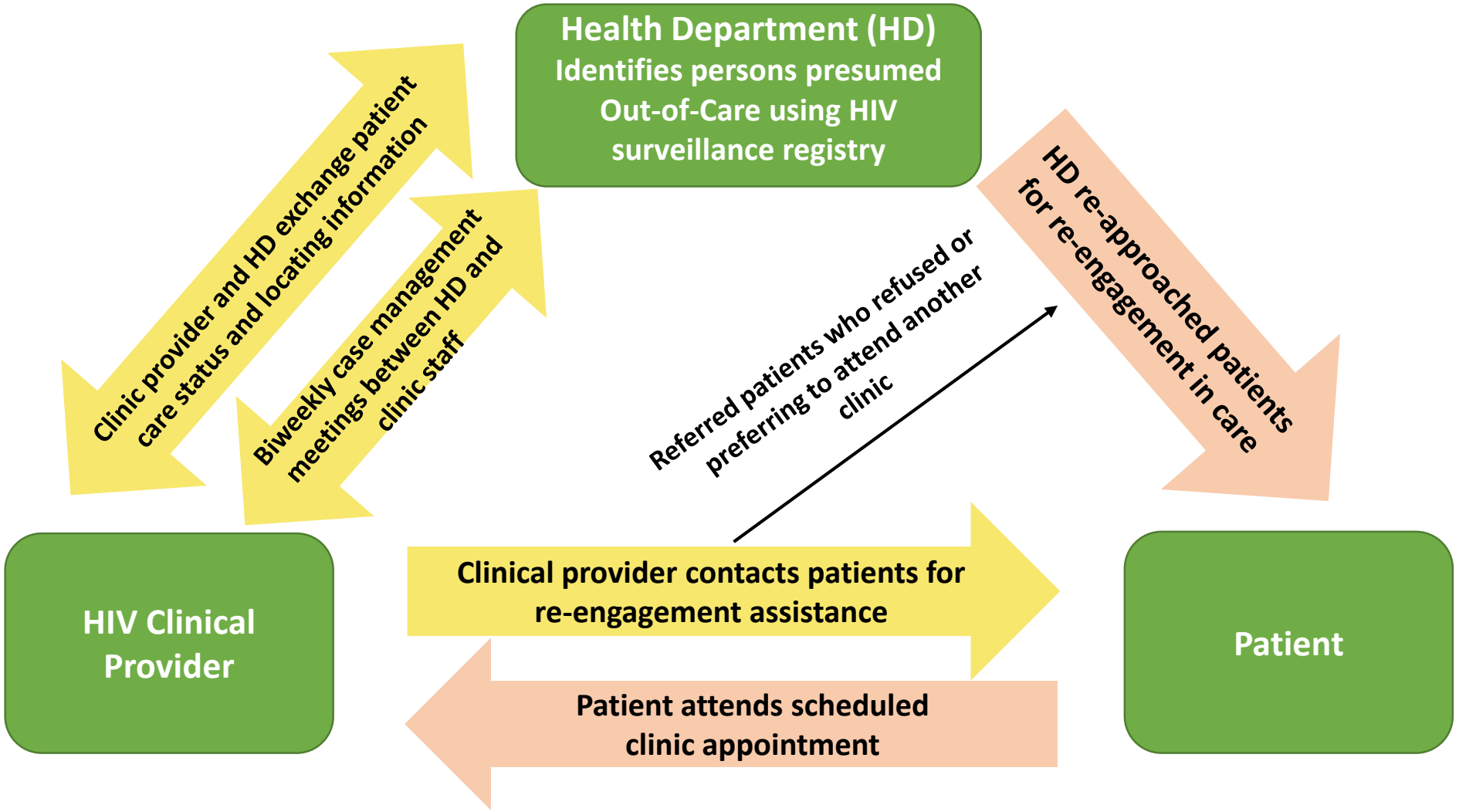
- **Existing collaboration:**
  - **DOHMH DIS assist clinic new diagnosed with partner services**
  - **Field visits to locate non-adherent newly diagnosed**
  - **Existing DOHMH and HIV Clinic staff implemented eD2C project**
- **DOHMH:**
  - **Field operations manager and supervisor**
  - **Disease intervention specialist**
  - **Data analyst**
- **HIV clinic:**
  - **Clinic administrator**
  - **Clinic medical director**
  - **Patient navigator**

NYC Health

Routine Data-to-Care (rD2C)

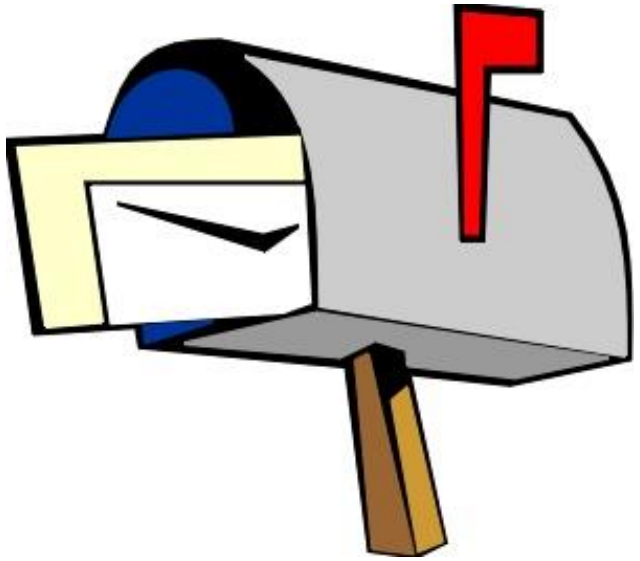


Enhanced Data-to-Care (eD2C)



Patient Outreach

Telephone calls, text messages, letters, in-person visits

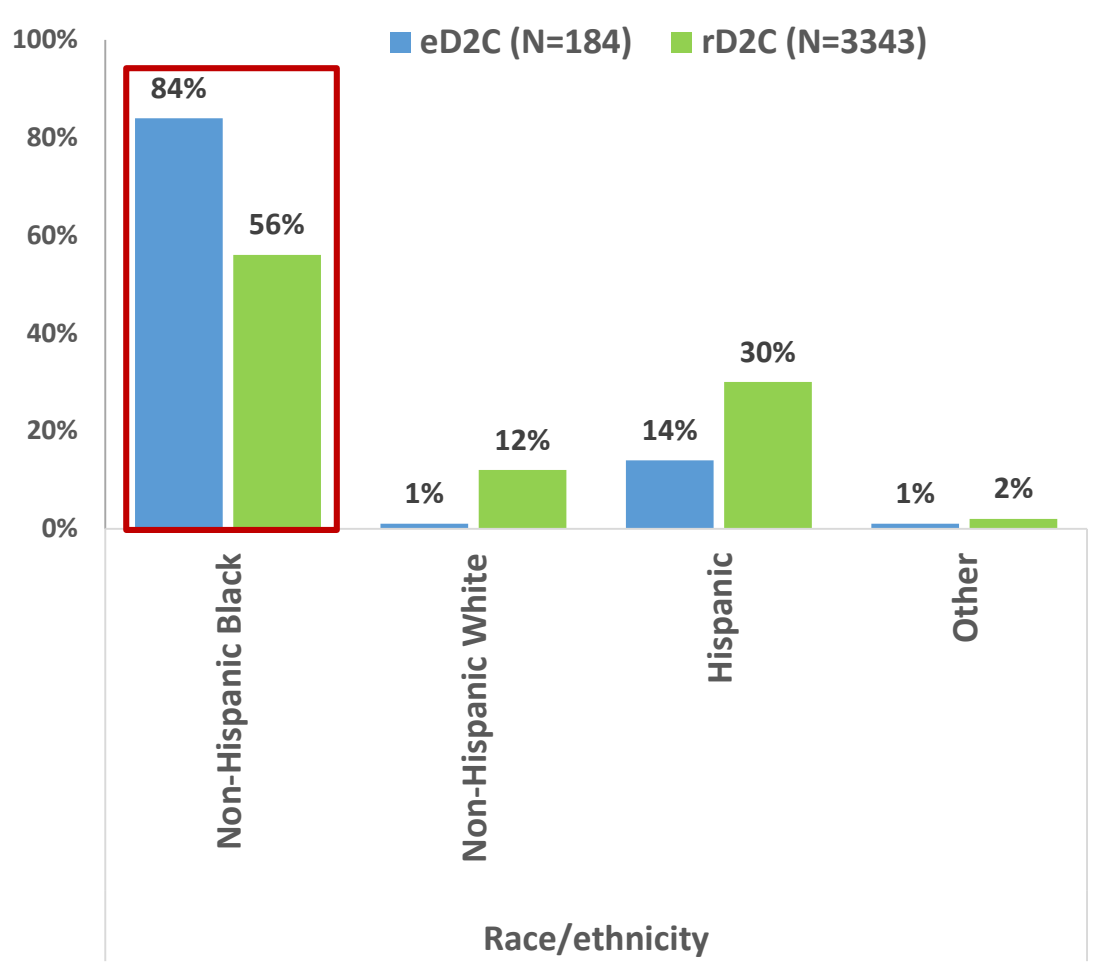


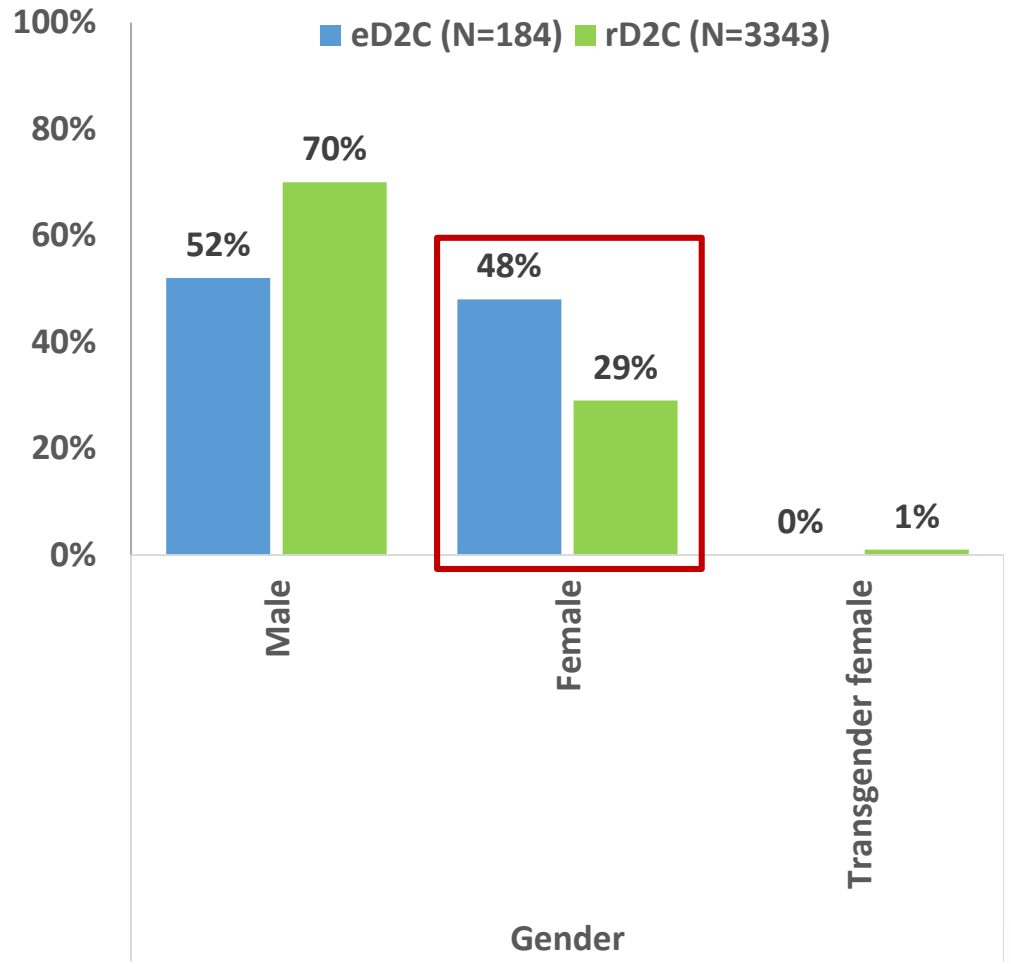
EVALUATION

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

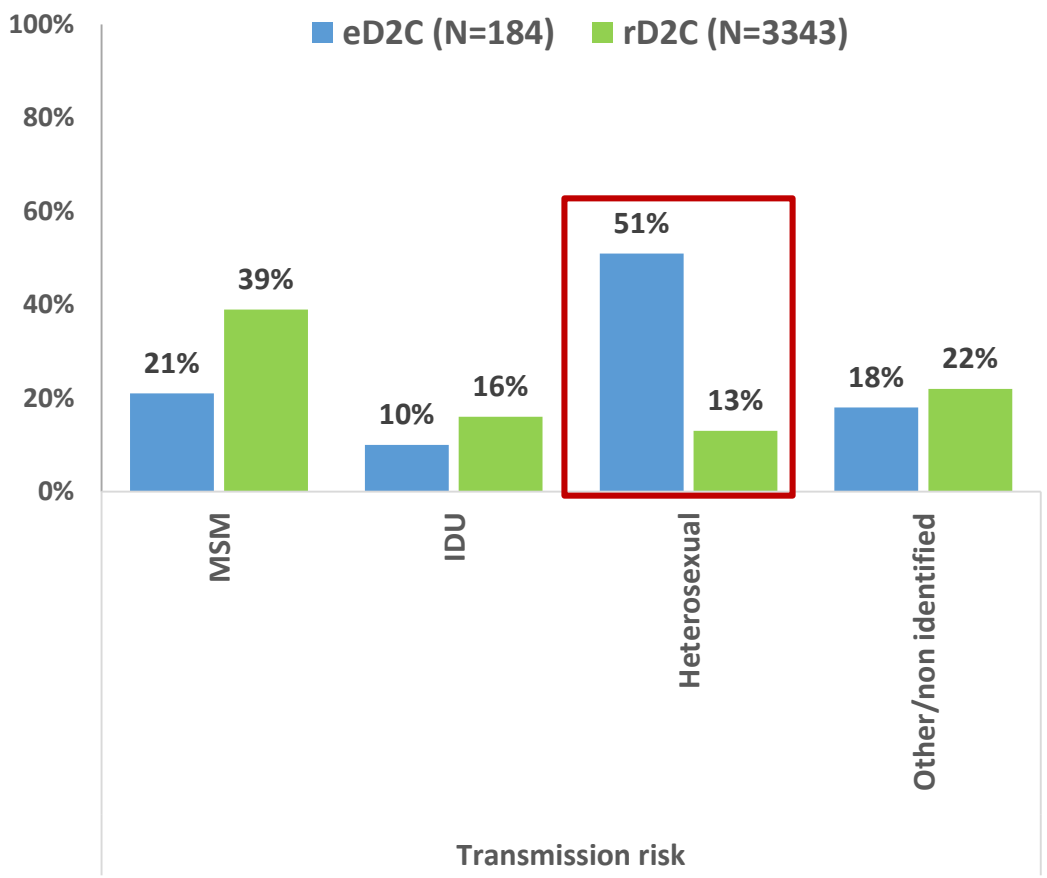


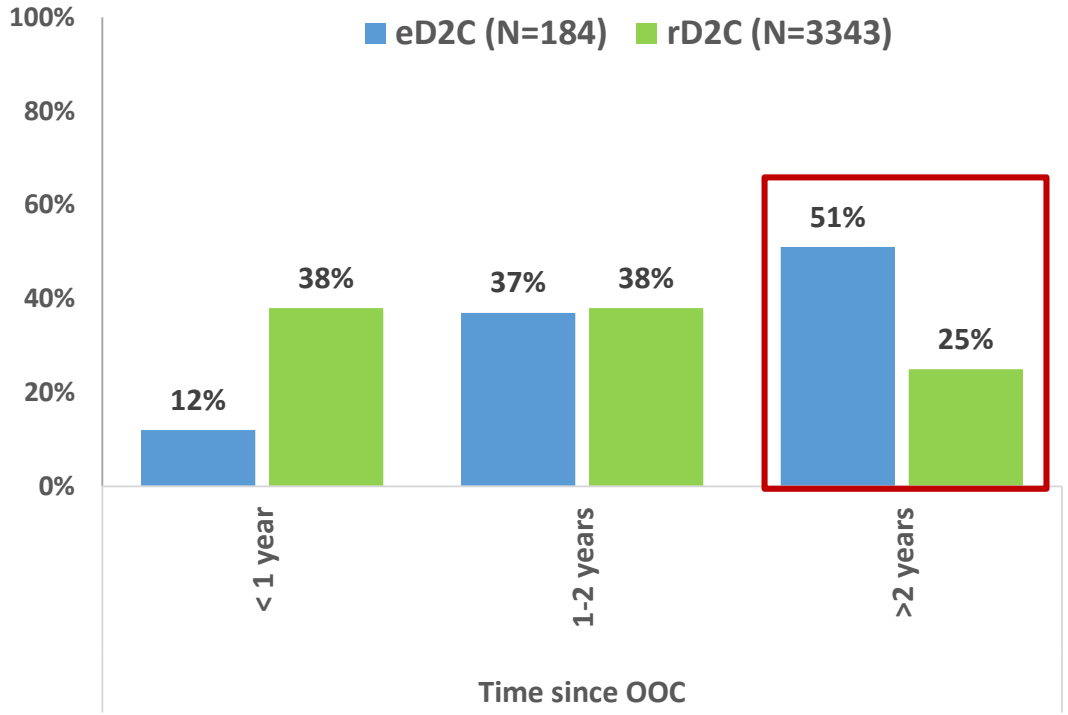


*Excluded persons found to be HIV-uninfected

**All p<0.001

HIV-related Characteristics of eD2C and rD2C Groups, March 2016-October 2017



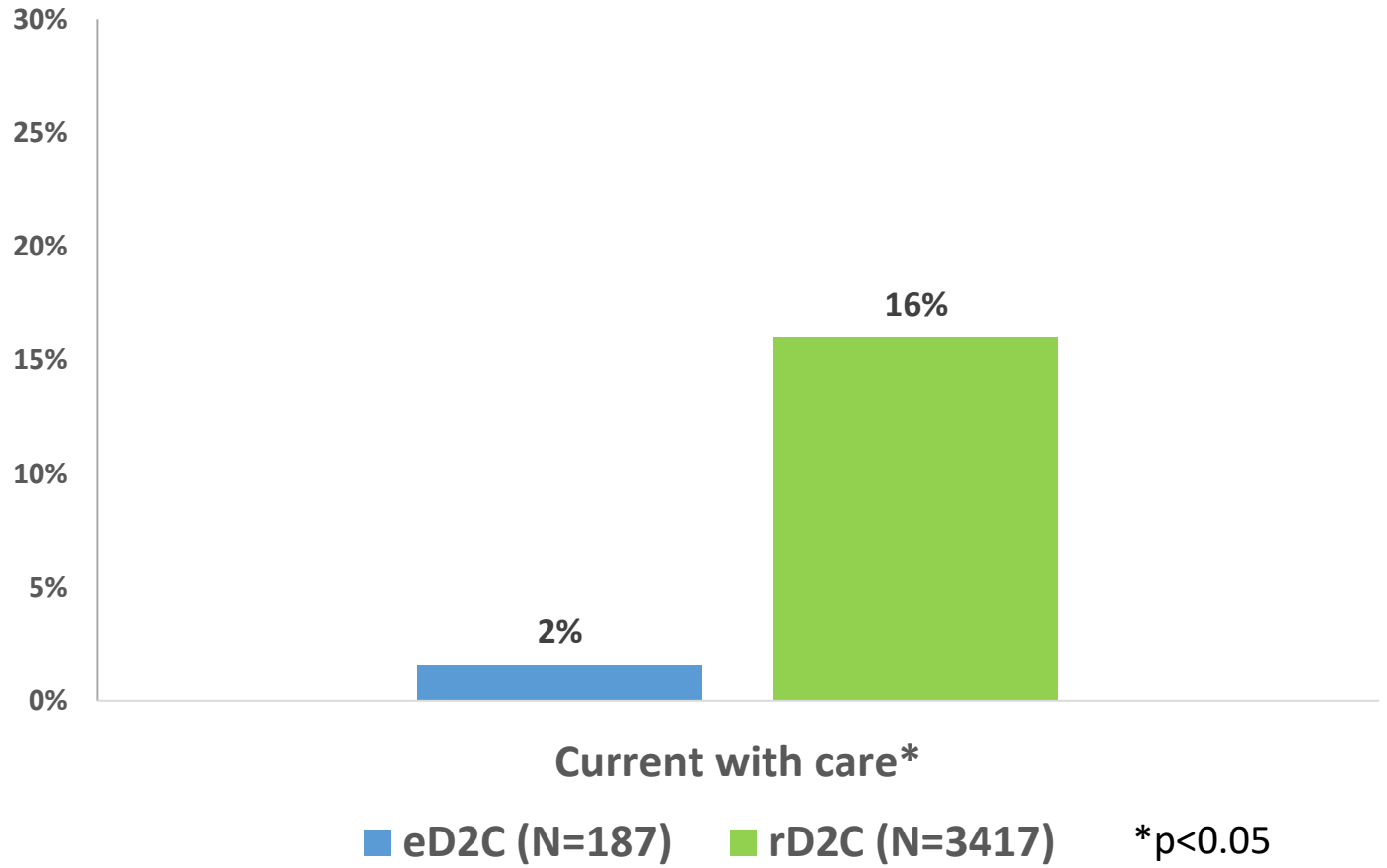


*Excluded persons found to be HIV-uninfected

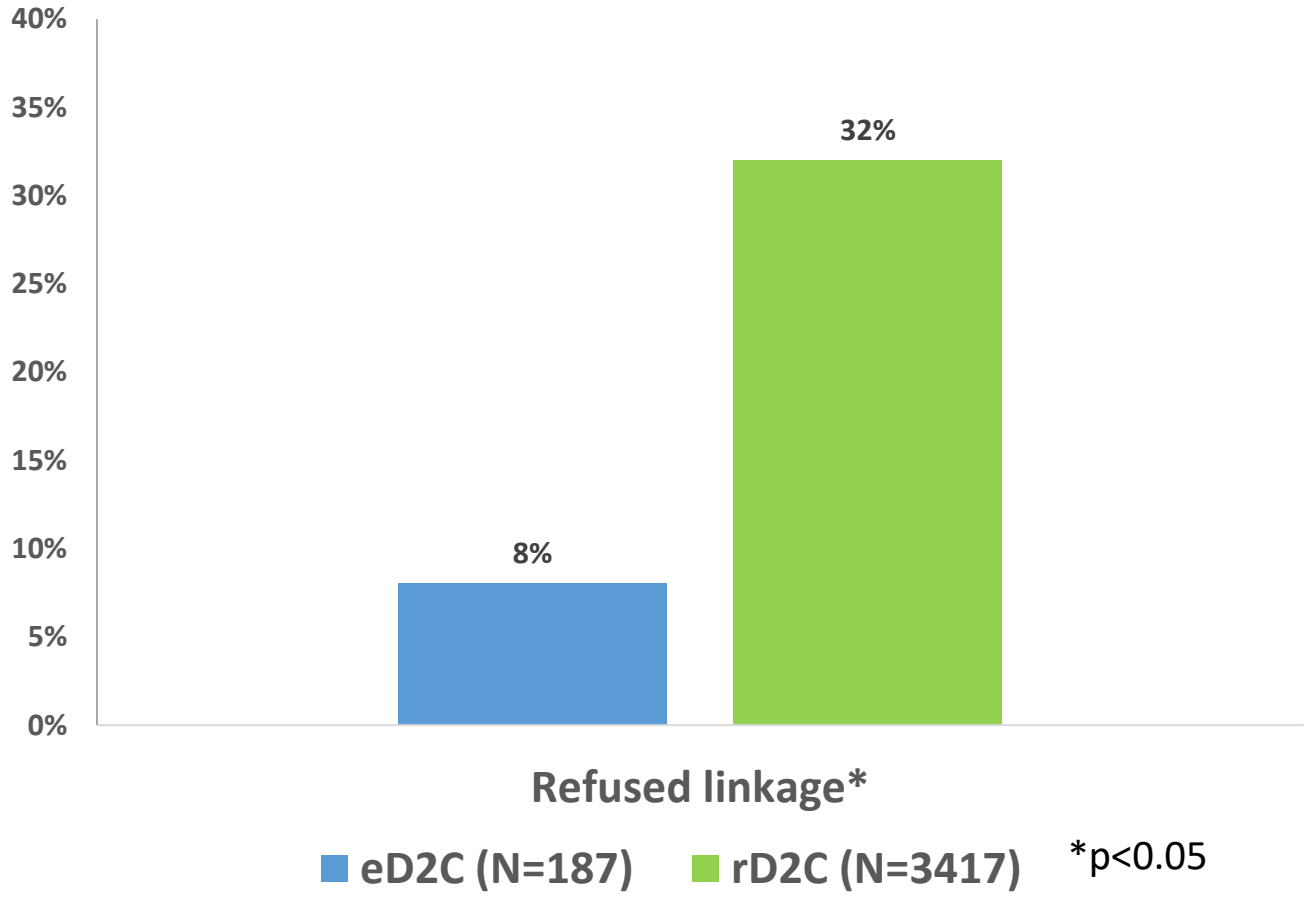
**All p<0.001

NYC Health

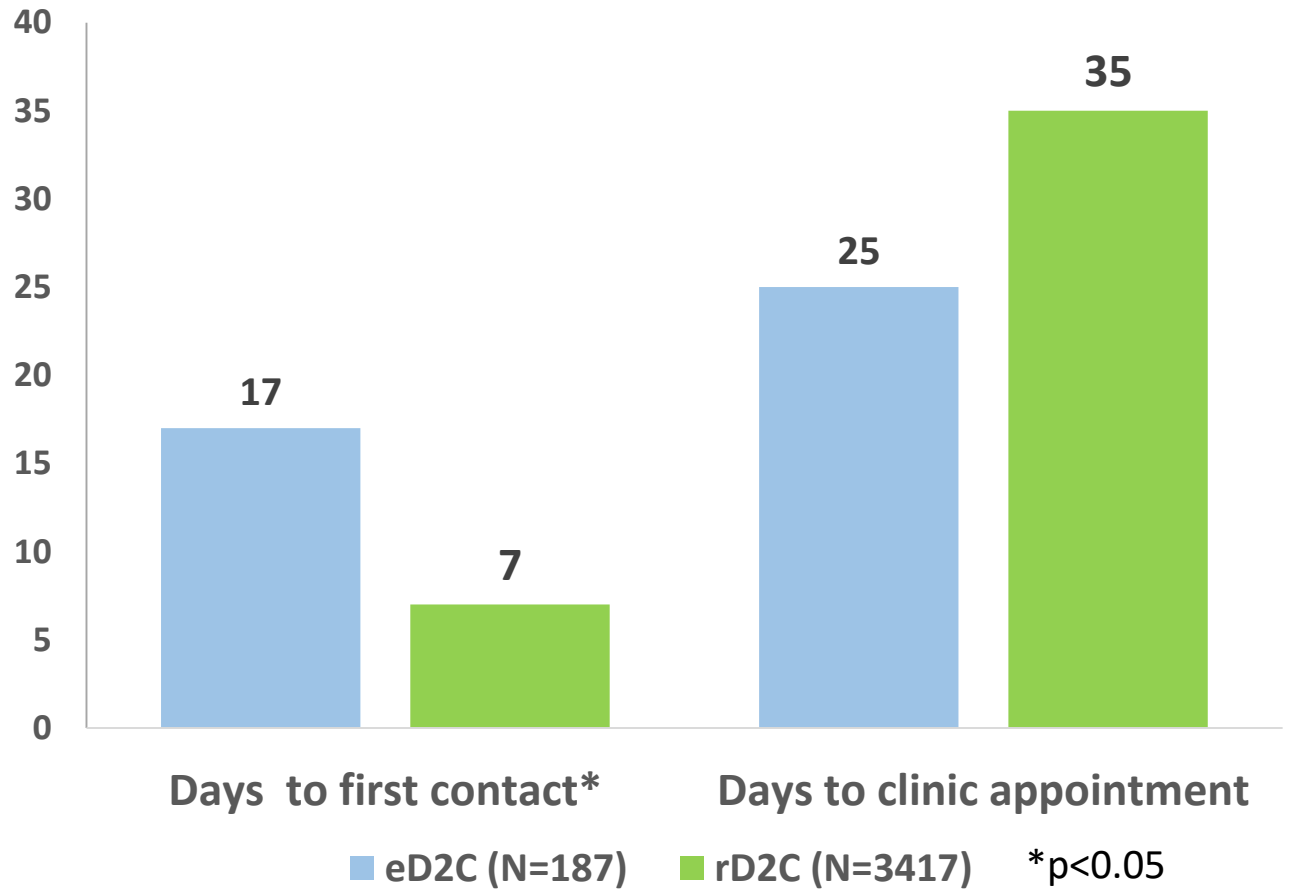
Proportions found Current-with-Care, March 2016-October2017



Proportions Refusing Re-engagement in Care, March 2016-October2017



Timeliness of Re-engagement Efforts from Initiation March 2016-October 2017



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

NYC Health

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

cudeagu@health.nyc.gov