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

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DC D-CFAR ECHPP Study Team

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- DC Dept of Health HIV/AIDS, Hepatitis, STD, TB Administration
  - Dr. Gregory Pappas, Senior Deputy Director
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  - Mr. Michael Kharfen, Bureau Chief, Capacity Building and Community Outreach Bureau
  - Mr. Nestor Rocha, Bureau Chief, Prevention Bureau
  - Mr. Gunther Freehill, Bureau Chief, CARE Bureau

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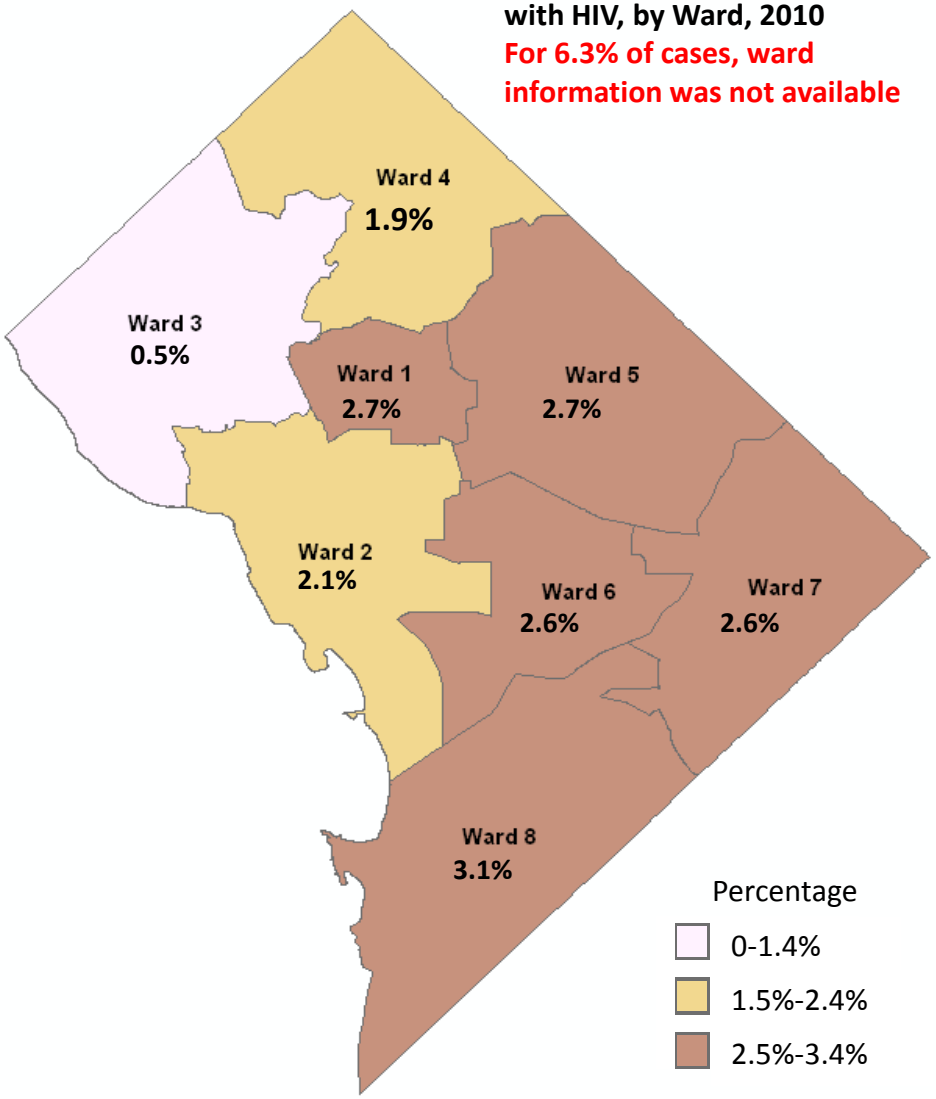
HIV/AIDS Epidemiology

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)

Proportion of persons living with HIV, by Ward, 2010
For 6.3% of cases, ward information was not available



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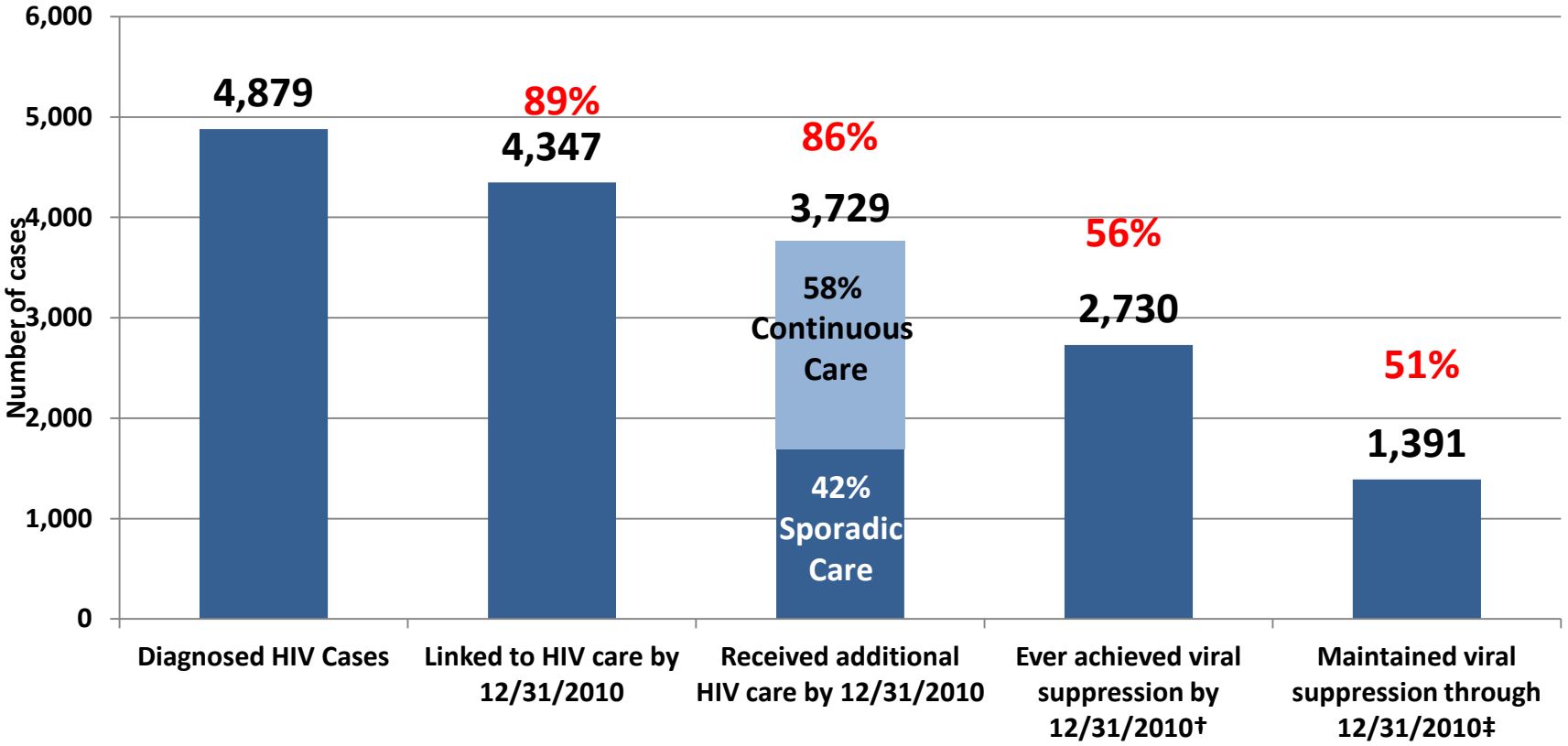
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC



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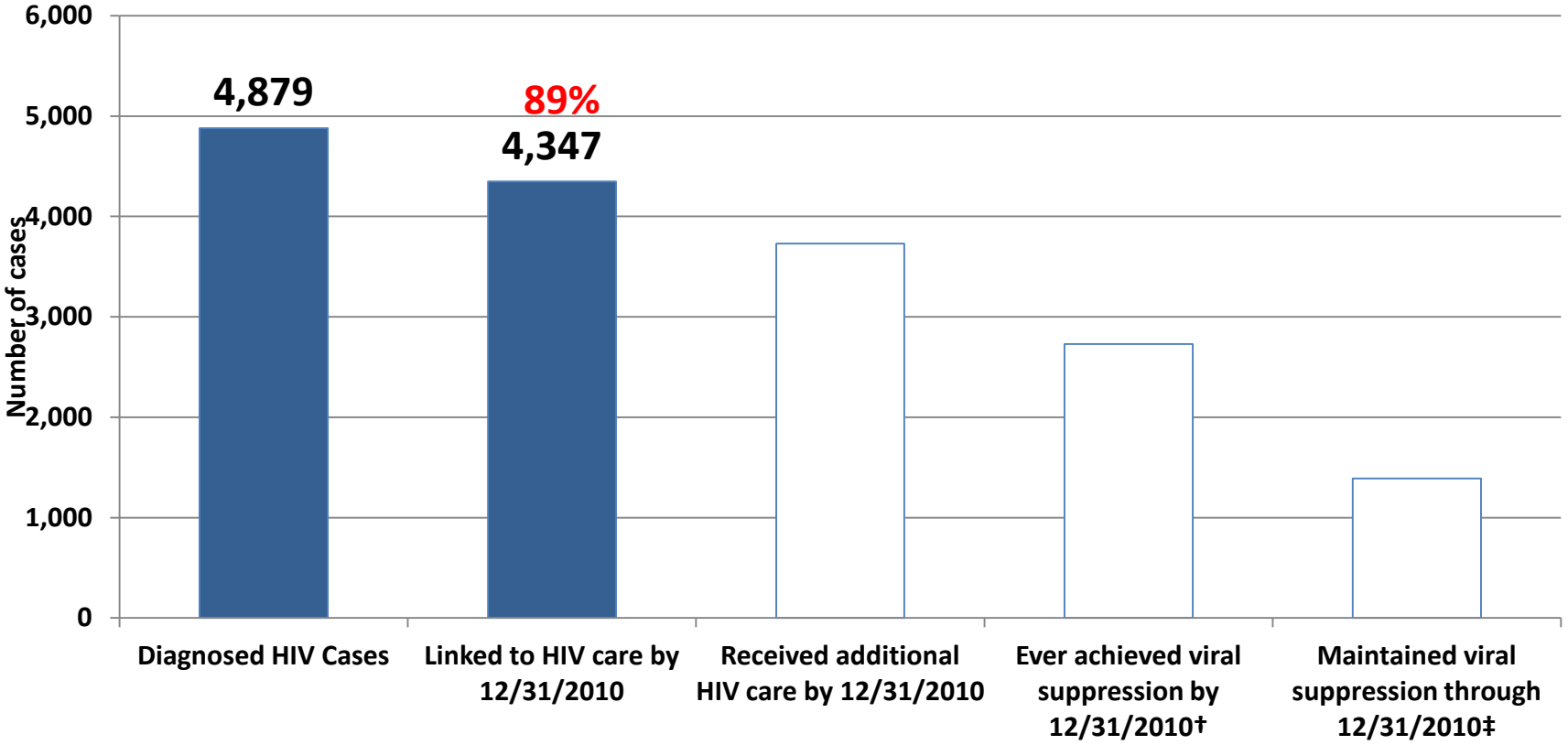
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC

ECHPP-I Focus Areas



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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

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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

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

- 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

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Results: nPEP and PrEP Provider Survey

- Surveyed 58 licensed ID physicians and AAHIVM certified HIV providers

	nPEP		PrEP	
	N	%	N	%
Aware of CDC guidelines	47	81.0	34	58.6
Protocols in place at practice	18	31.0	7	12.1
Ever prescribed				
Yes	34	58.6	13	22.4
No	23	39.7	42	72.4

- 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

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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)

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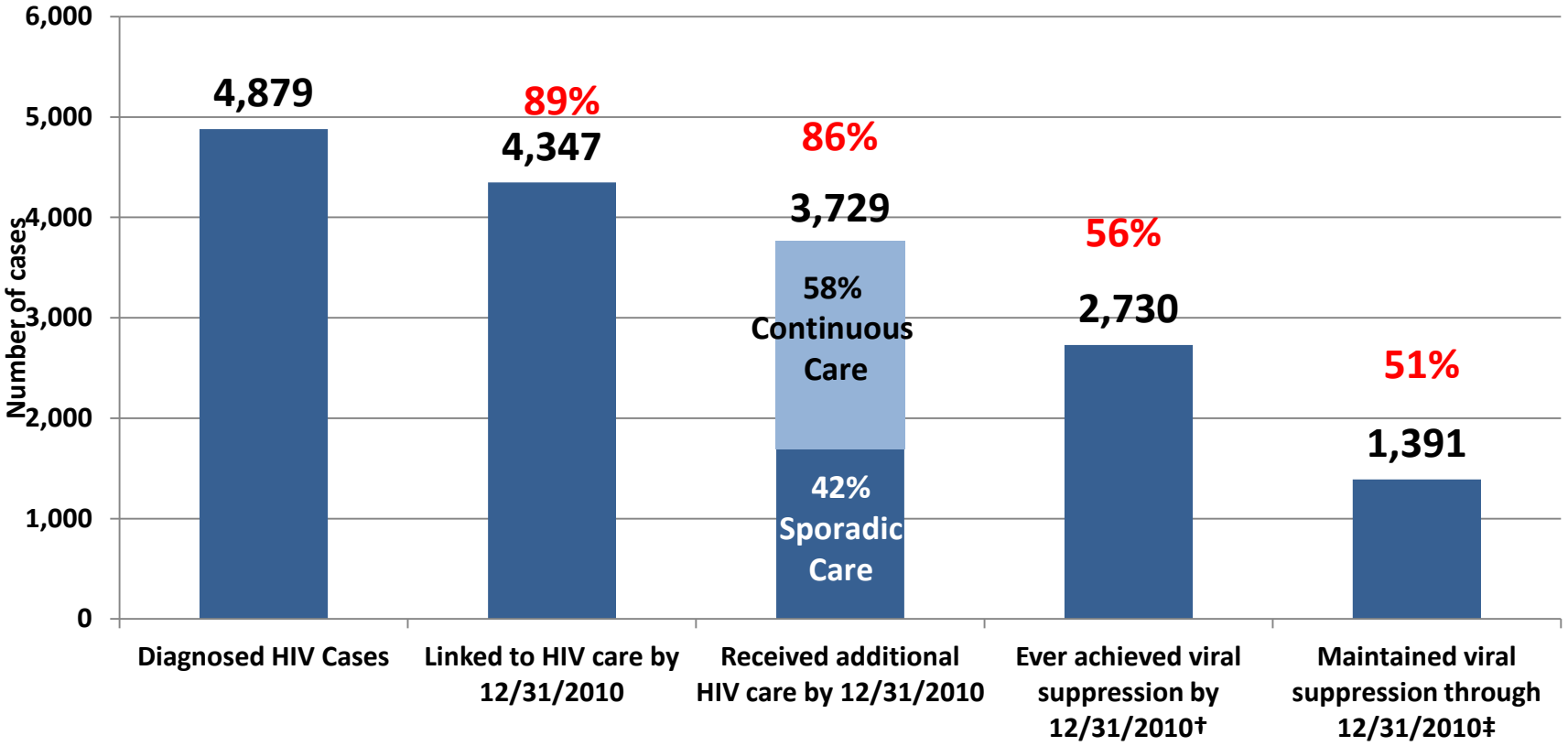
ECHHP-II Supplement Activities

HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC



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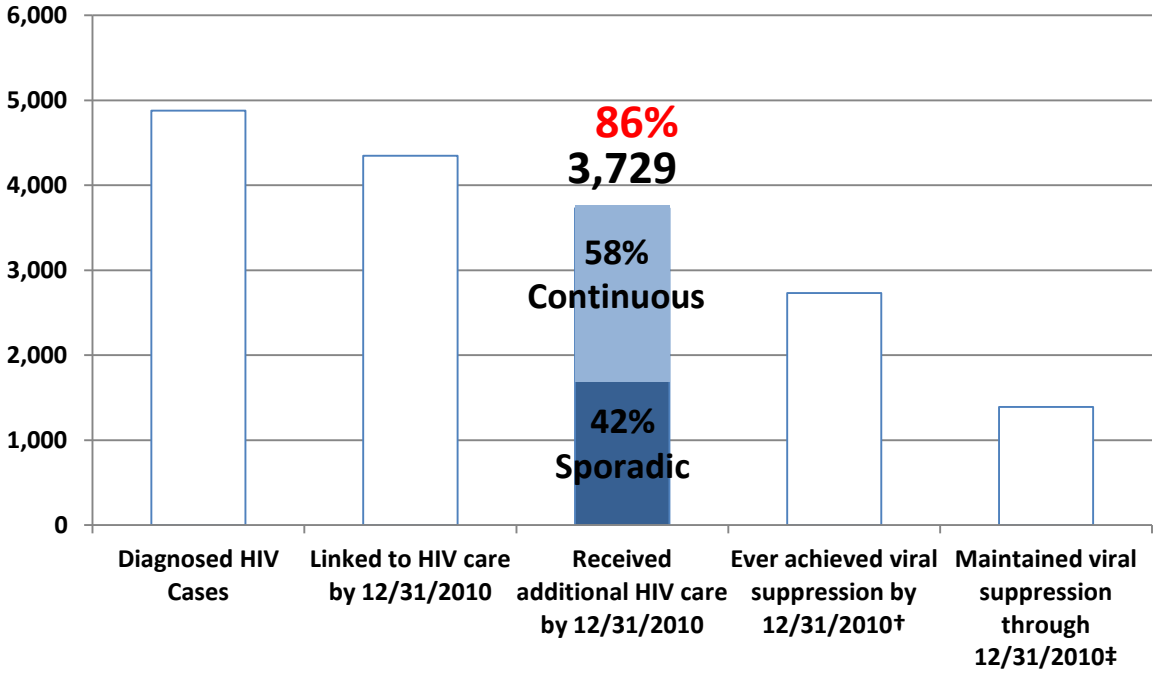
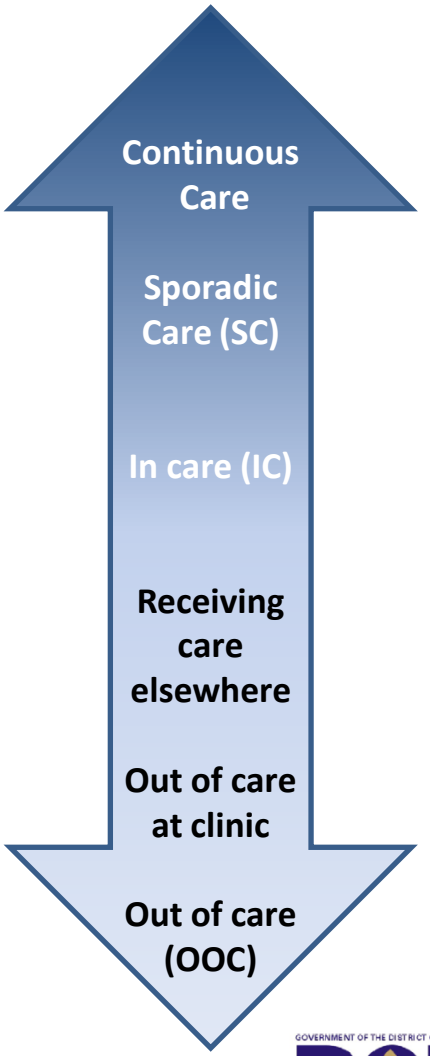
HIV Continuum of Care for Cases Diagnosed 2005-2009, Washington, DC

ECHPP-II Focus Areas





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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

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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

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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

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Questions

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