2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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The New Standard of Care: Three Successful Models Providing Immediate Access to Treatment and Care

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CrescentCare, New Orleans

Objectives

- Review rationale for immediate initiation of HIV antiretroviral therapy
- Describe CrescentCare's procedure to provide this service
- Review data from immediate start intervention at CrescentCare

What Is CrescentCare?

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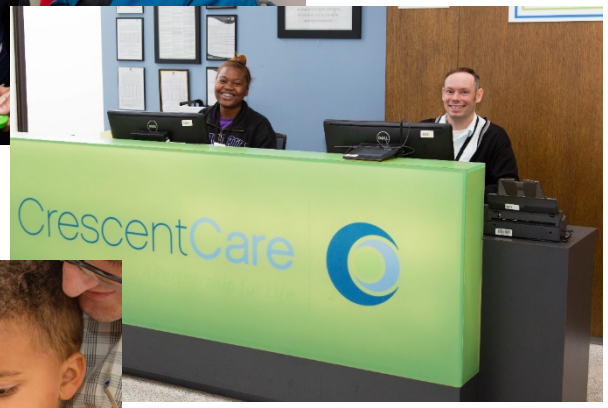
- Started as an ASO in 1984
- FQHC in 2013
- Primary care for all ages
- Specialty care for people living with HIV
- Robust HIV and STI testing program
- Oral Health Care
- Dedicated: PrEP, Gender, HCV Clinics
- Behavioral Health (medical and non-medical)
- Addiction Medicine
- Insurance enrollment



The Growing Reach of CrescentCare's HIV Testing

2011: 2,785 HIV Tests

2012: 3,131 HIV Tests

2013: 4,647 HIV Tests

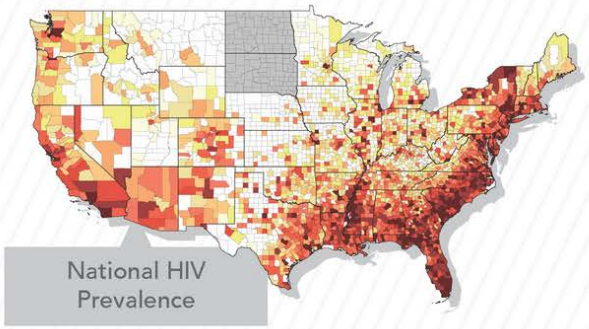
2014: 5,710 HIV Tests

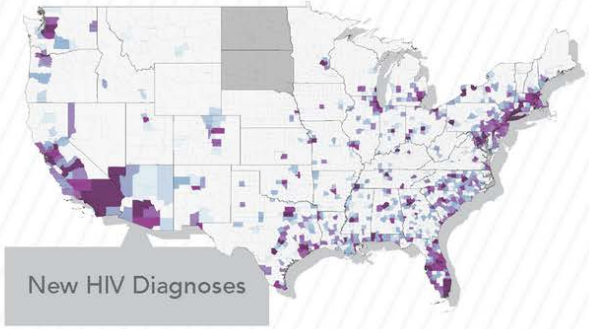
2015 – 2016: 16,335 HIV Tests

2017: 12,024 HIV Tests

Where is HIV now?

HIV has always been about what you do; **today it is also about where you live.**

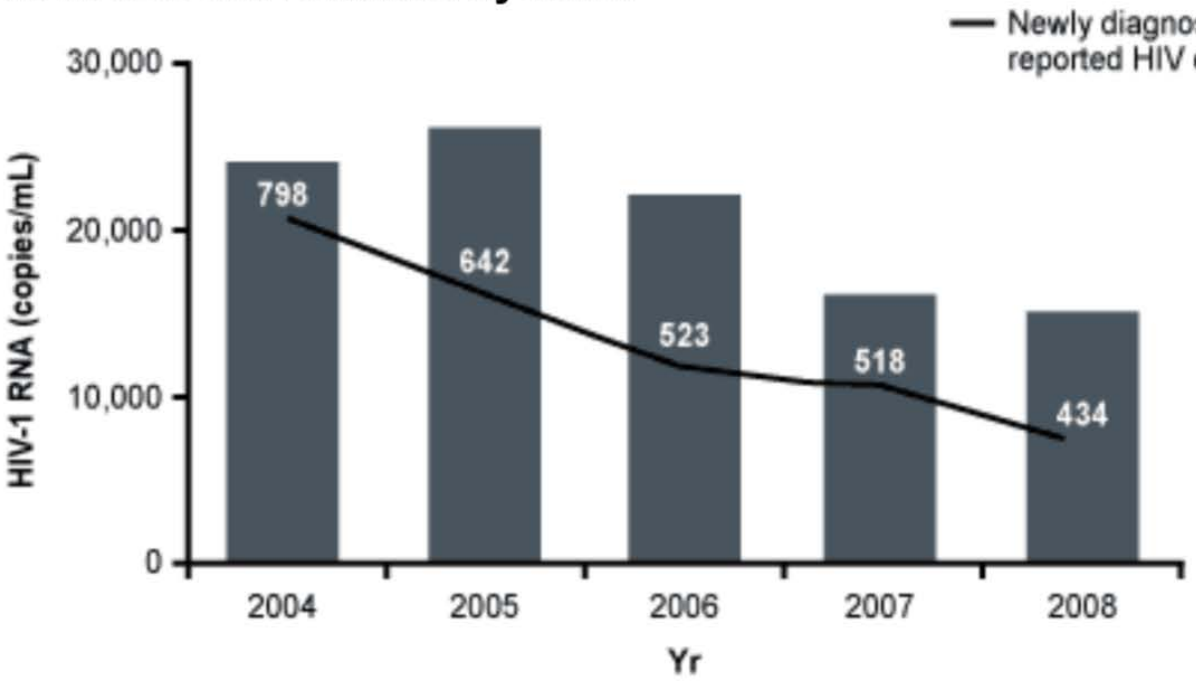




92% of new U.S. HIV diagnoses occur in **25% of counties.**

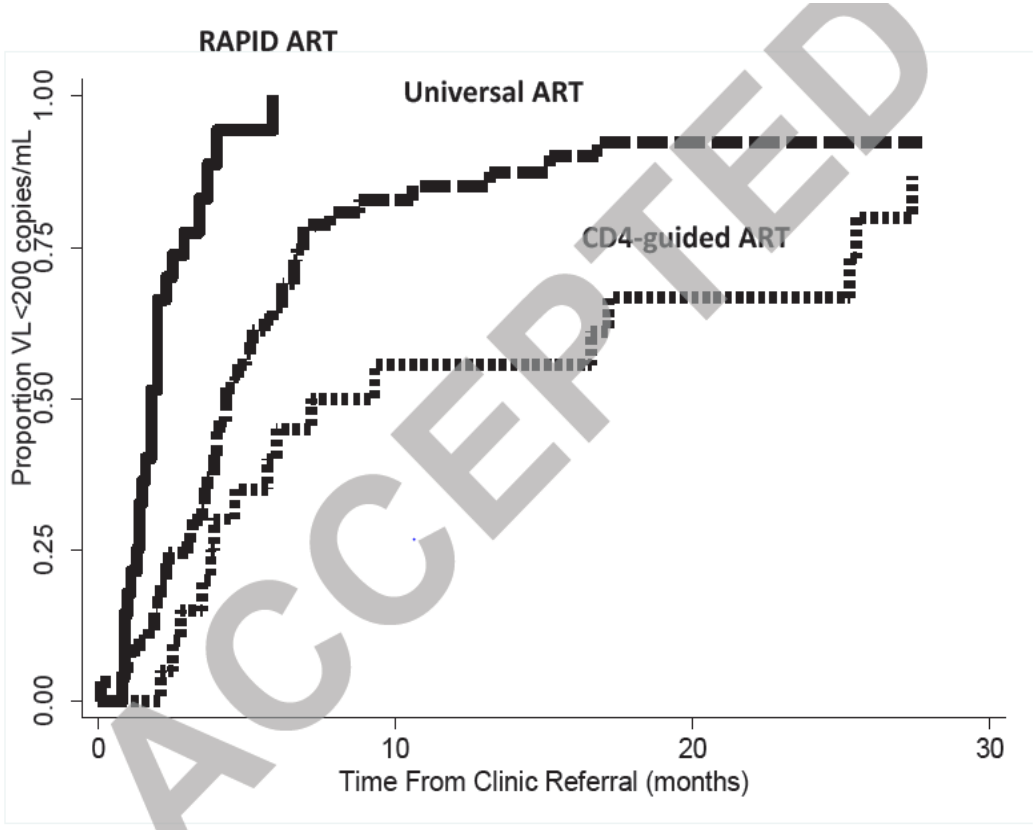
…these three cities have the **highest new HIV diagnoses rates** in America

Figure 5. Reductions in community viral load and new infections in the San Francisco HIV/AIDS surveillance system.[17]



UCSF Data

The Effect of Same-Day Observed Initiation of Antiretroviral Therapy on HIV Viral Load and Treatment Outcomes in a U.S. Public Health Setting Pilcher et al. JAIDS 2017



CrescentCare Start Initiative (CCSI): Patients diagnosed are seen by a provider within 72 hours (optimally same-day) and provided 30 days of ART.

Early Intervention Services (EIS): Same protocol but patients contacted our clinic over 72 hours since diagnosis. Range: 4 days – 22 years

Total numbers

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Project started: 12/1/2016

First CCSI Patient Seen: 12/6/2016

Expanded to EIS: 12/21/2016

Total numbers: 253 (As of November 19th, 2018)

153 CCSI

100 EIS

Procedure

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Testing:

- Courthouse, Healthcare for the Homeless, Venue-based, Movement, CAN, Brotherhood, STI Clinic

Internal Referrals:

- Client brought down to clinic, linkage navigator notified for data tracking purposes

External Referrals:

- Planned Parenthood, Tulane Uptown Medical Care, UMC, Tulane Hospital, Ochsner, local PCP

Procedure/Methods

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Medical Provider Visit:

-HIV Lifecycle, importance of adherence, U=U discussed

-Comorbidities assessed

-Diagnosis verified

-Provider option to not rx, alter medications if suspected resistance

-30 day-supply of TAF/FTC/DTG

-DOT

Procedure

- Meet with Eligibility and enroll in Medicaid/RW services
- Labs drawn including cbc, cmp, HIV rna, CD4 count, genotype, hla-b5701 etc.
- Referral for case management only if necessary i.e. housing insecurity, significant substance use

1. Patient confirmed positive
2. Linkage specialist contacted by cellphone. 24 hour phone line
3. Appointment scheduled with provider, labs, eligibility.
4. DIS called to verify that the patient is truly treatment naive/newly dx.
5. Uber transportation for patient arranged if needed.
6. Patient completes registration form, fqhc form, signs consents.
7. If patient has active Medicaid, send rx to Pharmacy and pick it up same day.
8. Intake labs drawn.
9. Provider 15-min appointment & dispenses first dose of ARVs in office and explains the importance of adherence. DOT
10. Follow-up appt scheduled for 3-4 weeks with HIV-RNA repeated at that time.
11. Patient completes Ryan White paperwork and Medicaid app/ LAHAP app as needed. Future assessment scheduled with case manager.
12. Linkage coordinator verifies that the patient attends the follow up provider visit. Then patient is referred to CHWs for future follow up.

CCSI/EIS Data Review

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Inclusion Criteria: clients enrolled into CCSI or EIS program from December 2016 through April 15th 2018

Total included for data review = 207

136 CCSI

71 EIS

Clients not included in *this* data review

4 CCSI Patients diagnosed but never linked

1 CCSI patient walked out before meds and then was incarcerated next day

3 EIS referred but never linked – (one passed away before appointment.)

2 EIS patients refused medications on day of diagnosis

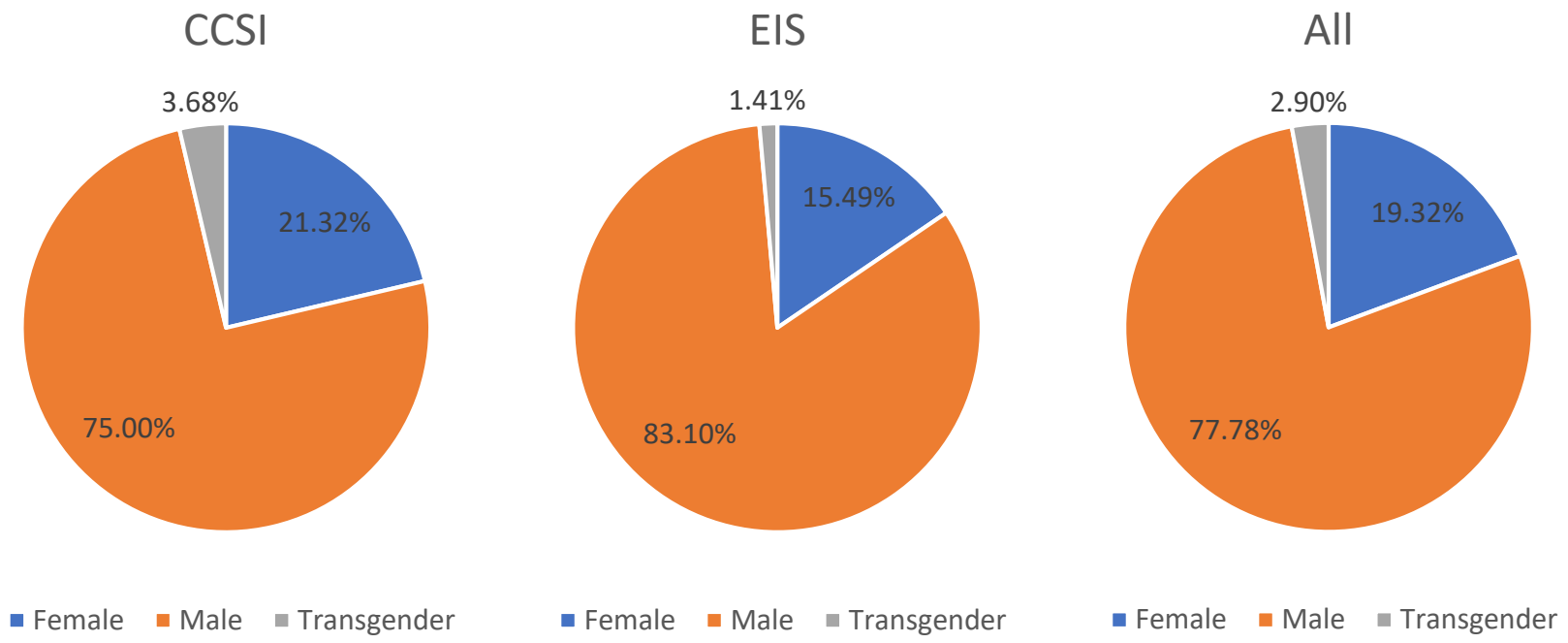
2 EIS patients were not started on ARVs due to being sent to ER at first visit.

Age & Gender

Median Age (CCSI) = 30

Median Age (EIS)= 31

Median Age (All)= 30



Demographics

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Race

Category	Race	%
CCSI	Black/AA	59.56%
	White	30.88%
EIS	Black/AA	67.61%
	White	22.54%
All	Black/AA	62.32%
	White	28.02%

Ethnicity

Category	Ethnicity	%
CCSI	Hispanic/Latinx	11.76%
	Non Hispanic/Latinx	86.03%
EIS	Hispanic/Latinx	7.04%
	Non Hispanic/Latinx	80.28%
All	Hispanic/Latinx	10.14%
	Non Hispanic/Latinx	84.06%

HIV Risk Factor

Category	Risk Factor	%
CCSI	Heterosexual Activity	33.09%
	MSM	50.74%
	PWID	3.68%
EIS	Heterosexual Activity	35.21%
	MSM	52.11%
	PWID	7.04%
All	Heterosexual Activity	33.82%
	MSM	51.21%
	PWID	4.83%

STIs with diagnosis

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Category	Dx	%
CCSI	Syphilis	25.00%
	Gonorrhea or Chlamydia	36.03%
	Hepatitis B or C	6.62%
EIS	Syphilis	30.99%
	Gonorrhea or Chlamydia	32.4%
	Hepatitis B or C	7.4%
All	Syphilis	27.05%
	Gonorrhea or Chlamydia	34.78%
	Hepatitis B or C	6.76%

Poverty Level and Insurance

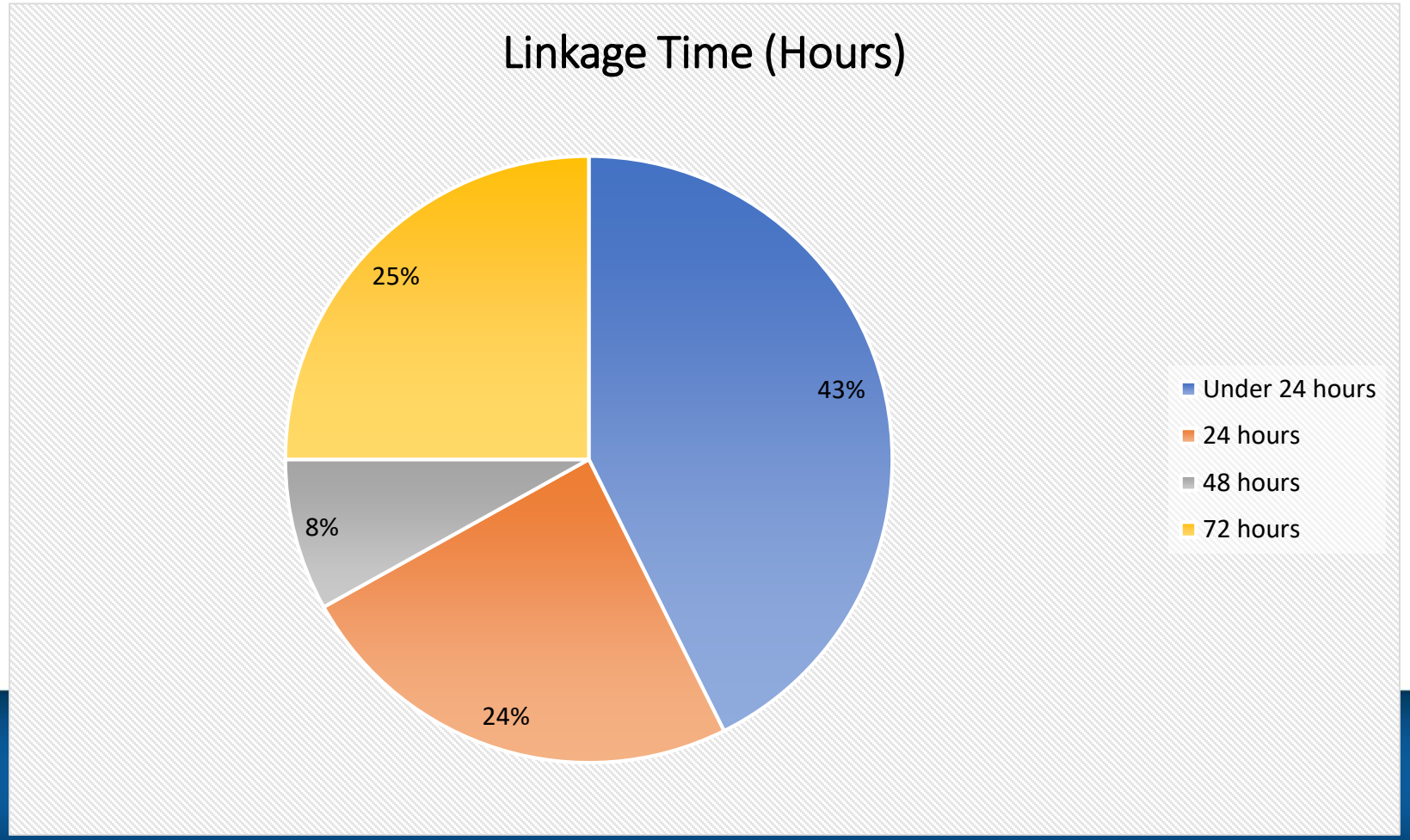
Federal Poverty Level

Category	FPL	
CCSI	Under 100%	39.71%
EIS	Under 100%	36.62%
All	Under 100%	38.65%

Insurance at Baseline

CCSI	Insured	16.91%
	Uninsured	83.09%
EIS	Insured	47.89%
	Uninsured	52.11%
All	Insured	27.54%
	Uninsured	72.46%

Linkage time for CCSI (Hours from Knowledge of Diagnosis to Appointment with a Provider)



Baseline Data

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Baseline CD4

Category	CD4 Median	CD4% Median
CCSI	455 cells/mm^3	27.4%
EIS	328 cells/mm^3	18.75%
Total	416 cells/mm^3	24.6%

Baseline Viral Load

Category	Viral Load Median (copies/ml)
CCSI	37,400
EIS	48,250
Total	41,700

Results

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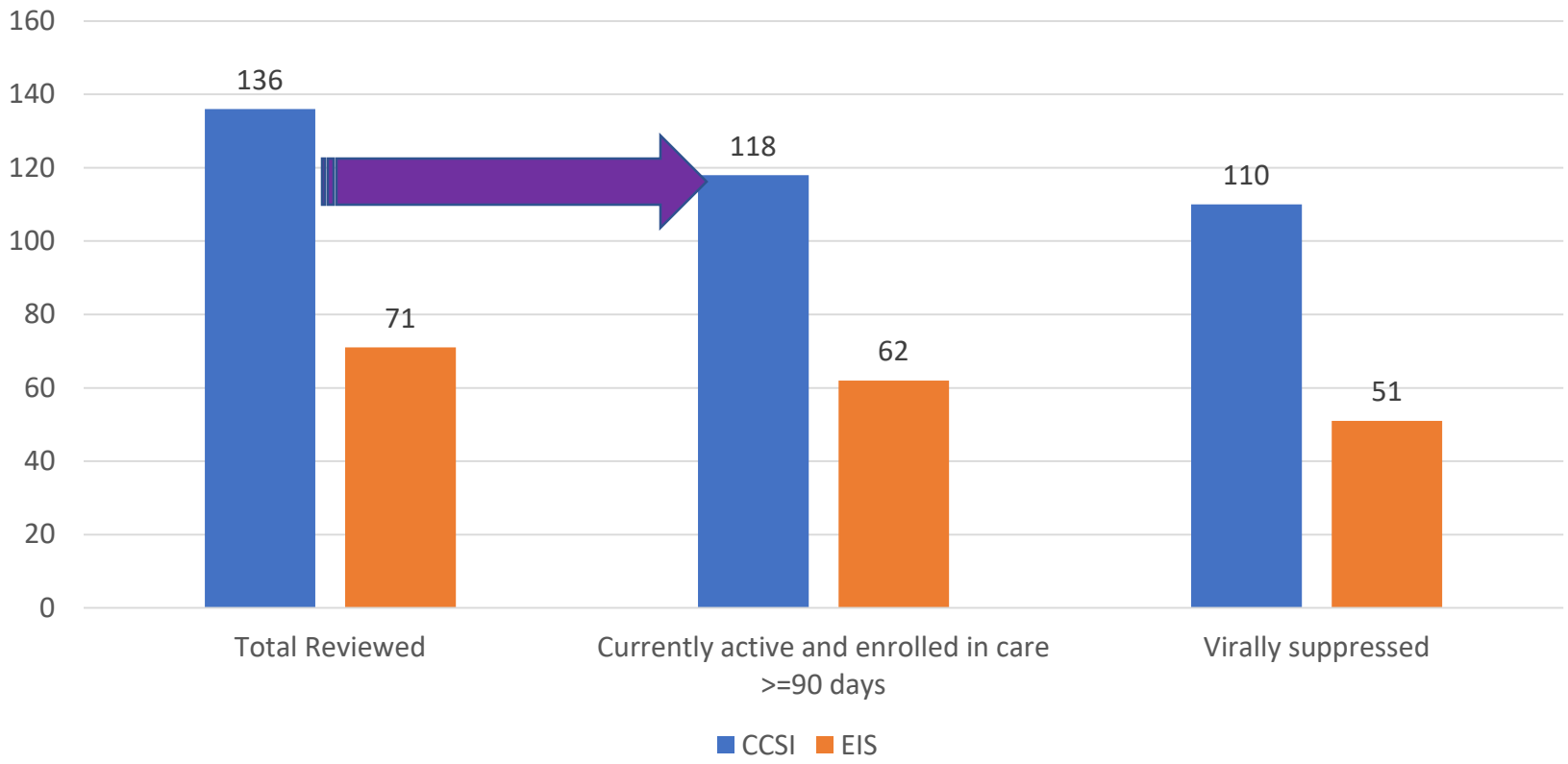
1. Time from Diagnosis to First Viral Load Suppression: CCSI
2. Time from Linkage to Care to First Viral Load Suppression: EIS

Category	Median (days)	Mean (days)
CCSI [1]	27	47.28
EIS[2]	25	53.28
Total	26	43.21

Continuum of Care



Inactives or New to CCSI

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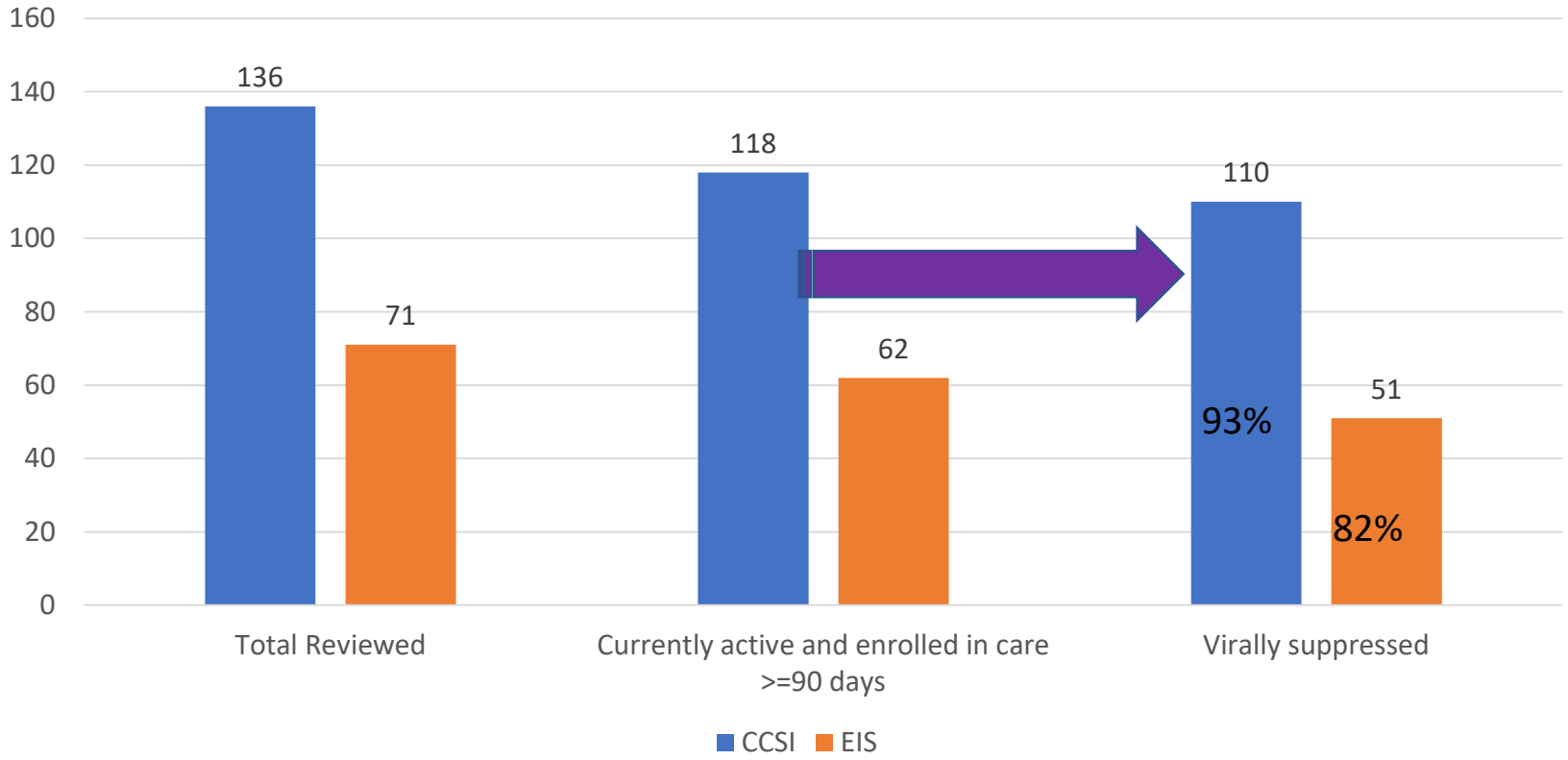
N=18

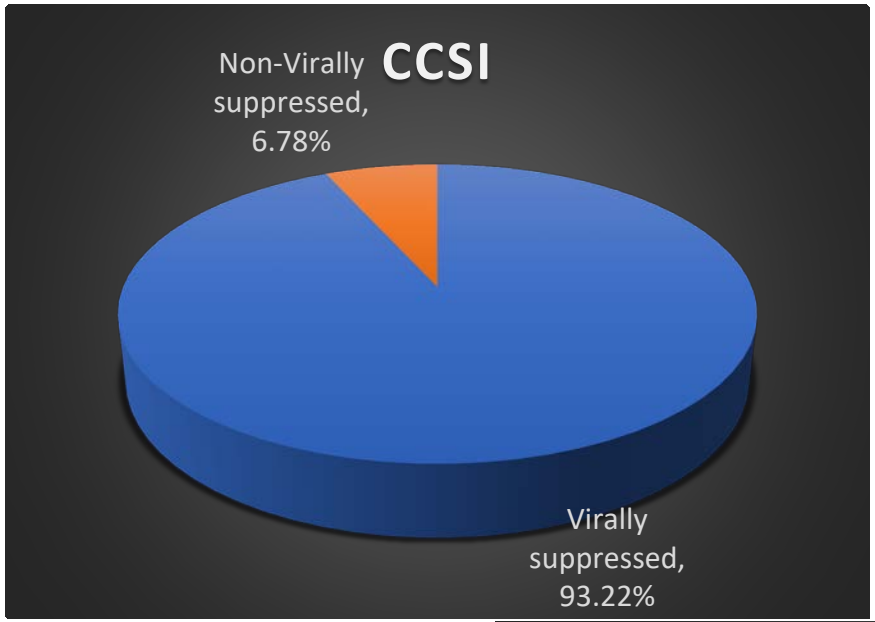
- 9 New to the CCSI program (in care less than 90 days)
- 9 Transferred Care
- 7 of the 9 patients are confirmed in care with an undetectable viral load

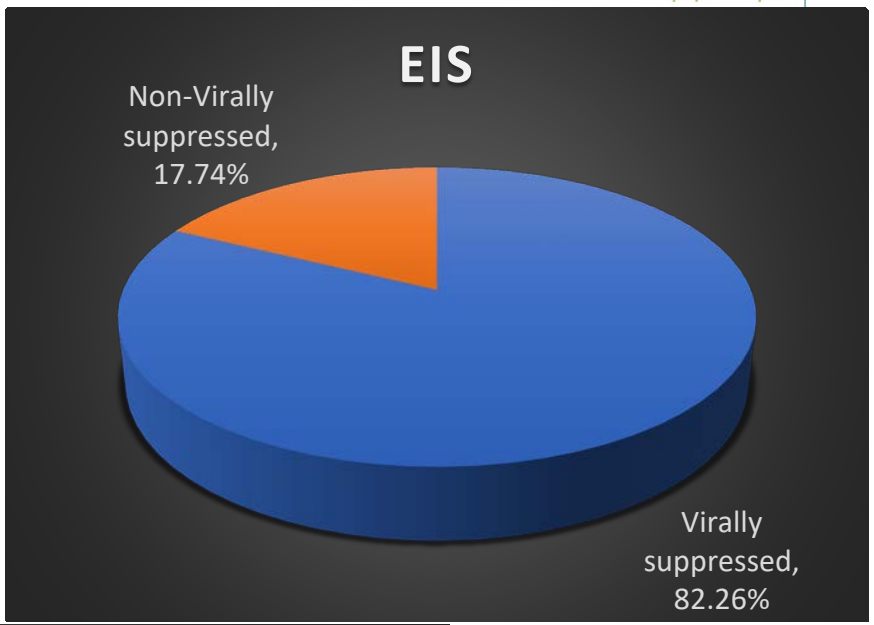
N=11

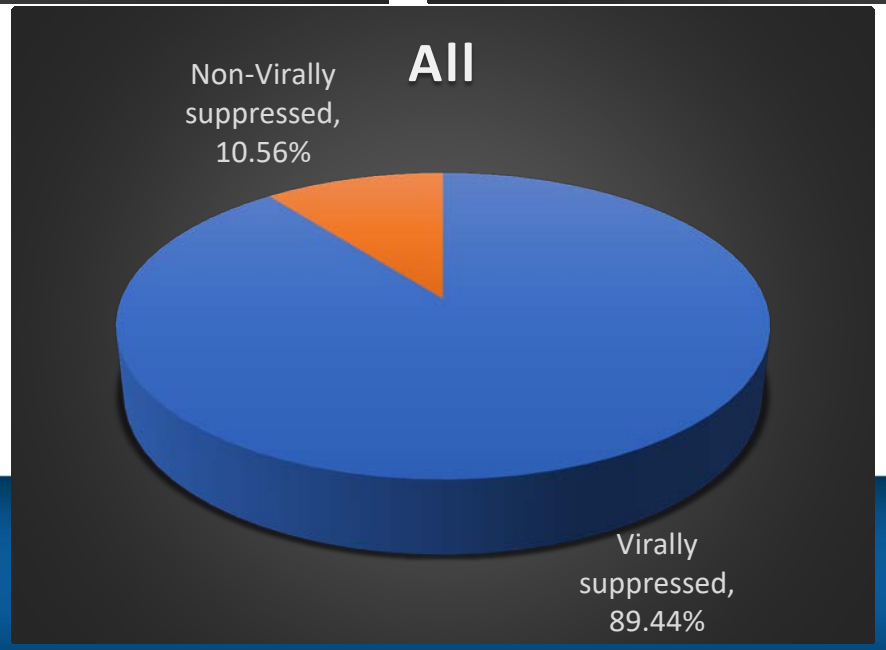
- 2 New to the EIS Program
- 6 Transferred Care
- 4 of the 6 patients are confirmed in care with an undetectable viral load.

Continuum of Care




CCSI
Non-Virally suppressed, 6.78%
Virally suppressed, 93.22%


EIS
Non-Virally suppressed, 17.74%
Virally suppressed, 82.26%


All
Non-Virally suppressed, 10.56%
Virally suppressed, 89.44%

Non-Virally Suppressed

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CCSI

3/8 patients who were not virally suppressed by end of the evaluation period have now been virally suppressed in May!

Three are back in care but not yet suppressed.

Two patients have been lost to follow up.

EIS

6/11 EIS patients have achieved vs in April/May!

Two EIS patients have been lost to follow up.

One out of state but returning soon.

Two back in care but not yet suppressed.

CD4 Count, Viral Suppression, Transmitted Resistance

CCSI:

All but two patients received TAF/FTC + DTG

107/119 genotypes were performed and reviewed.

20/119 (17%) with transmitted resistance

3/20 with M184V/I with two previously on PrEP

All patients with transmitted resistance achieved viral suppression.

EIS:

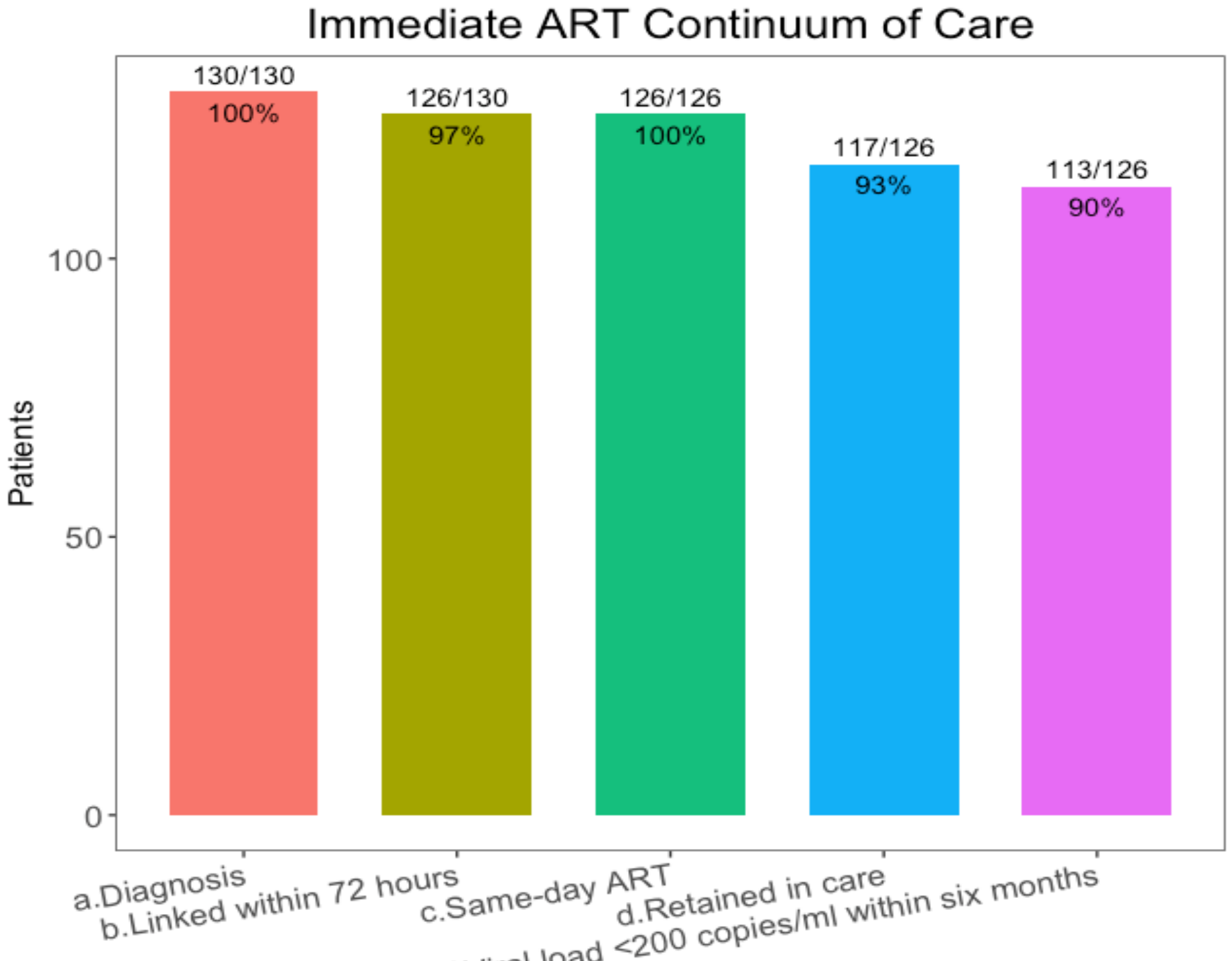
All but four patients received TAF/FTC + DTG

63/65 genotypes were performed

6/63 (9.5%) with transmitted resistance.

2/6 with M184V/I no previous PrEP exposure

5/6 achieved viral suppression with 1/6 lost to follow up



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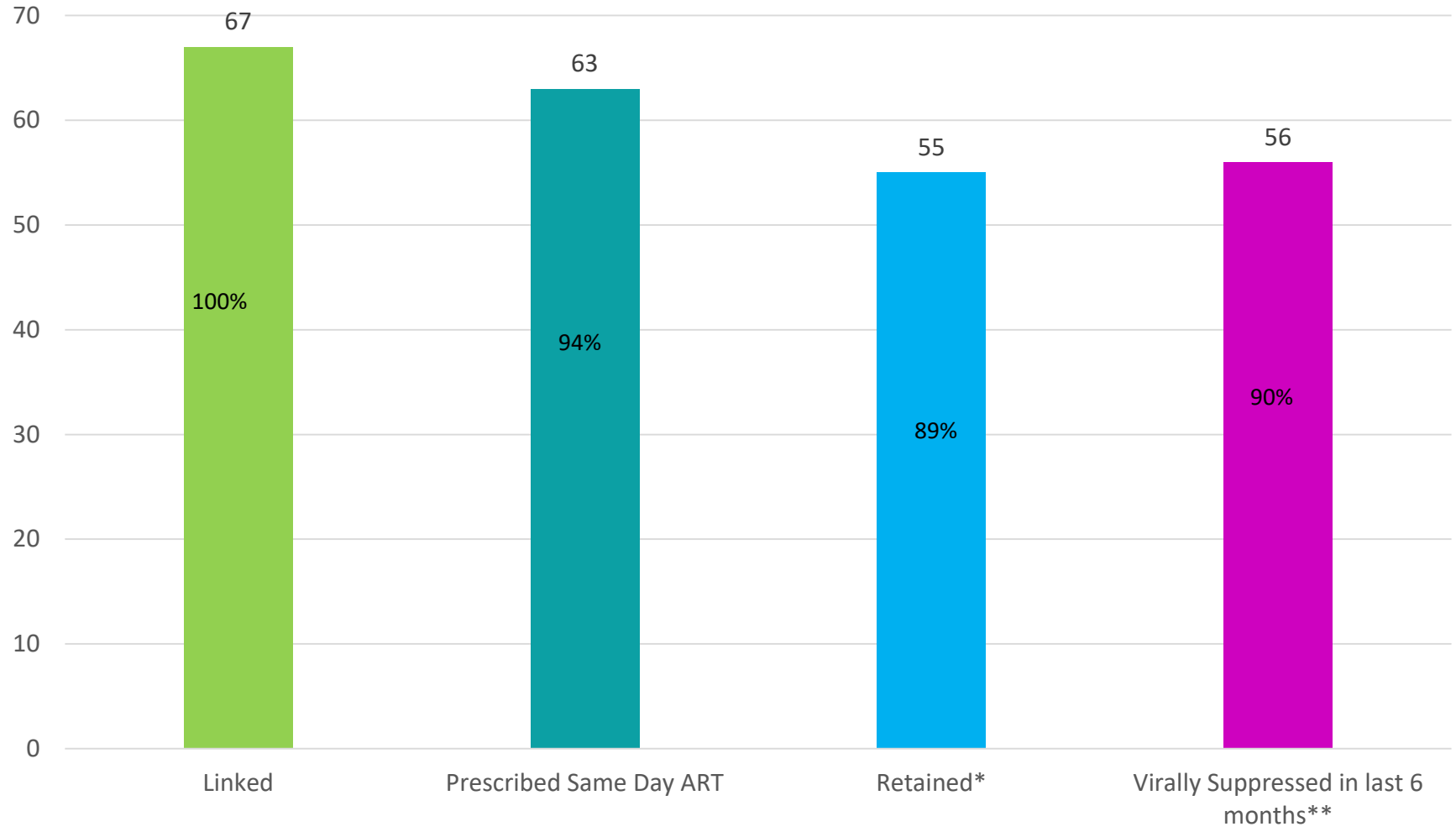
EIS Continuum of Care



*Retained at our facility. 4 patients moved out of state, 1 switched clinics in state.

**Viral load obtained from our clinic or the state database. 5 patients moved out of state.

How to Start ART Safely

With Minimal Clinical Data

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DHHS Recommendations, 2018[1]

- Avoid NNRTI-based regimens
- Recommended regimens[a]
  - BIC/TAF/FTC (recommended, but not yet listed in DHHS guidelines)
  - DTG + tenofovir[c]/FTC
  - DRV/r or DRV/c[b] + tenofovir[c]/FTC

IAS Recommendations, July 2018[2]

- Encourage rapid initiation of ART, including same day initiation, if feasible
- Recommend unboosted InSTI regimens as initial therapy

Rationale for Recommendations[1]

- Transmitted mutations conferring resistance to NNRTI > PI or INSTI
- Resistance to DRV and DTG emerge slowly
- Transmitted HIVDR to DRV is rare
- Single case of transmitted HIVDR to DTG
  - Subsequently randomized to BIC/TAF/FTC and achieved VS

1. US DHHS. Guidelines for Use of Antiretroviral Agents in HIV-1–Infected Adults and Adolescents. 2017. Last updated May 30, 2018. https://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf. Accessed May 31, 2018; 2. Saag MS, et al. *JAMA.* 2018;320(4):379-396. https://jamanetwork.com/journals/jama/fullarticle/2688574.

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Issues/Troubleshooting

1. CERV completion and eligibility specialist visit same-day
   - CCSI visit becomes, well, not so rapid
2. Documentation of HIV status (community referrals)
3. Discordant rapid HIV testing results
4. What if patient cancels or misses their 1st follow-up visit & is out of medications?
5. People outside of MSA
6. Changing the culture of the clinic
7. Medication reimbursement & Part A Support

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Conclusions:

Our test-and-start strategy at a non-academic federally-funded health center in a high prevalence city has been successful in achieving rapid virologic suppression in almost all clients during the study period.

There are differences in engagement between newly diagnosed patients (viral suppression 93%) and those who deferred immediate linkage (viral suppression 82%) P - 0.0071.

Immediate ART leading to rapid viral suppression will be a key component of ending the HIV epidemic.

Thanks

Our Patients

Fran Lawless

New Orleans Regional Planning Council

Katie Conner

Pam Holm

Nicholas Van Sickels

Isolde Butler

Yue Huang

Nicole Shatz (and all CHWs)

CrescentCare Staff