NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HIV Outbreak Among PWIDs in Northeast MA: responses, lessons learned, and ongoing challenges

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Disclosures

We have no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe 3 key local and regional responses to this outbreak
2. Identify opportunities to combine health department and community-based capacities to respond to new HIV diagnoses in PWID
3. Describe 3 challenges to effective implementation of evidence-based testing, prevention, linkage and retention in care strategies for PWIDs, and how Ryan White funding can be leveraged to overcome these

Presentation overview

- Background about Lawrence, MA and the Greater Lawrence Family Health Center (GLFHC)
- Timeline of outbreak
  - Key lesson 1 – track your data
  - Key lesson 2 – partner w MDPH
- Response to outbreak
  - Key lesson 3 – cultivate local relationships (SSP)
  - Key lesion 4 – go to where patients are (MHU)
  - Key lesson 5 – try new things (same day ART, DOT, PEP to PrEP)
  - Key lesson 6 – leverage existing resources and look for new ones (MDPH, Ryan White)
  - Key Lesson 7 – ask for help (provider collaborative, MDPH, CDC)
- Summary of key lessons
- Ongoing challenges and future directions

Obtaining CME/CE Credit

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http://ryanwhite.cds.pesgce.com

Lawrence, Massachusetts

The city's **72,043 residents** live within its **seven square miles**, making it one of the most densely populated urban communities in the country (2000 U.S. Census).

More than **51 percent** of Lawrence residents live **below the federal poverty levels** and

Nearly **76 percent** of the population is **Latino** – the city has the largest proportion of Hispanics of any Massachusetts community

Hard hit by the opioid epidemic: **OD deaths** increased from 12 (2012) to 45 (2016)

Greater Lawrence Family Health Center

- **Established in 1980**
- **Over 600 employees** serving nearly 60,000 patients (250,000+ visits) annually
- **Six primary care sites**, 2 school based health centers, 14 Healthcare for the Homeless sites
- **Home to the Lawrence Family Medicine Residency,** the nation's first community health center based residency program
- **HIV Program** serves around 350 pts
  - Ryan White Part A and C
  - MDPH-funded PICSR

Experience of 2016-2017

2016: Began recording every new pt and exiting pt in a safe spreadsheet in order to compile HRSA linkage to care requirements

MR #	Last Name	First Name	male =1	dx rec'd date	new GLFHC	existing GLFHC	date of 1st med visit in weeks	intake 30 days Y = 1 N = 0	Linked 30 days	Risk	Age	Clinic	Where Dx	Hispanic = 1 (not)=0	not hispanic	HIV=1	AIDS	CD4 at Dx

June 2016: Noticed 5 new diagnosis in two months among PWID, including 1 acute HIV infection – a dramatic increase from previous years

Lesson 1: Track your patients by name

Experience of 2016-2017

August 2016: Called MDPH to alert them to our findings

MDPH initiates investigation, identifies initial cluster, notes homelessness as common thread

August 2016: Started intensive outreach

HIV and Prevention staff engaged new pts into care immediately

Mobile HIV testing

Increased community testing

Met with local board of health

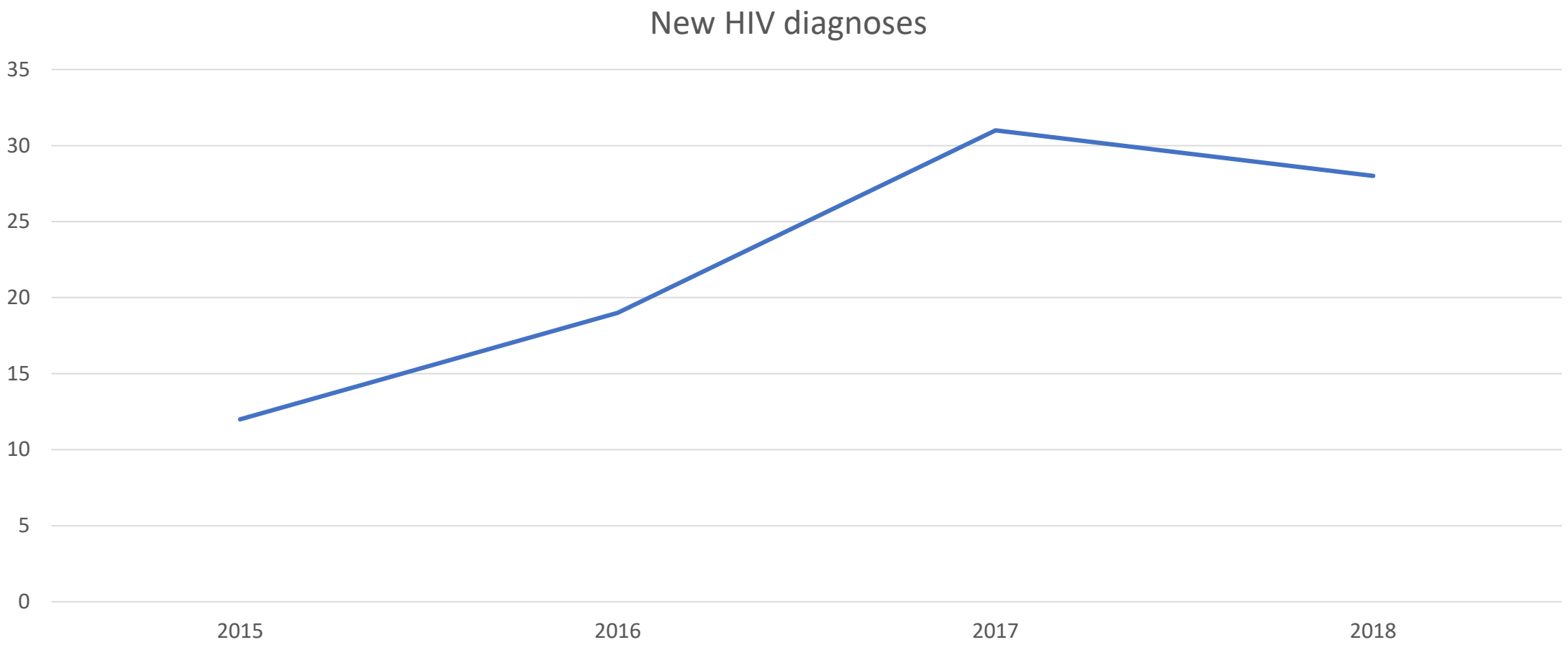
Worked with Partner Services (MDPH)

Jan 2017: Approved by MDPH to provide Syringe Services

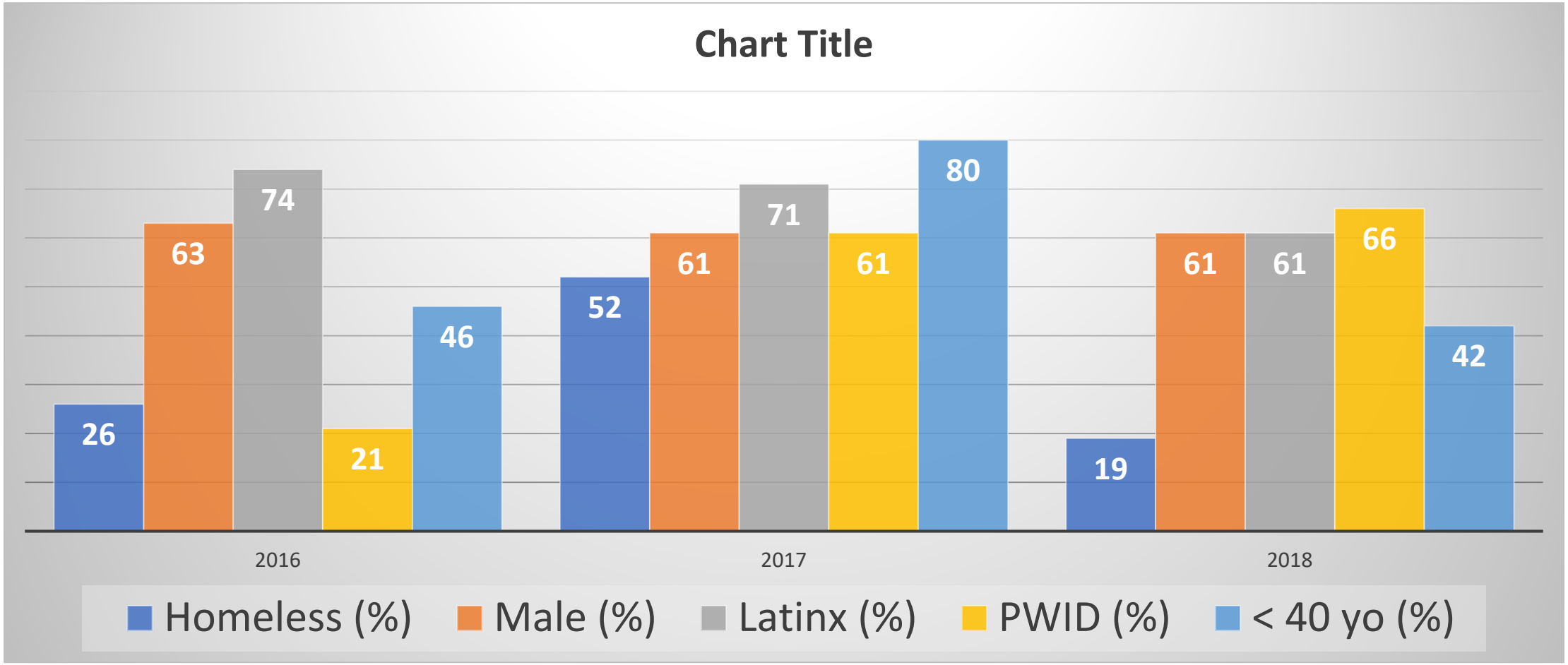
Summer 2017: New diagnosis continue to be made, called MDPH again

Lesson 2: Partner with MDPH

New HIV infections over time



New HIV infections, demographic categories



Response to the Outbreak

- Evidence-based Harm Reduction tools
  - Syringe Service Program approved by local board of health and began funding from MDPH Jan 2017, now provide over 10,000 syringes a month
  - Healthcare for the Homeless/Mobile Buprenorphine began July 2018 as part of e2i (SPNS)

Lesson 3: Cultivate local relationships

Response to the Outbreak

- Deliberate, intensive outreach and case management to engage patients into care
  - Walk the streets
  - Mobile phlebotomy
  - ART in “non-traditional” care settings
  - Monthly meetings to review each high risk patient

Lesson 4: Go to patients

Response to the Outbreak

- Treatment as Prevention
  - Same day ART start
  - Care delivery in non-traditional settings
  - DOT
  - PEP to PrEP
  - Mobile Buprenorphine – focusing on HIV and homeless pts

Lesson 5: Try new things

Response to the Outbreak

- Realigned staff to respond to the needs
  - RN's and CHW's responsible for these patients
  - Cross trained staff in MAT, HIV and Viral Hep
- Applied for additional funding to expand testing, treatment, support services – thanks largely to MDPH

Lesson 6: Leverage existing resources and look for new ones

MDPH Investment in Region

- $1.7M in new state and federal resources allocated by MDPH to the region, leveraging existing infrastructure with Ryan White, CDC, SAMHSA, & State resources

Lesson 6: Leverage existing resources and look for new ones

Response to the Outbreak

- State-wide medical collaborative

- CDC Epi-Aid spring/summer of 2018

Lesson 7: Ask for help

Statewide provider collaborative

Lesson 7: Ask for help

Background: Why Now?

- Massachusetts among **top 10 states with the highest opioid overdose** rates in the nation (National Institute of Drug and Alcohol, Feb 2018).
- Massachusetts named by CDC among 7 states with **hepatitis C rates twice the national state average**. (MMWR, May 12, 2017)
- November 2017: Massachusetts **DPH announces uptick in cases of HIV among people who inject drugs**
  - 14% of new infections in PWID, compared with 6-8% in previous years
- March 2018: 3 top infectious disease societies (IDSA, HIVMA, PIDS) release statement citing **25-50% of all ID consultations are for infections in patients who use drugs** and make policy recommendations

Background: How did it come together?

- Organic
  - 11/2017 – Dr. Brody comes to GLFHC as part of NEAETC lecture series
  - 1/2018 – Conference call between Dr. Brody and GLFHC
  - 2/2018 – Started recruiting members

Goals at the outset

- Information sharing: challenges on the ground, best practices, lessons learned.
- Resource sharing
- Serve as a liaison with MDPH
- Advocacy
- Inter-network collaborations (research/QI/funding)

Recruitment

- Reached out via email to all ID, and HIV specialized providers in our personal networks who were caring for PWID
  - Academic medical centers
  - Community health centers
  - Jails/prison based providers
  - Healthcare for the Homeless Programs
- Snowball approach: Those contacts reached their contacts
- Targeted recruitment of Ryan White Programs in geographic locations known to have high rates of opioid use disorder (OUD)

Current Membership

- 33 individual members
  - All regions of state except Cape/Islands represented
- Total institutions represented statewide:
  - 6 major academic medical centers
  - 9 community health centers
  - 7 DOC/HOCs
  - 1 healthcare for the homeless program

First Meeting: March 2018

- First conference call with 14 attendees
- Subsequent meetings with on average 10-12 members in attendance.
- Meetings held approximately monthly

Administrative Supports

- Medical Student assisting with setting up conference call line, meeting minutes, maintenance of drop box of resources, setting meeting time, sending reminder emails

Priority Issues

- Poor transitions of care/limited continuity of care for PWID which contributes to poor outcomes
  - Hospital ⇔ outpatient
  - Jail/prison⇔outpatient
- Limited access to medications for opioid use disorder in jails/prisons
- Limited access to HIV/HCV screening in some jail/prison settings
- Challenges with accessing Medicaid post-release
- Challenges of providing HIV/HCV screening for highest risk individuals (street homeless, active substance use disorders, highly mobile)→ need for improved point of care testing strategies
- Limited access to HCV treatment in jails/prisons
- Limited uptake of pre-exposure prophylaxis for HIV among most vulnerable PWID

Key Activities

- Share data; share grant and training opportunities

- Share clinical tools/strategies/best practices for PWID
  - PrEP/nPEP for PWID
  - Integration of addictions care into HIV prevention and care

- Identify advocacy landscape, key stakeholders and set priorities
  - Focus on improving access to addictions care in jails/prisons and post-release
  - Addressing limited HIV/HCV screening in jails/prisons
  - Advocacy activities
    - Meeting with leadership at jails/prisons
    - Meet with local, state and federal legislators
    - Meet with members of state Medicaid program to discuss issue of insurance post release
    - Leveraging relationships with ID/HIV societies to join efforts of other advocacy groups in supporting MA state house bill to include medications for OUD in jail/prisons
    - Op Eds

Successes thus far

- Relationship built between our group, and advocacy arms of key ID societies and those working on improving access to better OUD treatment in jails/prisons
- New collaborations/networks built to improve transitions of care
  - Creation of list of all ID providers in MA state HOCs/DOCs
- As a result of advocacy with Suffolk County House of Corrections, BHCHP will partner with South Bay House of Corrections to provide medical treatment for OUD (including buprenorphine) to incarcerated people. Will include wrap around supports including linkage to care services post-release. SAMHSA funded.
- GLFHC to partner with Essex House of Corrections to provide on-site HIV testing

Looking to the future

- Focus advocacy agenda and hone advocacy strategies
  - Consider how to use the collaborative voice most impactfully
- Deepen relationships with state DOCs/HOCs, State Medicaid Program, MDPH, legal advocates, and community based organizations
- Consider sustainability of efforts

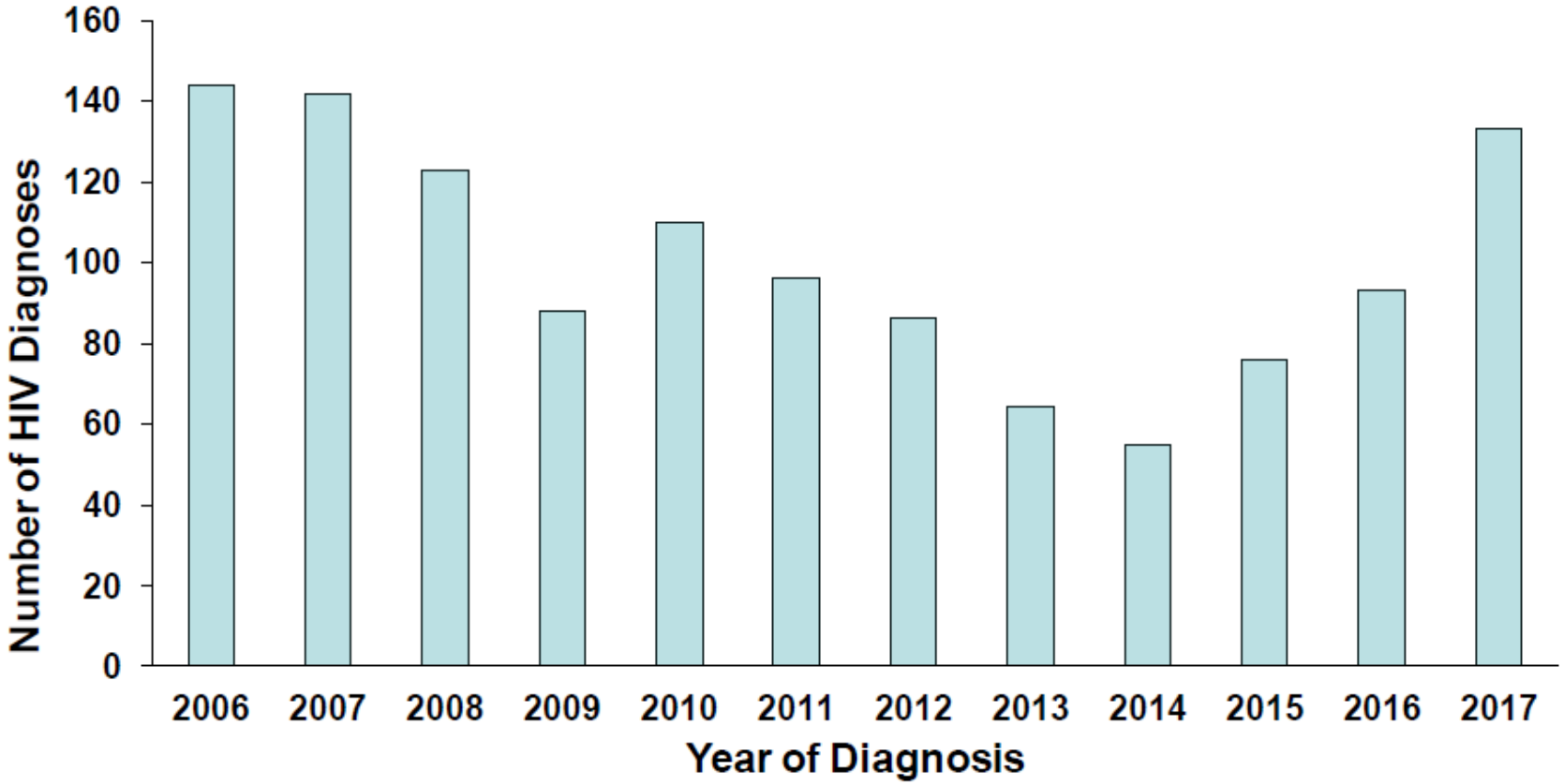
Leveraging Ryan White and other resources in response to the outbreak of HIV infection among persons who inject drugs in northeastern Massachusetts:2015-2018

Lesson 2: Partner with MDPH

Lesson 6: Leverage existing resources and look for new ones

Lesson 7: Ask for help

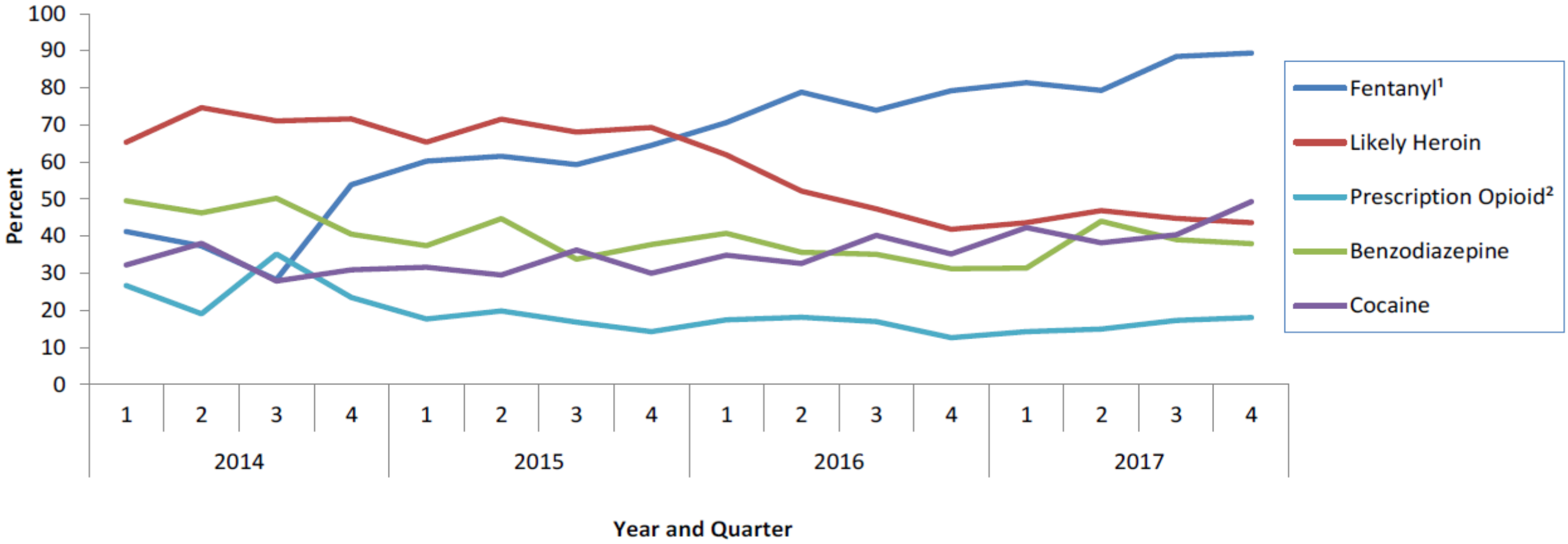
Diagnosis of HIV Infection Among PWID by Year of Diagnosis: Massachusetts, 2006–2017*



Data Source: MDPH HIV/AIDS Surveillance Program; Data as of 05/01/18

*2017 Data are preliminary and will change.

Figure 4. Percent of Opioid-Related Deaths with Specific Drugs Present MA: 2014-2017



Source: MDPH Data Brief, May 2018

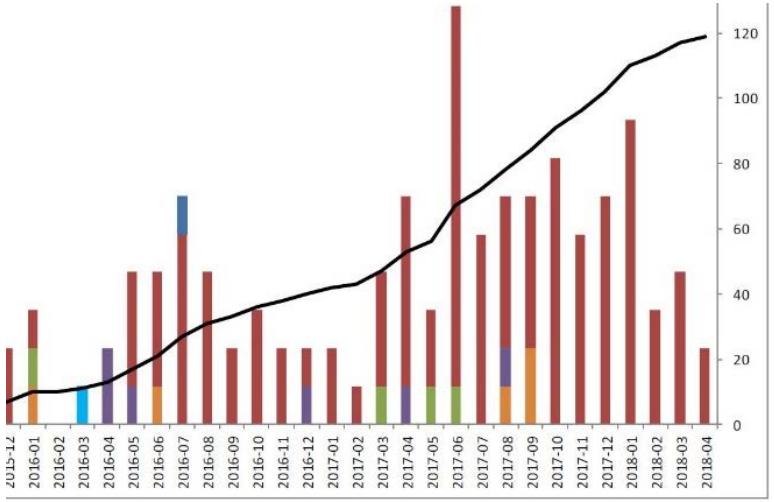
CDC Epi-Aid Investigation in Lawrence and Lowell, Massachusetts

WHY HERE?

WHY NOW?

WHAT CAN BE CHANGED TO REDUCE INFECTIONS?

The Investigation



Surveillance

Interviews

Chart Abstraction and other field work

Preliminary Data

- 122 HIV+ were diagnosed during 2015–2018 who met case definition criteria
- Transmission risk category was predominately injection-drug use (85%)
- 90% had laboratory evidence of HCV (either HCV antibody or RNA positive)
- Approx. 90% were linked to HIV care; 56% had most recent HIV VL <200 copies/mL.

Responses to date

- Community stakeholder meetings held at start of (May) and following (July) Epi Aid
- Adopted molecular HIV surveillance statewide
- Examining surveillance data needs of LBOHs and providers
- New SSP approved in Lowell, allowing MDPH funding
- Doubled MDPH field epidemiologist capacity in region
- **Invested $1.7 million in Federal and State resources in region**

Leveraging resources

- Funding: Ryan White+CDC+State+SAMHSA+HOPWA
- Integration of prevention & care
- Integration of surveillance & program
- Comprehensive PWID health promotion service model
- State Public Health Laboratory 4th generation testing, HIV/HCV co-testing, and HCV RNA testing
- Relationships

Leveraging resources, cont.

- High quality care and service provision
  - High quality HIV treatment at Lawrence and Lowell CHCs
  - Emerging HCV treatment programs
  - Growing PrEP capacity
  - Availability of Medication Assisted Treatment (MAT)
- Awareness among PWID of HIV risk associated with syringe sharing

Response: Substance Use, Risk, & Treatment

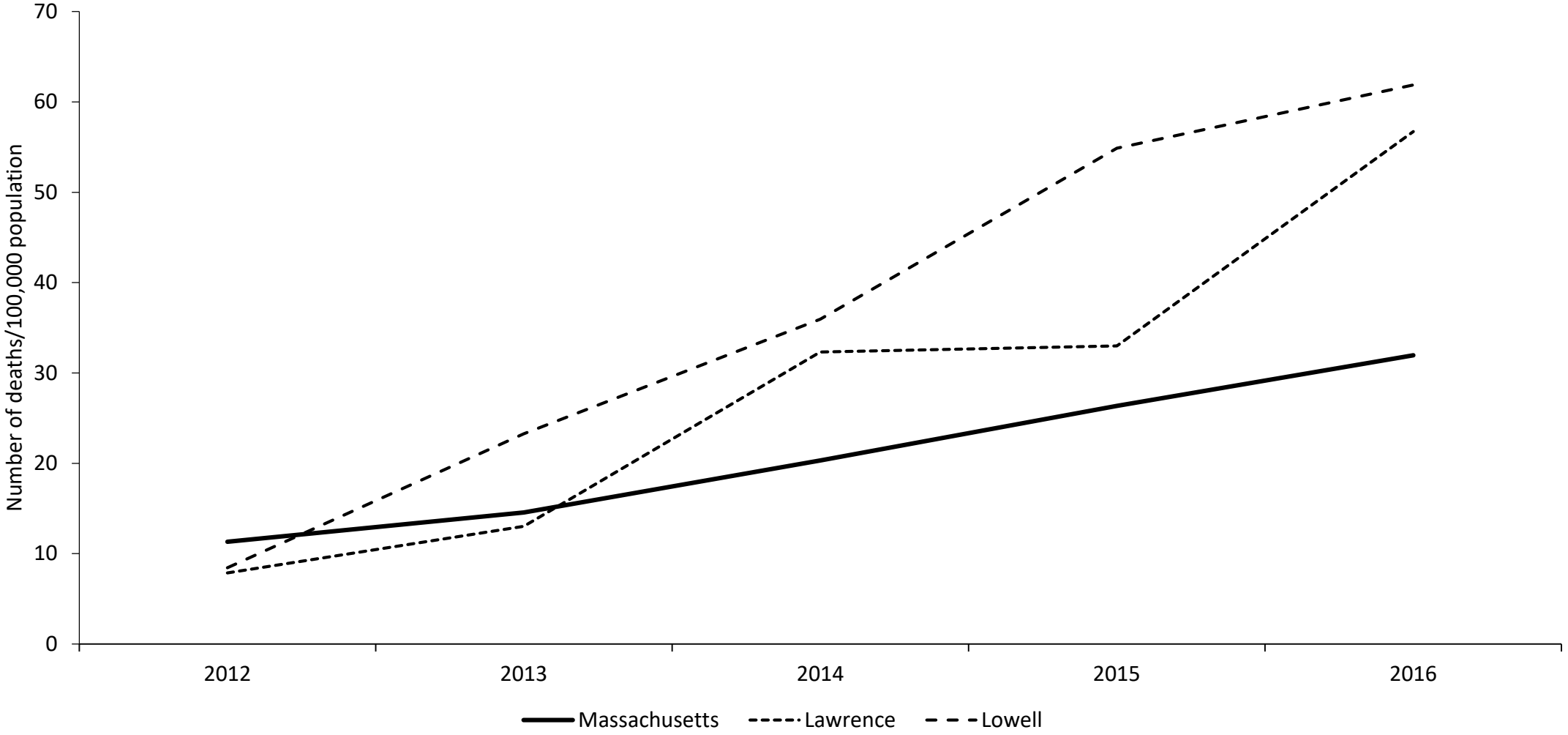
Challenges:

- Impact of fentanyl use on behavior
- Limited access to syringe services
- Perceptions of HIV risk associated with sharing injection equipment, and sexual risk
- Perception that people are cycling through inpatient treatment
- Homelessness & limited shelter/housing resources

Actions:

- Increased investment in fixed and mobile SSP capacity, Overdose Education/Naloxone Distribution, and shelter
- Developing additional referral pathways to treatment, e.g. proposed first responder training on MAT access

Number of deaths from opioid overdose/100,000 in Massachusetts, 2012–2016



Source: MDPH Data Brief, Feb 2018

Response: HIV and HCV Testing & Treatment

Challenges:

- HIV testing is not routinely offered in EDs and is limited in jails.
- Perceptions among PWID interviewed of hepatitis C as the “common cold”
- Homelessness & stigma impact access

Actions:

- Expanded testing/linkage programs (fixed and mobile)
- Funded new corrections-based testing and post-release linkage programs
- Funded services at shelter
- Doubled field epidemiology capacity
- Continued monitoring of HIV virologic suppression & direction of linkage/re-linkage services
- Developing new HCV user-level educational materials development
- Collaborated with NEAETC to offer HCV treatment technical assistance

Putting it all together….

Summary of Key Lessons

- Know your data by using name-based system
- Partner with MDPH and other key stakeholders
- Cultivate local relationships
- Go to where the patients are
- Try new things
- Leverage existing resources and look for new ones
- Ask for help

Ongoing challenges and future directions

Challenges

- Frequent incarceration
- Transient population
- Other communities in region affected where we don't have a presence
- Ongoing under-treated substance use disorder

Future directions

- Cross training of staff: HIV, SUD, Viral Hepatitis, SSP/OEND
- Expand Mobile SUD treatment
- Provide HIV testing and linkage to care in local Houses of Correction and Emergency Departments
- Expand SSP
- Expand PrEP/PEP to PrEP
- Advocacy
- Law Enforcement Collaboration

Questions?

THANK YOU