Identifying Facilitators and Barriers along the HIV Continuum of Care -
Washington, DC: DC D-CFAR
ECHPP Supplement Activities

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HIV/AIDS Epidemiology

Prevalence of HIV in the District of Columbia, 2010

• 14,465 reported living with HIV in the District at the end of 2010
• 5,272 new HIV cases reported between 2006 and 2010
• 2.7% of the District’s population diagnosed with HIV
• 1/3-1/2 of people in DC may be unaware of their HIV status
(Source: DC NHBS data)
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC

- Diagnosed HIV Cases: 4,879
- Link to HIV care by 12/31/2010: 4,347 (89%)
- Received additional HIV care by 12/31/2010: 3,729 (86%)
- Ever achieved viral suppression by 12/31/2010†: 2,730 (56%)
- Maintained viral suppression through 12/31/2010‡: 1,391 (51%)

†At least one viral load test result prior to 12/31/2010 was ≤400 copies/mL.
‡All subsequent viral load test results were ≤400 copies/mL.
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC

ECHPP-I Focus Areas

![Bar chart showing the number of cases and percentages for various stages of care.]

- **Diagnosed HIV Cases**: 4,879 cases
- **Linked to HIV care by 12/31/2010**: 4,347 cases (89%)
- **Received additional HIV care by 12/31/2010**:
- **Ever achieved viral suppression by 12/31/2010†**:
- **Maintained viral suppression through 12/31/2010‡**

†At least one viral load test result prior to 12/31/2010 was ≤400 copies/mL.
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ECHPP-I Objectives and Methods

• Objectives:
  – Evaluate the District’s HIV testing portfolio
  – Assess the use of social network testing among high-risk groups
  – Evaluate the District’s linkage to care portfolio
  – Assess the feasibility of nPEP and PrEP scale-up

• Methods:
  – Quantitative: HIV/AIDS surveillance data, provider surveys, costing data
  – Qualitative: key informant interviews, focus groups
Results: HIV Testing

• Conducted key informant interviews with testing coordinators and directors from DC DOH-supported testing sites (n=7)
• Variation was evident between sites in how they understood and implemented testing
• Testing implementation strategies were found to be diverse and appropriate given the testing context
• Challenges identified included:
  — Funding and resource constraints
  — Concerns regarding sustainability of testing programs
  — Third party reimbursement, particularly for rapid testing
• Strong testing staff commitment was exhibited at all sites and was a facilitating factor across sites and testing programs
Results: Social Network Testing

• Focus groups conducted among IDUs, Male-to-female (MTF) transgenders, and Black MSM to assess acceptability and attitudes regarding SNT

• Themes
  – Recognition of high-risk behaviors and prior experience with HIV testing
  – Reluctance to test due to stigma and confidentiality issues
  – When selecting index members for testing, serostatus may not be a critical factor
  – Each population had distinct socio-cultural issues that influenced their testing behaviors and need to be taken into account
Results: Linkage to Care

• Comparison of MCM (n=13) vs. non-MCM (n=64) sites:
  – In FY 2010, cases diagnosed at MCM facilities were significantly more likely to be
    • Engaged in care (72.3% vs. 59.6%, p<0.0001)
    • Virally suppressed (62.5% vs. 58.4%, p<0.001)
  – Among those engaged in care in MCM-funded and non-MCM funded facilities, similar proportions were virally suppressed in both settings (73.9% vs. 73.4%, p=0.7637)
- Availability of MCM services leads to improved clinical outcomes
- Qualitative interviews (N=9 organizations)
  - Differing models and processes of linkage to care among organizations
  - Strong patient-provider relationship, and availability of comprehensive services allowed for more successful linkage
  - Barriers to linkage include limited resources, patient factors such as co-morbidities, and linking patients tested in a non-clinical setting or after normal clinic hours
Results: Costing Analyses of Linkage to Care Programs

Table 1: Cost Effectiveness of Navigator Programs, April 2010-March 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>Latino Navigator</th>
<th>Wards 7 and 8*</th>
<th>Adolescents and sex workers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of referrals</td>
<td>249</td>
<td>45</td>
<td>6</td>
</tr>
<tr>
<td>b. Number of linkages to care</td>
<td>50</td>
<td>33</td>
<td>5</td>
</tr>
<tr>
<td>c. Total program cost</td>
<td>$200,000</td>
<td>$124,201</td>
<td>$125,000</td>
</tr>
<tr>
<td>d. Cost per referral**</td>
<td>$803</td>
<td>$1,378</td>
<td>$10,417</td>
</tr>
<tr>
<td>e. Cost per linkage to care***</td>
<td>$4,000</td>
<td>$1,879</td>
<td>$12,500</td>
</tr>
</tbody>
</table>

- The Latino Navigator program achieved the lowest cost per referral
- The program for Wards 7 and 8 residents achieved the lowest cost per linkage to care
- The program for adolescents and persons engaged in sex work converted 83% of its referrals into successful linkages to care vs. 73% (ward 7/8) and 20% (Latino Navigator program)
- Difference in cost per referral may be attributed to clinic-based program (Latino-focused program) vs. CBO based
Results: nPEP and PrEP Provider Survey

- Surveyed 58 licensed ID physicians and AAHIVM certified HIV providers

<table>
<thead>
<tr>
<th></th>
<th>nPEP</th>
<th>PrEP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Aware of CDC guidelines</td>
<td>47</td>
<td>81.0</td>
</tr>
<tr>
<td>Protocols in place at practice</td>
<td>18</td>
<td>31.0</td>
</tr>
<tr>
<td>Ever prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>34</td>
<td>58.6</td>
</tr>
<tr>
<td>No</td>
<td>23</td>
<td>39.7</td>
</tr>
</tbody>
</table>

- More likely to prescribe nPEP and PrEP to patients who had:
  - Sex with HIV+ partner (both)
  - Hx of IDU (nPEP only)
  - Hx of STDs (PrEP only)

- Key barriers to both nPEP and PrEP scale-up and use:
  - HIV resistance
  - Cost reimbursement
Results: nPEP and PrEP Scale-Up
Key Informant Interviews (N=9)

• nPEP major themes included:
  – General acceptability of PEP among providers
  – Private physicians reported weighing patient risk and adherence when prescribing
  – ED physicians reported weighing the cost vs. benefits

• PrEP major themes included:
  – Experience with prescribing PEP but little to no demand for PrEP at time of interviews
  – Mixed levels of acceptability among providers
  – Acknowledge that need to be ready to deal with patients who are interested in PrEP
  – Concerns raised regarding cost, adherence, which patients should receive PrEP
  – Little interest in using PrEP for serodiscordant couples, preference to focus treatment of achieving viral suppression in infected partner
ECHPP Presentations at 2012 National HIV Summit Conference

• **Oral sessions**
  - A Cost-Effectiveness Analysis of the Washington, D.C. Department of Health’s HIV/AIDS Testing and Linkage to Care Programs (Wedeles J et al)
  - Provider Knowledge, Use, and Barriers to the Uptake of PEP and PrEP (Castel AD et al)
  - Linkage, Engagement and Viral Suppression Rates among HIV-Infected Persons Receiving Care at Medical Case Management Programs in Washington, DC (Willis S et al)

• **Poster sessions**
  - A Qualitative Assessment of Facilitators and Challenges to the Scale up of HIV Testing in the District of Columbia (Skillicorn et al)
  - A Qualitative Assessment of Facilitators and Challenges to HIV Linkage to Care Models in Washington, DC (Peterson J et al)
  - A qualitative exploratory study of social network testing among three high risk populations (Peterson J et al)
ECHHP-II Supplement Activities
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC

- **Diagnosed HIV Cases**: 4,879
- **Linked to HIV care by 12/31/2010**: 4,347 (89%)
- **Received additional HIV care by 12/31/2010**: 3,729
  - **Continuous Care**: 2,730 (58%)
  - **Sporadic Care**: 1,000 (42%)
- **Ever achieved viral suppression by 12/31/2010†**: 2,730 (56%)
- **Maintained viral suppression through 12/31/2010‡**: 1,391 (51%)

†At least one viral load test result prior to 12/31/2010 was ≤400 copies/mL.
‡All subsequent viral load test results were ≤400 copies/mL.
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC
ECHPP-II Focus Areas

- Diagnosed HIV Cases: 5,000
- Linked to HIV care by 12/31/2010: 3,729
  - Continuous Care: 86%
  - Sporadic Care (SC): 14%
- Received additional HIV care by 12/31/2010: 58%
- Ever achieved viral suppression by 12/31/2010†: 42%
- Maintained viral suppression through 12/31/2010‡: 58%

†At least one viral load test result prior to 12/31/2010 was ≤400 copies/mL.
‡All subsequent viral load test results were ≤400 copies/mL.
HAHSTA Continuum of Care Activities

• In 2008, conducted “Recapture Blitz” to identify persons known to have previously been in care but who had since fallen out of care and re-engage them into care

• Results: Among 1,365 client names submitted from 5 sites:
  • 29 (2.1%) people had died
  • 328 (24.0%) were out of care
  • 1,008 (73.8%) had changed providers

• HAHSTA also promoting the establishment of a patient-centered medical home (PCMH) model inclusive of HIV specialists, support services, and community outreach

• Need additional data to define necessary components for implementing PCMH model
  – From both patient and provider perspective
  – To identify barriers and facilitators of engagement in care
  – To assess the quality of healthcare currently being provided
ECHPP-II Activities

Aim 1) To identify predictors of retention in HIV care through linkage of clinic-based and surveillance data, and patient-level surveys.

• Methodology
  – 3 clinics will participate in recapture blitz
  – Surveys administered to 100 IC patients, 100 OOC patients, and 100 patients in SC
  – Assess unmet needs, patient-provider relationship, facilitators, and motivators for re-engaging in care including use of FIs

• Analysis
  – Individual-level survey data will be linked to both clinic data and surveillance data in order to obtain a comprehensive picture of the care trajectory of these patients
  – Identify predictors of retention in care and modifiable risk factors for poor engagement in care
  – Compare measurement of HRSA HAB and other standard retention in care measures using clinic data compared to surveillance data
ECHPP -II Activities (cont’d)

Aim 2) To identify individual and structural-level barriers and facilitators to engagement and retention in HIV care through the conduct of qualitative interviews with patients and providers.

• Patient Focus Groups (N=6)
  – Engaged in HIV primary care within 3 months of an HIV diagnosis (“early engagers”) vs. engaged in care after 3 months of diagnosis (“late engagers”)
  – Remained in care consistently (“continuously in care”), persons who have been engaged in HIV care inconsistently (i.e., had gaps in HIV care of ≥6 months at one time) and persons who were in care but have dropped out of care
  – Receiving care elsewhere/changed providers
ECHPP-II Activities (cont’d)

• Provider Interviews (N=15):
  – HIV primary care providers at differing site types (n=10)
  – Program directors of existing linkage, navigation, and engagement in care programs in DC (n=5)
  – Domains will include understanding LTC and EIC approaches, establishment of a PCMH model and discussion of existing local interventions (e.g. peer-based, community health worker programs, conditional cash transfer programs) and identification of best practices that could potentially be expanded at a city-wide level

• Analysis
  – Conduct thematic coding and qualitative data analysis using Atlas.ti
  – Identify relevant themes and constructs
Next Steps

• ECHPP-I
  – Finalizing costing analyses
  – 6 posters and oral presentations at 2012 National HIV Summit
  – 5 manuscripts being drafted
  – Presented findings to DC DOH HAHSTA Senior Management Team
  – Organizing meetings with DC DOH HAHSTA counterparts to share detailed findings

• ECHPP-II
  – Meet with HAHSTA staff
  – Identify collaborating clinical sites
Questions

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