

# Enhancing Care Engagement and Re-engagement

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# Comparison of HIV Indicators for MSM - San Francisco, 2004-2011.

	2004	2011
<b>Unrecognized HIV infection</b>	21.7%	7.5%
<b>Tested for HIV in last 6 months</b>	44.1%	57.8%
<b>Currently on HIV treatment</b>	Not available	88%
<b>HIV incidence</b>	2.6%	1.0%
<b>Newly diagnosed cases</b>	630	307

# Affordable Care Act Transitions

- **In 2014, Affordable Care Act (ACA) will expand access to healthcare coverage**
  - Medicaid Expansion (Medi-Cal in CA)**
  - Insurance Exchanges (Covered California in CA)**
- **For many people living with HIV, ACA will cause transition from Ryan White → Medicaid/Exchanges**

# **Aim 1 – To explore policy options for structural interventions and systems improvement to maximize patient retention in HIV care during the transition to health care reform**

- **Conduct key informant interviews with providers, administrators and social workers to assess the challenges of transition from Ryan White programs to Medicaid.**
- **Summarize challenges and response strategies for key emerging themes.**

# California's Bridge To Reform



- In 2010, California received a Medicaid Waiver from the federal government to implement *early* expansion of ACA coverage:
  - Transition of Seniors and People with Disabilities (including people living with HIV) from Medi-Cal fee-for-service to **Medi-Cal managed care** (e.g. HealthNet, Anthem BlueCross, Kaiser) in 2011
  - Creation of the **county-run Low-Income Health Programs** (LIHP.) in 2011: If income-eligible, people living with HIV *required* to enroll in the county program

# Study Questions

- **How do these new health coverage programs impact the quality and comprehensiveness of HIV care and treatment and patient retention in California?**
- **How will lessons learned from these transitions affect planning for the larger transitions that will occur nationwide in 2014, and for meeting the five-year goals of the National HIV/AIDS Strategy?**

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## **Aim 2 – To develop a better understanding of community views on sharing health information and surveillance data among health care providers**

- Conduct a community consultation in collaboration with Project Inform, a community-based organization, that reflects the diversity of community interest groups and those highly affected by HIV, particularly around privacy concerns.**

# Background

- In November of 2012, **Project Inform** held a **National Think Tank** attended by 30 representatives of health departments, AIDS advocacy organizations and people with HIV.
  - Purpose was to discuss the acceptability of using HIV case registries, reported laboratory data and electronic medical records systems to link and retain people with HIV in care and treatment.
- **The participants came to the think tank with a broad set of views on this topic – some supportive of this approach and some opposed.**

# National Consensus Points

- The benefits of using surveillance data to link and re-engage people to care and treatment outweigh the risks.
- Health jurisdictions nationally should consider implementing data-based linkage programs.
- Engagement programs needed to be constructed with significant care to prevent breaches of confidentiality for people with HIV.
- Programs should always be developed and implemented as a result of extensive dialogue among health departments, people with HIV and their advocacy groups.

# Methods

- To follow up from the national think tank, Project Inform proceeded to collect information about current and planned linkage programs in San Francisco,
- January of 2014, Project Inform gathered a representative of DPH and representatives of 10 HIV advocacy groups.
- Most, but not all were familiar with the linkage & retention programs conducted by DPH.

# Linkage & Retention Programs

- **LINCS** – A program that uses Disease Control Investigators and community outreach staff to contact newly diagnosed positives and offer partner notification and linkage support. Patient navigators also use a case management framework to support efforts by patients who have fallen out of HIV care to help them overcome barriers to care and achieve improved health outcomes.
- **PHAST** – Located at San Francisco Hospital, this program uses data on newly diagnosed positives in city operated and city funded clinics to conduct outreach and support linkage. The program also conducts outreach to individuals found to have fallen out of care. Outreach is primarily conducted by clinic staff.

# Linkage & Retention Programs

- **RSVP** – Re-engaging Surveillance-identified Viremic Patients ---  
The RSVP project examines the feasibility of using the HIV surveillance registry in San Francisco to identify and contact patients with an unsuppressed HIV viral load who appeared to have fallen out of care, interview them, and re-engage them in HIV care.
- **RAPID** – This program conducts outreach to individuals identified with acute HIV infection and work to connect them to care and medical treatment within one day.

# Common Themes

- **General support among all ten for engaging in activities – so long as they are carefully conducted.**
- **Nine said that their views of these programs had evolved over time, partly because HIV name reporting has not had major implications.**
- **Participants noted how this issue may be particularly sensitive in light of a larger national discussion about government surveillance in our lives and significant data breaches.**
- **Community stakeholders wished to continue a dialog to assure these programs are well run.**

# Issues Raised

- We should not let our concerns about privacy and disclosure prevent us from engaging with people (benefits > risks).
- Some clients view these efforts as coercive. This may be particularly true for young men of color.
- More client and not entirely public health focused – wrap around service are important.
- Those linked or returned to care can be a small number, but require significant time and resources.
- Having HIV+ people conduct outreach and share their experience is desirable.



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Dana Van Gorder, David Evans - Project Inform  
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## Participating Community Agencies:

SFGH - Ward 86

SF HIV Services Planning Council

HIV/AIDS Provider Network

San Francisco AIDS Foundation

Mission Neighborhood Health Center

AIDS Legal Referral Panel

AIDS Emergency Fund

Alliance Health Project

GWU CFAR supplement (PI:Charlebois) to the GIVI/UCSF  
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# **Examining Clinic-Based and Public Health Approaches to Ascertainment of HIV Care Status**

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# Background

- **Identification and re-engagement of out-of-care HIV-infected individuals is a priority**
- **Silent transfers, migration, incarceration, and death can result misclassification of care status**
- **More work is needed to understand the impact on the domestic HIV care cascade**

# Background

- **Public health surveillance registry data and clinic-based tracking efforts may provide different information about care status for the same patients**
- **How best to use these sources together to identify out of care patients is unknown**

# Specific Aims

- **To determine via tracking the true outcomes of a sample of patients at a large public hospital HIV clinic in San Francisco who by electronic medical record query are lost to follow up**
- **To use the San Francisco Department of Public Health surveillance registry to classify these patients as in care or out of care**
- **To compare results from both sources**

# Methods

- **Active clinic cohort defined as individuals with at least one kept primary care visit after April 1, 2010**
- **Lost to follow up group defined as those who were at least 210 days (7 months) “late” for an HIV primary care visit as of April 6, 2013**
- **10% random sample tracked through chart review and a variety of outreach methods (phone, email, mail, in-person) from April to December 2013**
- **Patients matched to surveillance registry data**

# Care Definitions

## Clinic-Based Tracking

In Care

Chart note documenting transfer of care  
Drop-in visit with primary care provider  
Patient self-report of primary care elsewhere  
Incarceration

Out of Care

Other types of visits (e.g. urgent care, social work) without evidence of primary care visits  
Chart note documenting patient as out of care  
Patient self-report

## Surveillance

In Care

Presence of CD4 or VL in 210 days prior to 4/6/13

Out of Care

Absence of CD4 or VL in 210 days prior to 4/6/13



# Tracking Ascertainment

Active Clinic Cohort = 3,099



Lost to Follow-up = 940 (30%)



10% Random Sample = 95



In-Care = 60 (63%)

Out of Care = 9 (10%)

Unable to Locate = 23 (24%)

Incarcerated = 2 (2%)

Dead = 1 (1%)

# The Ascertainer



# Yield of In-Person Tracking

- **The tracker outreached 26 individuals in person over a one-month period**
- **4/26 (15%) located**
  - 3 in care
  - 1 out of care
- **All individuals had a positive response to the in-person outreach**

# Tracking vs. Surveillance Data

	<i>Surveillance</i>		
<i>Patient Status As Ascertained by Tracker</i>	Out of Care	In Care	Total
Out of Care	4	5	9
In Care	22	40	62
Status Unknown	16	7	23
Total	42	52	94

Note: This table removes the deceased individual, whom surveillance also classified as deceased.

# Tracking vs. Surveillance Data

- **By both tracking and surveillance, 40 of 94 individuals (43%) were in care**
- **Surveillance classified 42 individuals as out of care but tracking found that 22 (52%) were in care**
- **Surveillance classified 12 individuals as in care that tracking was unable to locate (7) or classified as out of care (5)**

# Tracking vs. Surveillance Data

	In Care by Surveillance with Suppressed VL	In Care by Surveillance with Detectable VL	Total
Out of Care by Tracking	3	2	5
Status Unknown by Tracking	5	2	7
Total	8	4	12

# Location Status of Individuals Surveillance Classified as Out of Care

**N=22**

- **Out of state = 10 (45%)**
- **In state, out of county = 7 (32%)**
- **In state, in county = 5 (23%)**

# Who was out of care as of April 6, 2013, by both tracking and surveillance?

Demographics	Last Visit	Last Labs	Result	Missed Visit?	Returned to Clinic Care	Notes
30 yo MTF	9/10	6/10	CD4 600 VL 5007	4/11	5/13 CD4 385 & VL 37, 324	Out of care x 3 years
39 yo M	8/12	7/12	CD4 375 VL <40	2/13	10/13 CD4 353 & VL 2902	ED visit 2/13
43 yo M	7/12	7/12	CD4 399 VL <40	7/12	5/13 CD4 548 & VL 17,997	Urgent Care visit 1/13
41 yo F	8/12	8/12	CD4 334 VL <40	1/13	7/13 from drug treatment with VL<40	Found by tracker



# Who was out of care as of April 6, 2013, by tracking and in care by surveillance?

Demographics	Last Visit	Last Labs	Result	Missed Visit?	Returned to Clinic Care	Other
43 yo M	4/12	10/12	CD4 561 VL <40	No	No	Planning move to LA
49 yo M	3/12	6/12	CD4 591 VL 1191	5/12	9/13 – did not do labs	Urgent Care & ED visits only
47 yo M	7/12	6/12	CD4 84 VL <40	3/13	4/9/13 CD4 131 & VL <40	Remained on ART, pharmacy visit 3/13
47 yo M	3/12	3/13	CD4 255 VL 433, 863	Yes	5/13 CD4 149 VL 9635	HIV specialty visits only
40 yo M	10/11	12/12	CD4 341 VL 21,793	1/13	4/22/13 CD4 234 VL 40,878	Urgent Care visit

# Conclusions

- **Surveillance estimates of those of out of care were higher than what was found by tracking, even if individuals the tracker was unable to locate are classified as out of care by lab data**
- **Matching with surveillance data prior to tracking potentially could have allowed us to remove 52/94 (55%) patients from the list**

# Conclusions

- **In care/out of care is a spectrum rather than a binary status**
- **Not all out of care states are the same**
- **Clinic-based in-person tracking appears acceptable in a small number of patients but this type of tracking is most likely useful for re-engagement when conducted within a short window after the last clinic visit**

# Policy Implications

- **Using clinic-based tracking and surveillance data together provides better ascertainment of care status than either method alone**
- **Surveillance data could help inform clinic outreach efforts**
- **Clinic-based in-person outreach supplemented by surveillance data may merit further study as a re-engagement strategy, as would the cost/cost-effectiveness of such a strategy**

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