Rapid Access for HIV Care and Prevention in a Center for Youth

Daniel H. Conway, MD

for the
Dorothy Mann Center
St. Christopher's Hospital for Children
Philadelphia, PA
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Introduction

- Implementation of the Care Continuum
- Structure of intensive multi-disciplinary care management in this model.
- Rapid Start of ART in Youth with HIV

THE CONTINUUM OF CARE FOR HIV MEDICINE

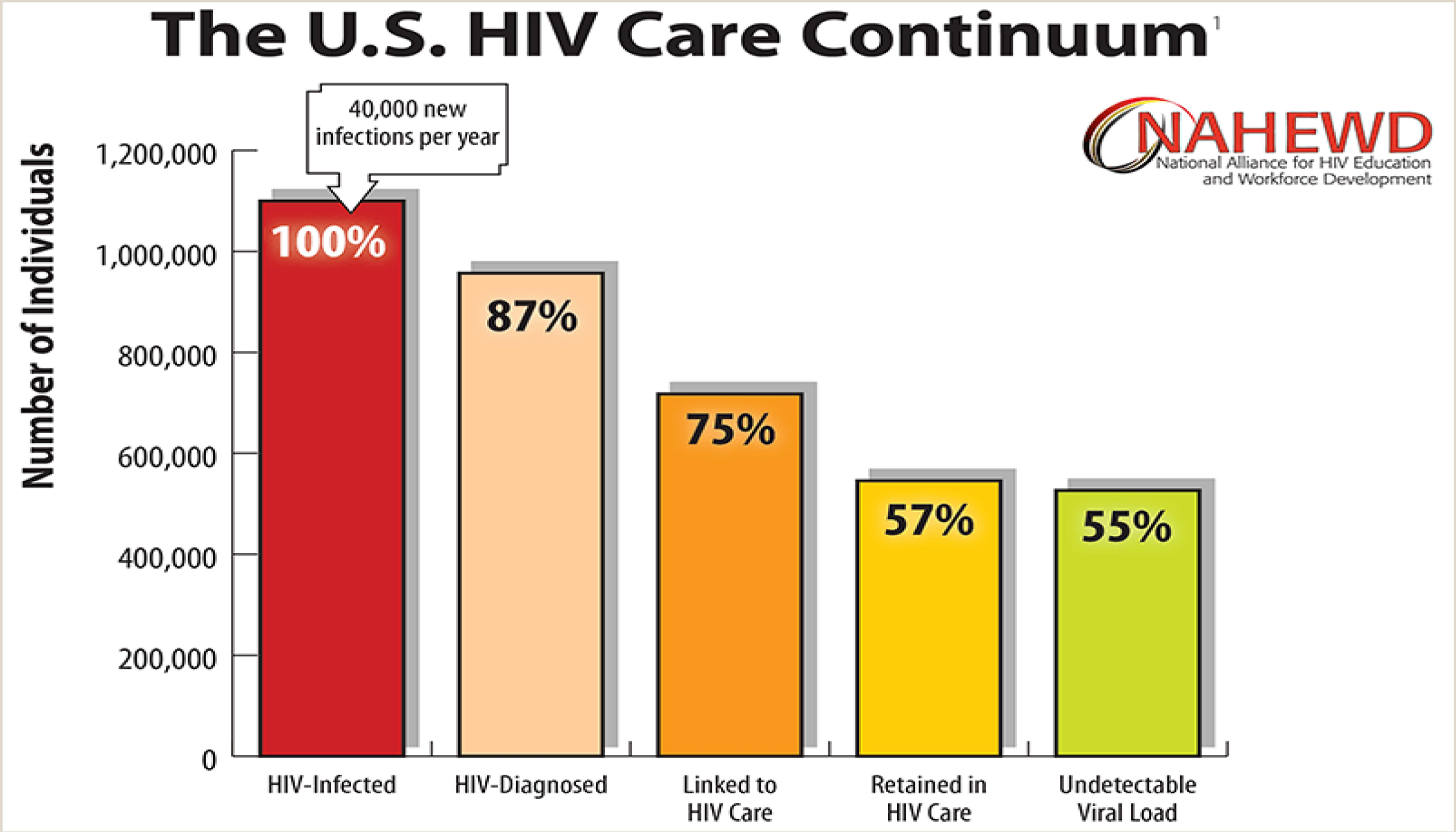
Daniel H. Conway, MD

Treatment as Prevention

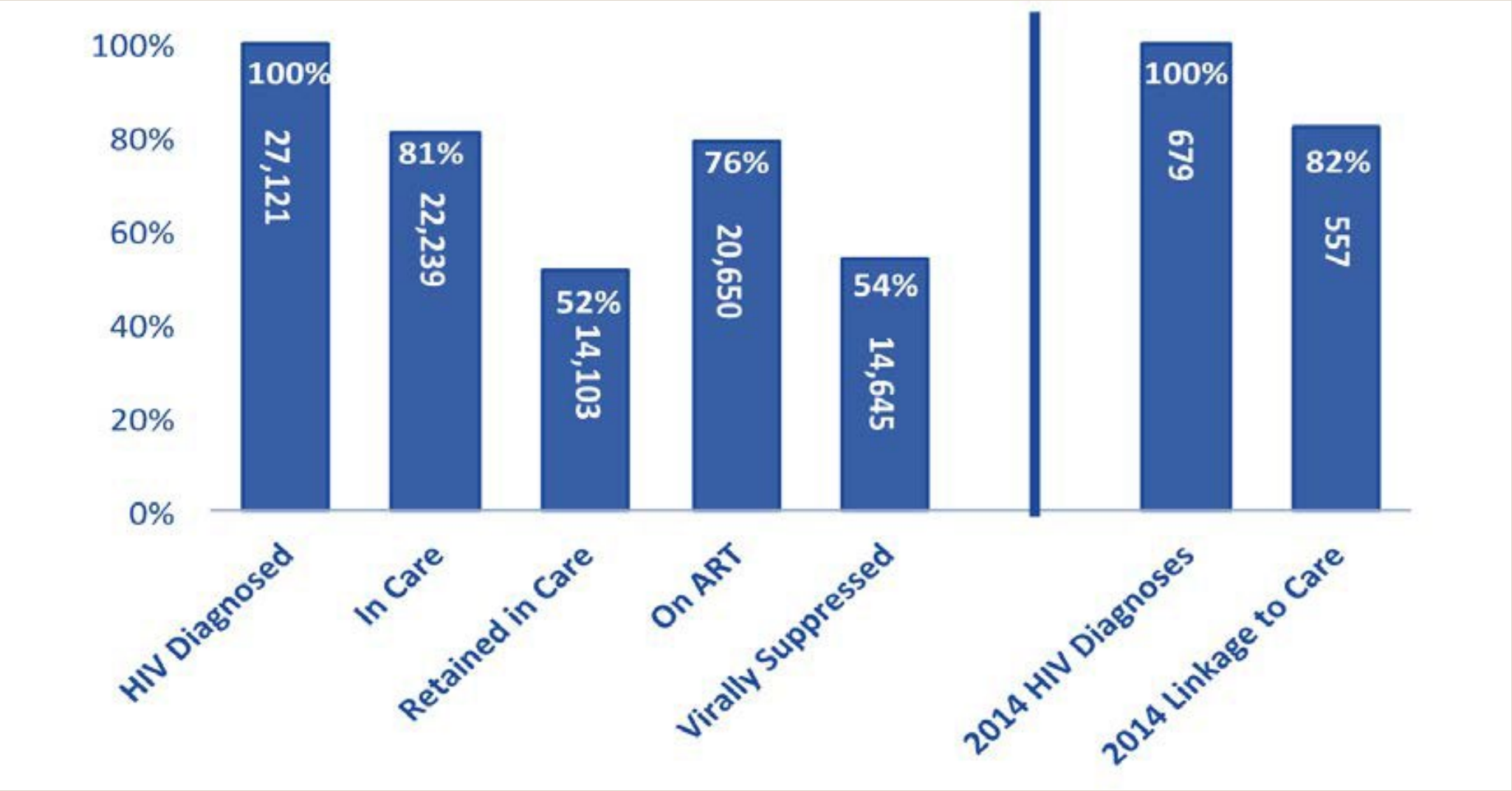
HIV CARE CONTINUUM:

THE SERIES OF STEPS A PERSON WITH HIV TAKES FROM INITIAL DIAGNOSIS THROUGH THEIR SUCCESSFUL TREATMENT WITH HIV MEDICATION

The U.S. HIV Care Continuum[1]

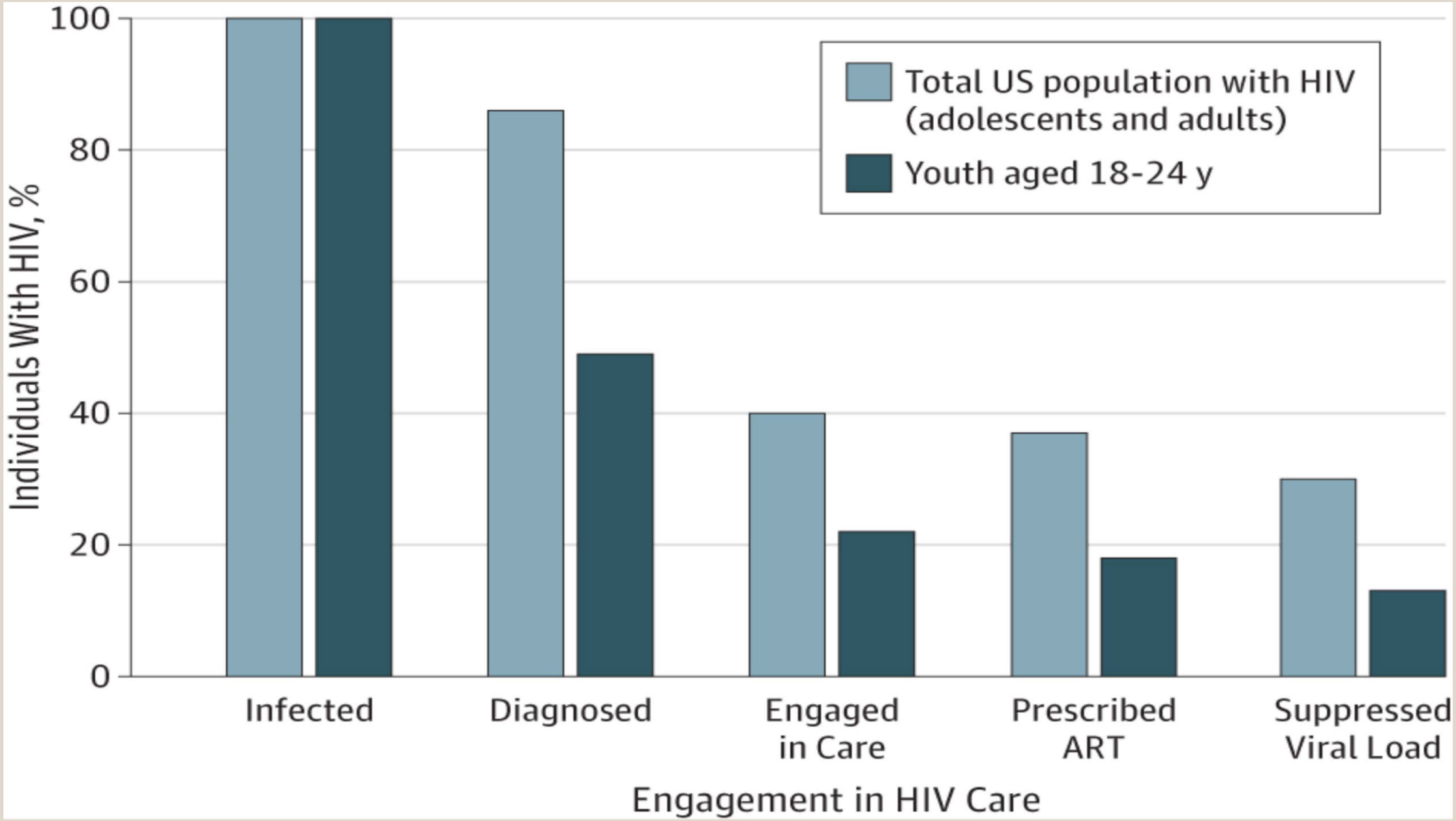


Philadelphia HIV Care Continuum, 2014



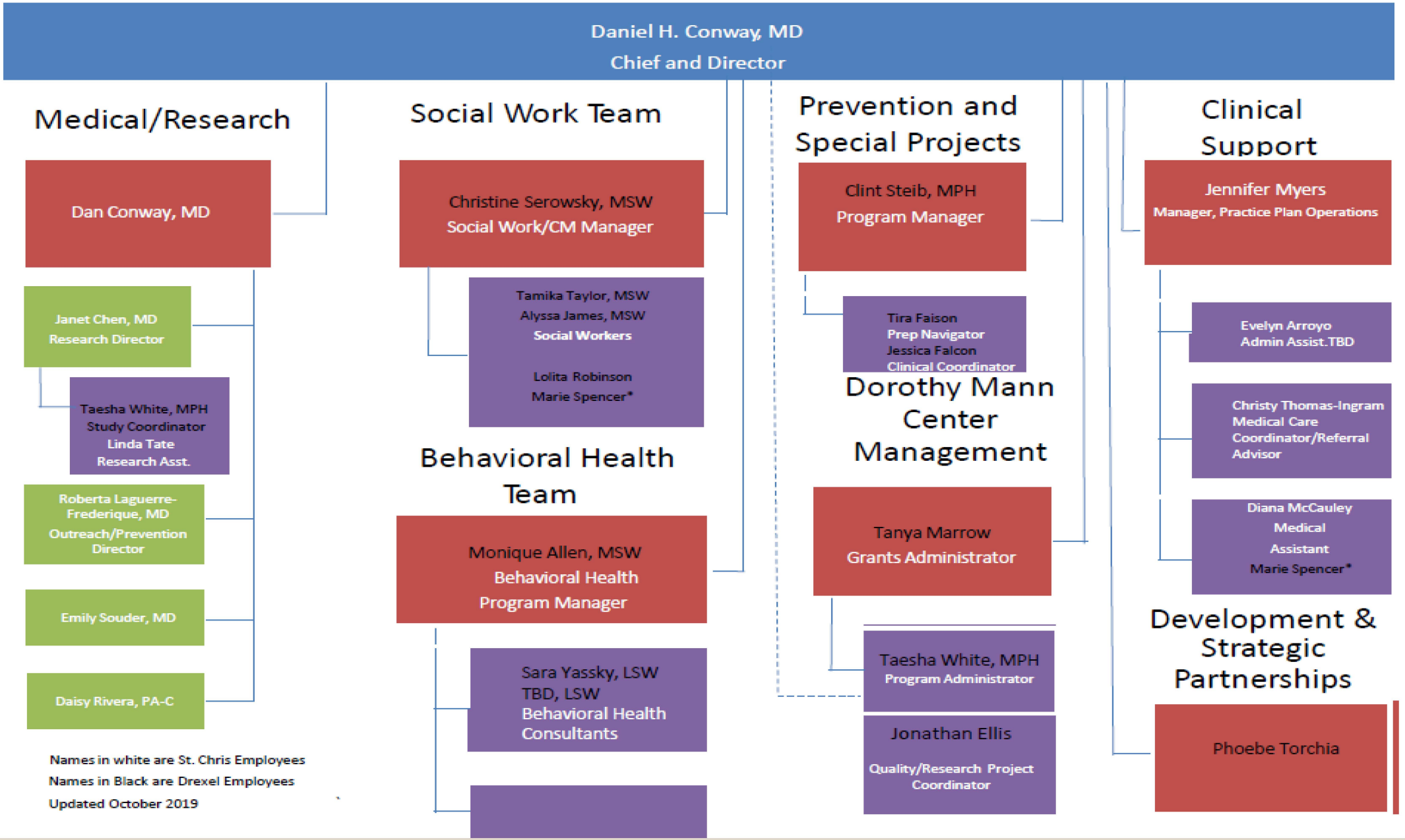
Adherence is key to maintaining undetectable viral loads

- Medication regimens need strict management.
- Failure to adhere to medications increases possibilities of resistance.
- Adherence management involves many techniques:
  - Technology improvement:
    - Combination pills that are long acting (reducing pill burden and dosing demands)
    - Development of new, more tolerable classes of medication (integrase inhibitors)
    - Development of drugs within classes that have dramatically more challenging fitness landscapes to the development of resistance (dolutegravir)
  - Reminder techniques
    - Alarms
    - Automatic delivery, refill reminders
  - Clinic-based systems to support adherence
- **The Section of Immunology has achieved 80% viral load suppression, great markers of reduced medical gaps in care with young, minority MSM and 75% viral load suppression with women of color.**


100
80
60
40
20
0
Individuals With HIV, %
Total US population with HIV (adolescents and adults)
Youth aged 18-24 y
Infected
Diagnosed
Engaged in Care
Prescribed ART
Suppressed Viral Load
Engagement in HIV Care

INTENSIVE MULTI-DISCIPLINARY HIV MANAGEMENT

Section of Immunology – Organizational Chart



Introduction

- Integrated care with multi-disciplinary availability is key.
- 100% of patients receive ART prescriptions.
- Intensive anti-retroviral adherence management with monthly appointments for youth is key.
- Immediate access- walk-in access and community-based outreach for reducing and managing lost to care is extremely important.
- Rapid Start Anti-retroviral prescribing is likely core to this success

Intensive ART Management-Medical Goals

- Monthly appointments- physicals and laboratories, early signs of ART non-adherence identified
- Education on adherence
- Education for prevention
- Sexual safety education
- Drug and alcohol counseling
- Vocational counseling
- Lost to care definitions are much more stringent here (by three months of “missing” one is lost to care)

Intensive ART Management

- Benefits
  - Close monitoring of adherence
  - Identification of barriers to adherence before long term troubles
  - Teen barriers- change in address, loss of insurance, etc often insurmountable without assistance
  - Early intolerance identified, early struggles with adherence identified
  - Reinforcing sexual health, frequent management of STD's – with frequent needs for treatment
  - Management of silent STD's allow for early public health intervention
- This means monthly appointments

Intensive ART Management

- We find few complaints to this approach
  - Hours conflicting- but we are flexible
  - Schedules can interfere
  - Some complaints about the length of visit, but complainants actually ask for all the services, which thusly extend the length of the visit.

Integrated multi-disciplinary approach

- All services involved: Social Work/MCM + Outreach, Behavioral Health, Medical
- Every visit provides an opportunity to work through varied goals with ART adherence the centerpiece of all goals
- Behavioral health contact- at any time, structured with a BHC assigned to each clinic session
- MCM/Social Work assigned to each session also- plus MCM client coverage
- New patient walk-in and medical back-up allows for coverage for the management of the first patient contact which can be extensive and intensive

Integrated multi-disciplinary approach

- MCM- assist with medication, education, goals, overcoming barriers in life to prevent adherence
- Behavioral Health- assist with psychological co-morbidities, finding long term counseling, long term psychiatric assists
- Medical- medical management and key primary managing data from BHC's and MCM for final plans
- BHC, MCM integrated into acquisition of surveys and data requirements like Depression screenings, etc
- Outreach- into community to find individuals lost to care or in need of special care

Access

- Access is a cornerstone of our fiscal plans, with walk-ins accounting for about 10-15% of our monthly visit volume.
- Access is key to our quality.
- Access is key to our general sense of decent care (no worries about waiting times to be seen, etc)
- All patients have such access as a rule
- Walk-ins, outreach “captures” can come in and absorb 4-5 hours of clinic time
  - Re-engagement with medications
  - MCM
  - Behavioral health needs

Immediate Access

- Immediate Access requires patient flow management
- Immediate Access requires back up by supervisors for all services and functions
- Immediate Access strains systems, so well-organized systems required.

Outcomes

- We are building quality metrics and goals we think respond to our ongoing deficits.
- Viral load suppression at 79-82% for all youth and largely for all sub-populations of youth. Adult women of color- 75%.
- Medical gap between 10-13%. Medical gap is defined as the percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.
- Surveys demonstrate immense satisfaction, repetitively.

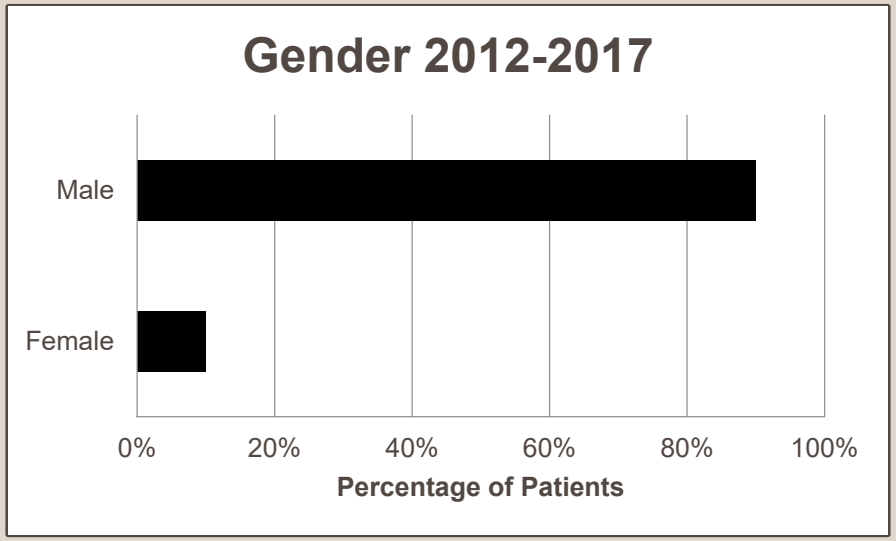
Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

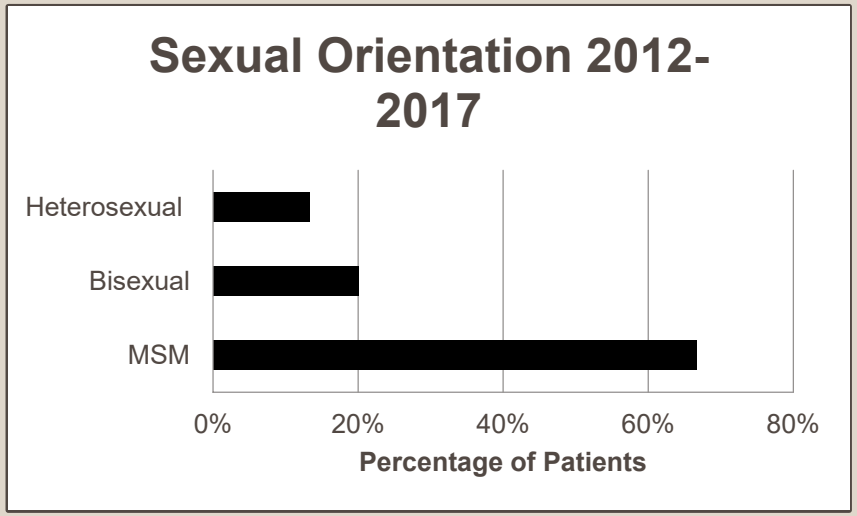
- Goal: Increase access to care and improve health outcomes for people living with HIV
  - Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis
  - Increase the percentage of people with diagnosed HIV infection retained in care
  - Increase the percentage of people with diagnosed HIV infection who are virally suppressed
  - Increase the percentage of PLWH retained in HIV care who are stably housed
- Goal: Reduce HIV-related disparities and health inequities
  - Reduce HIV related disparities in new diagnoses among high-risk populations
  - Reduce disparities in viral suppression

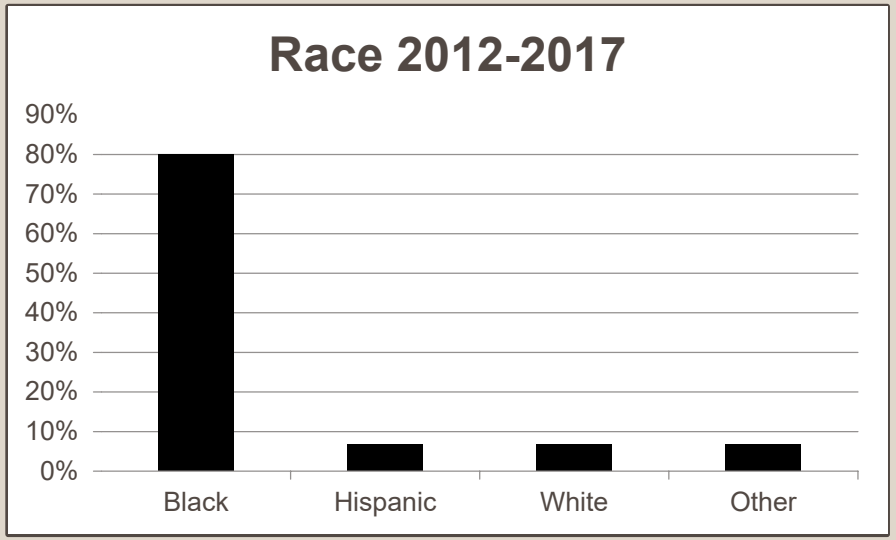
Rapid Start for YMSM

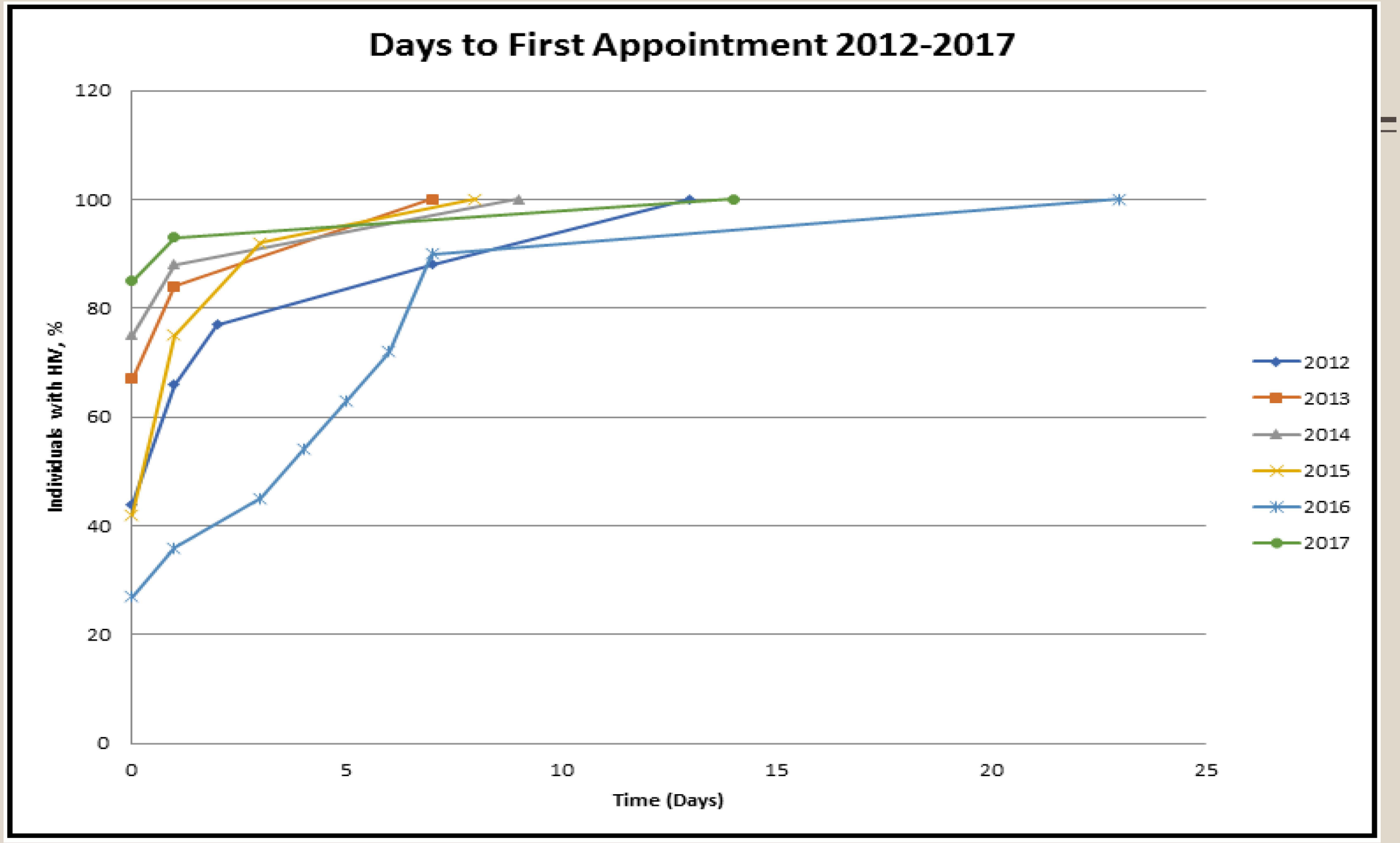
- In 2012, new initiative began in our group
- The then-Section Chief, Dr. Jill Foster, engaged us in a new plan.
- We would pull in all new referrals immediately.
- Which rapidly built ground-work for rapid start of ART.
- Immediate appointment, with transportation to clinic if needed.
- Fast turn-around, into immediate ART prescribing.
- All members of team meet and interact with new referral.
- First visit takes hours.

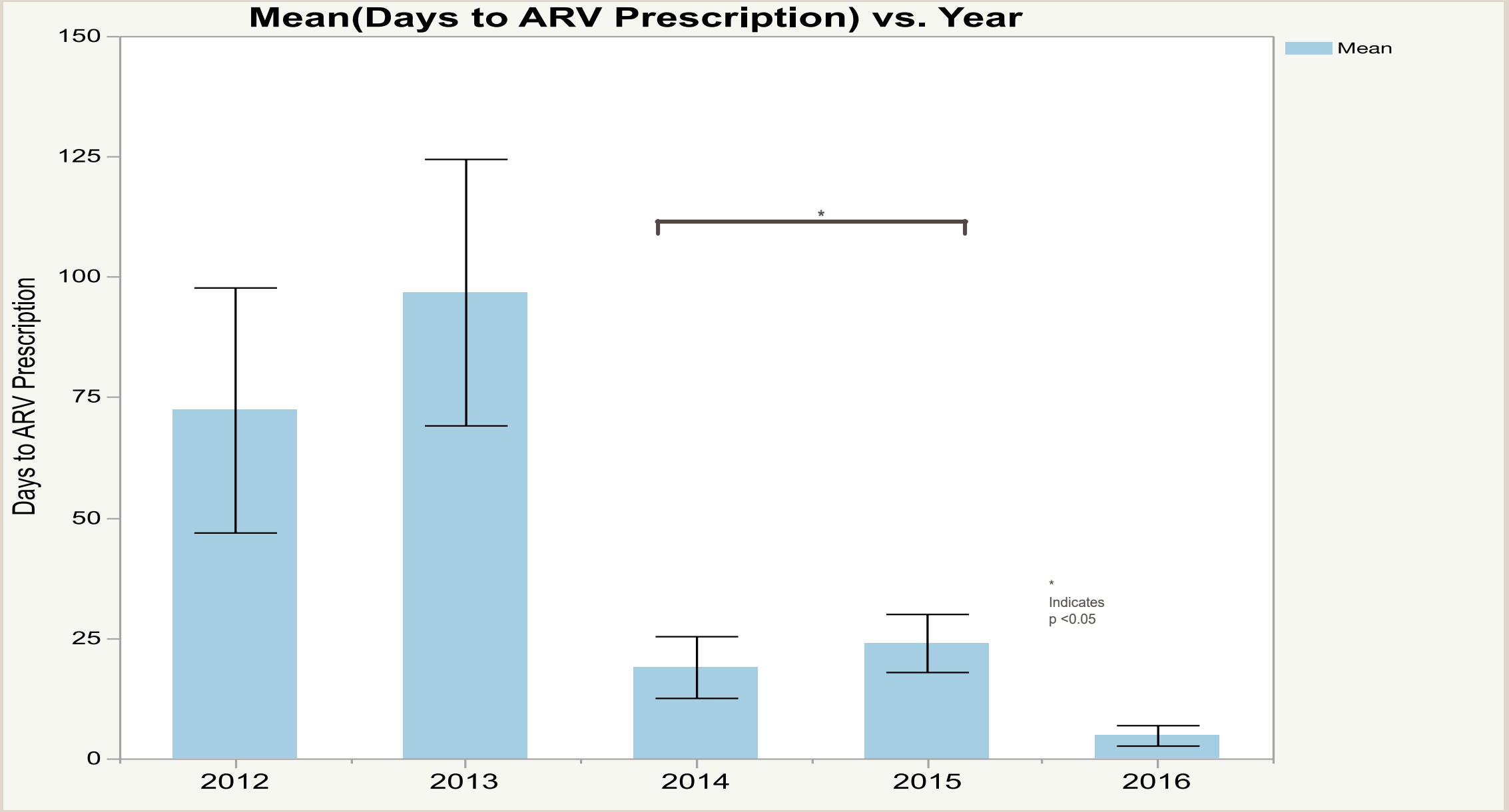
Patient Demographic

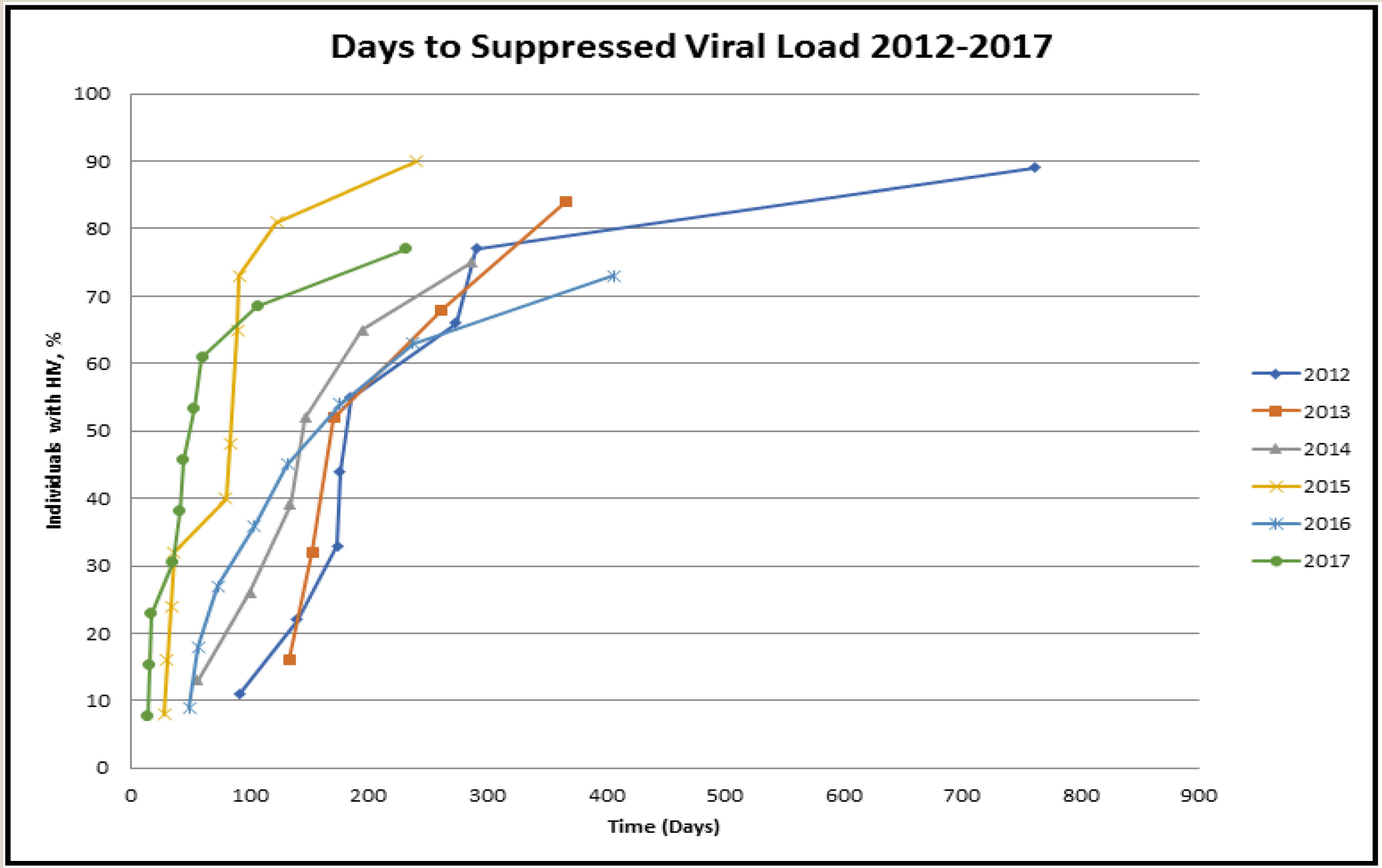







Days to First Appointment 2012-2017
120
100
80
60
40
20
0
Individuals with HIV, %
0
5
10
15
20
25
Time (Days)
2012
2013
2014
2015
2016
2017


Mean(Days to ARV Prescription) vs. Year
Mean
Days to ARV Prescription
150
125
100
75
50
25
0
2012
2013
2014
2015
2016
*
*
Indicates
p <0.05


Days to Suppressed Viral Load 2012-2017
Individuals with HIV, %
100
90
80
70
60
50
40
30
20
10
0
0
100
200
300
400
500
600
700
800
900
Time (Days)
2012
2013
2014
2015
2016
2017

Can this be replicated? We think so.

- Scaling however will be linear. Size will not allow for economies. Close management of all functions needed. (Patient flow, work load, etc).
- Deep commitment and administrative buy-in required.
- Attempts to replicate in PrEP side.
  - Challenges with commitment of patients
  - Challenges with resources
  - Intense management is resistant
  - Care gaps larger
  - Rapid start faces challenges with insurance, commitment, and interest.

PrEP Rapid Access/Rapid Start

- We have two parallel prevention programs.
- We have a PEP program associated with our sexual assault/child protection group.
- Most are given ART and we see the next day. We see many women with PEP, and half our PrEP patients are women. The PEP portion seems to have more adherence (>90% pick up prescriptions and report adherence/adverse effects).
- For those we move to PrEP program, we have enormous care gaps
- If engage, however frequent visits occur to our center (>6 times a year). (50% engage). Adherence to ART is not however guaranteed despite engagement. Less than 25% of all women use the PrEP well, which is half of those engaged.

PrEP Rapid Access/Rapid Start

- The second program is a rapid access with YMSM, usually from an on-site adolescent clinic.
- We often visit in the adolescent center, seek engagement with multiple disciplines, are often rebuffed for engagement and time.
- Here with have larger gaps, less engagement, less follow-through.
- Adherence here is poor, 15-20% identify adherence.

- Many opportunities exist for improving YMSM PrEP care gaps and adherence.

Conclusions

- Challenging populations can have better than expected outcomes for viral load suppression.
- Intensive monitoring, high access, multi-disciplinary approaches to HIV management can support patient adherence to therapy and close barriers to medical care.
- While providing important care for the patient, this is a public health intervention, reducing transmission.
- YMSM of color can engage in rapid starts of ART
- Excellent outcomes are reasonable to consider.
- Moving program to PrEP model has been more complicated.

Thank you!


BERNIE
GREGORY BLY BERG
1951 ~ 1993
VENEZUELA
HORIZONS
BEAUTY