NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Sustaining Health System Navigation in a Complex HIV Clinic Setting

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Learning Objectives

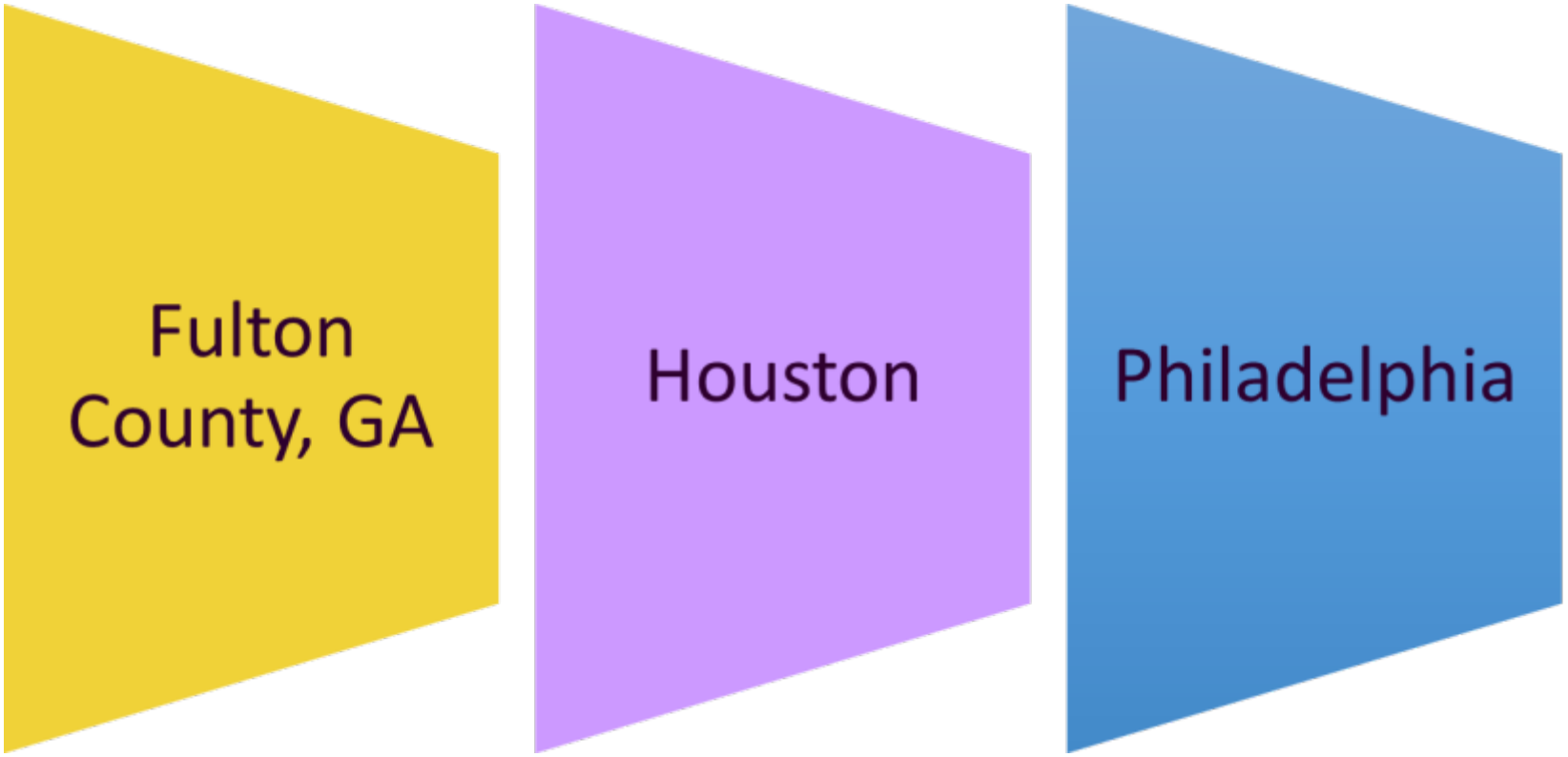
- Describe strategies to integrate health system navigation into existing programs
- Identify methods to tailor programs to address the unique needs of patients at high risk for dis-engagement from care
- Discuss ways to sustain navigation programs in times of funding change and insecurity

Overview

- Project setting
- Project implementation
- Data results
- Case Studies
- Sustainability

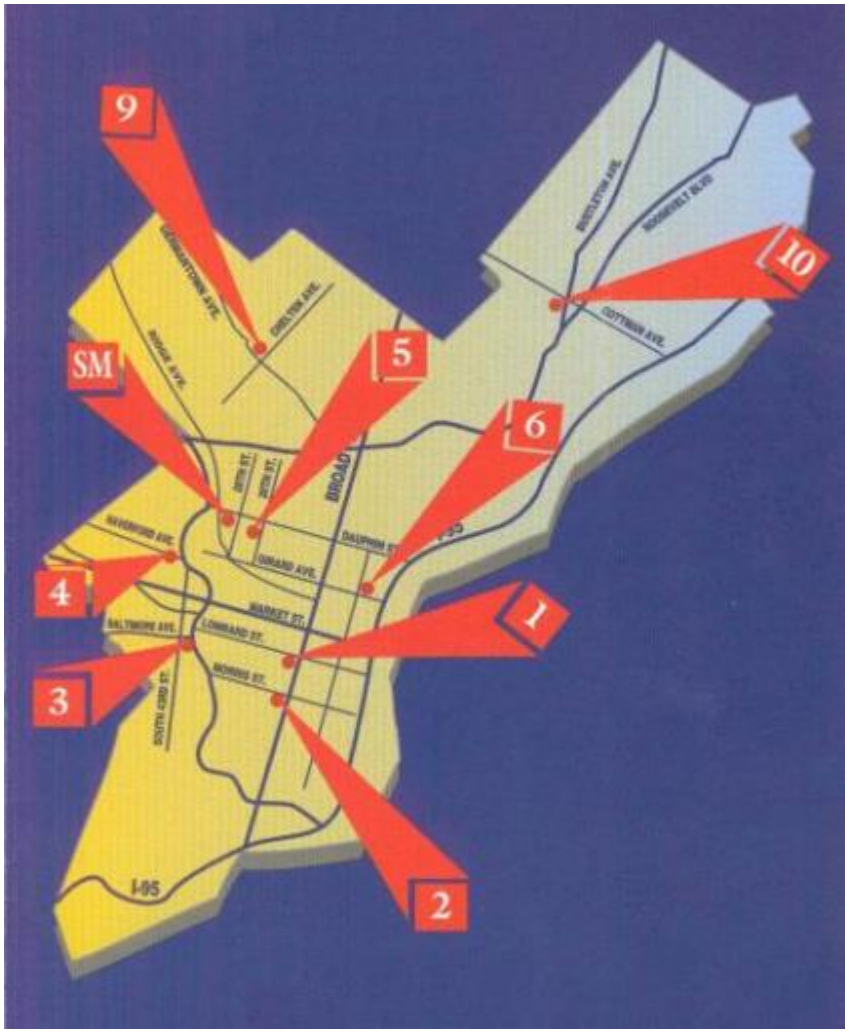
Project Setting

3-site HIV Care Collaborative (HCC) – Health Departments Funded by Merck Company Foundation July 2012 – July 2015

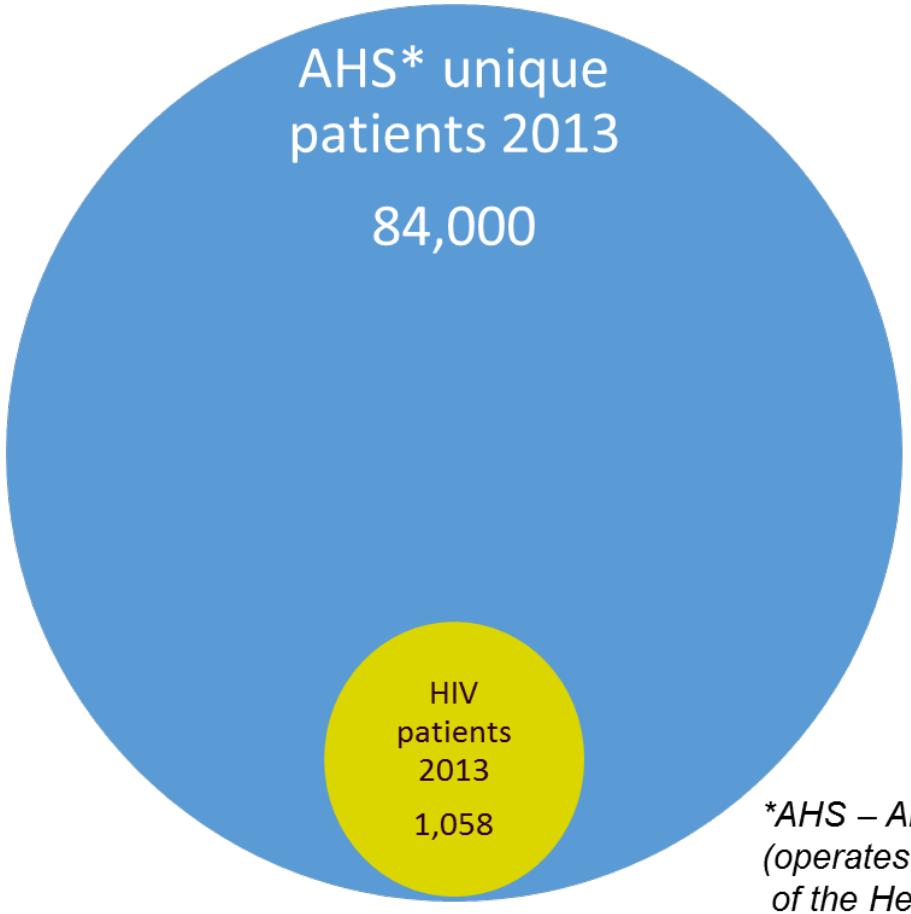


Project setting

- City health centers provide comprehensive care to Philadelphia residents
  - 8 FQHC lookalike facilities in Philadelphia's neighborhoods
  - Each center has an HIV clinic operating 1-2 days a week
  - Each center offers routine HIV testing



Project setting

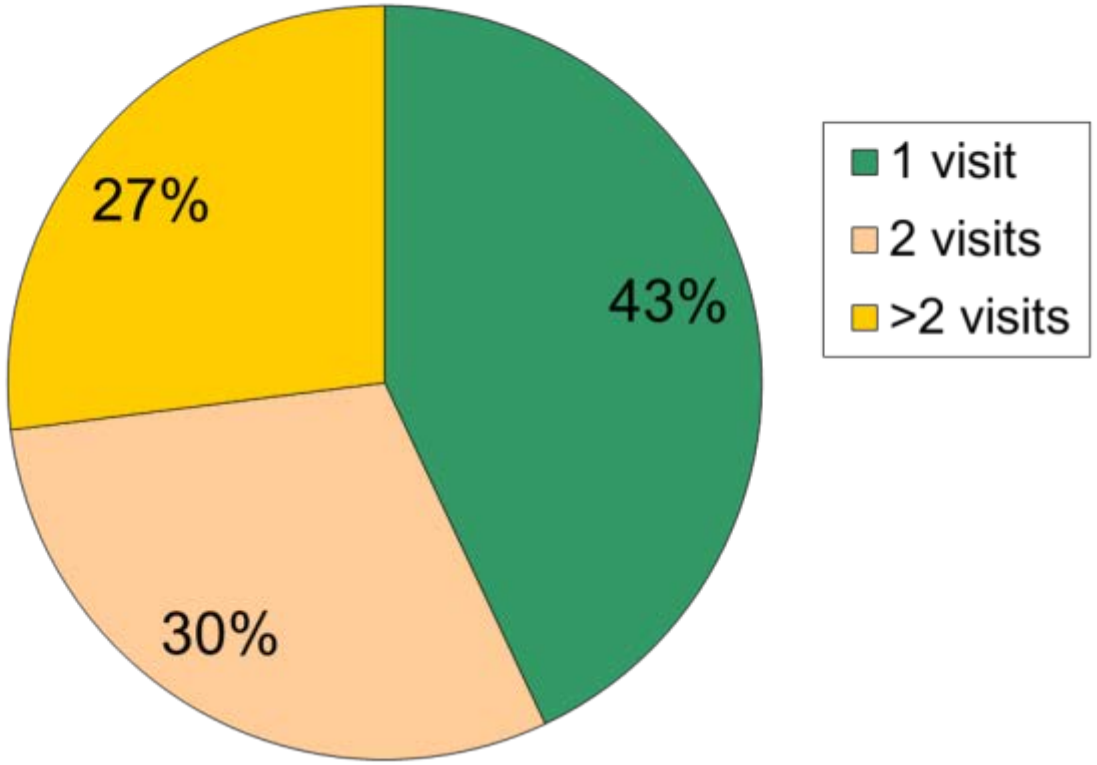


AHS – Ambulatory Health Services (operates the eight city health centers of the Health Dept)

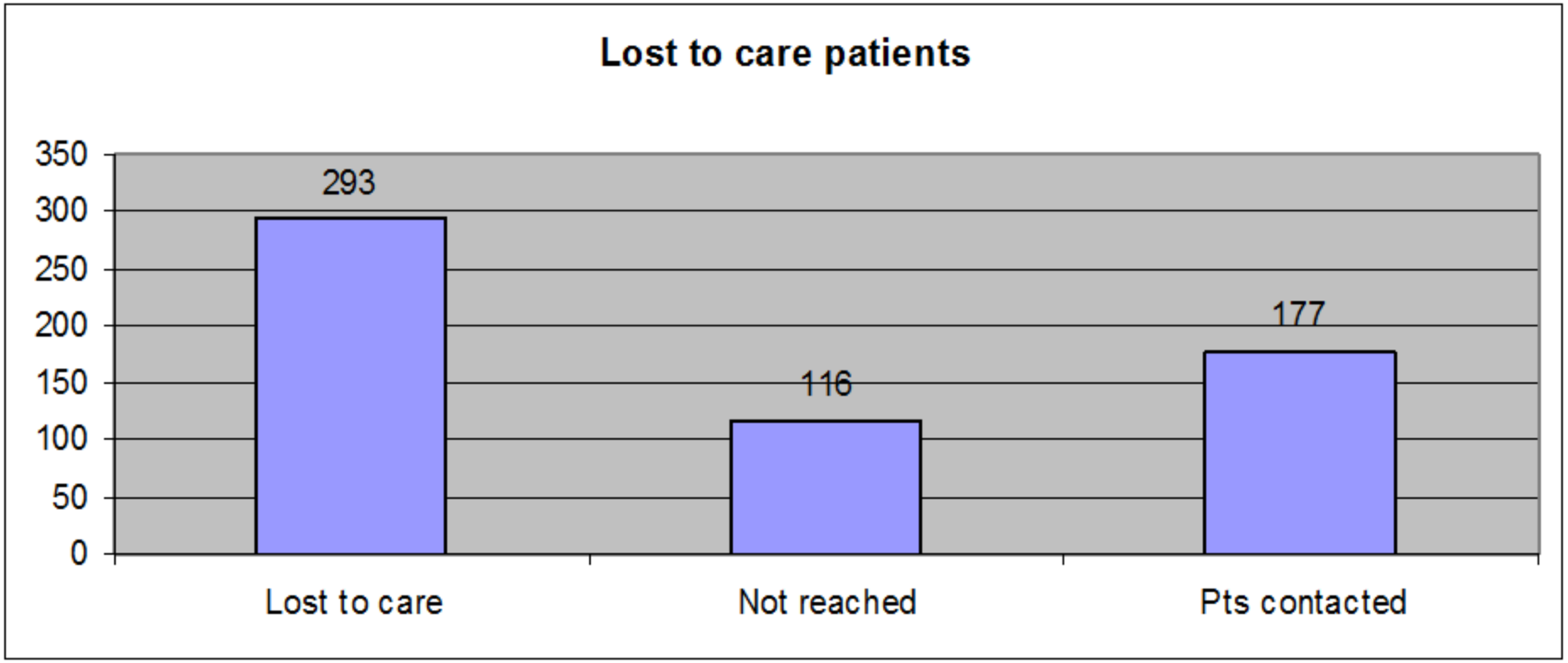
First Visits Important for Retention

AHS 2012

Number of visits for new HIV positive patients lost to care in 2012 (n=46)



Outreach Data, Nov-Dec 2012

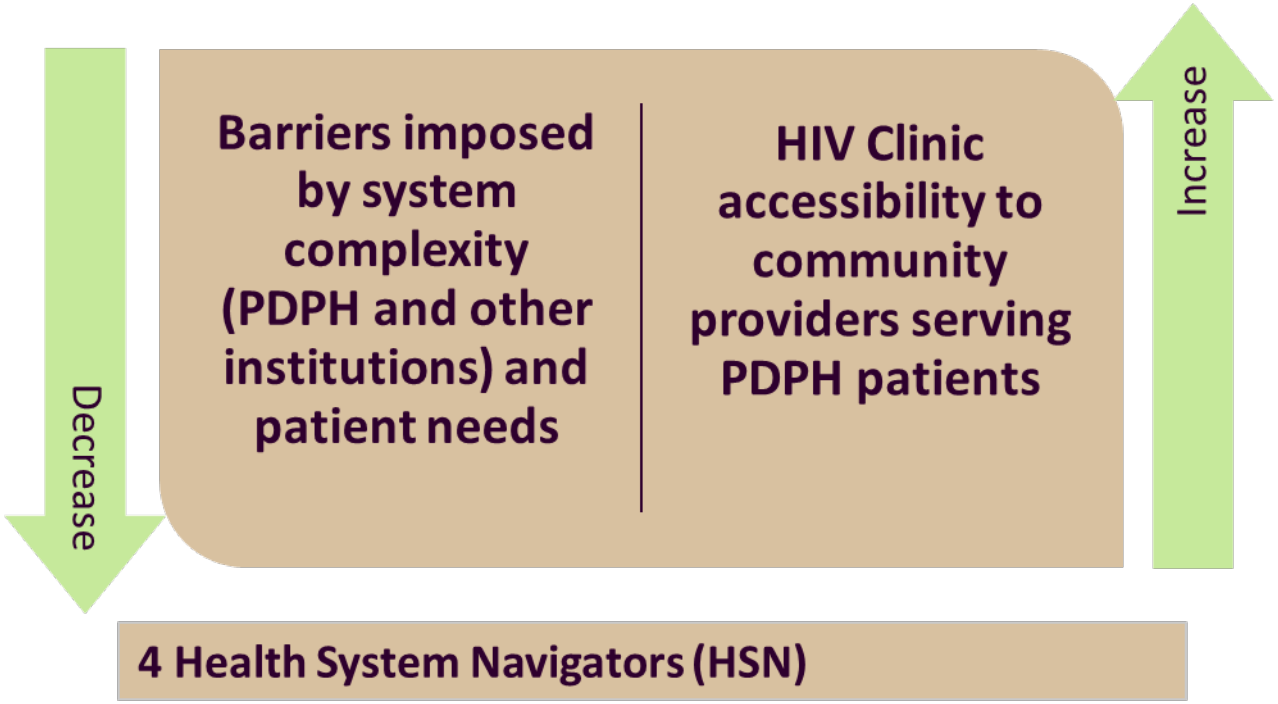


Non-medical services available to health center HIV patients

- Case management
- Social services
- Transportation assistance
- Housing assistance
- Insurance counseling
- Appointment reminders
- Substance abuse rehabilitation
- Adherence counseling
- Nutrition counseling and support

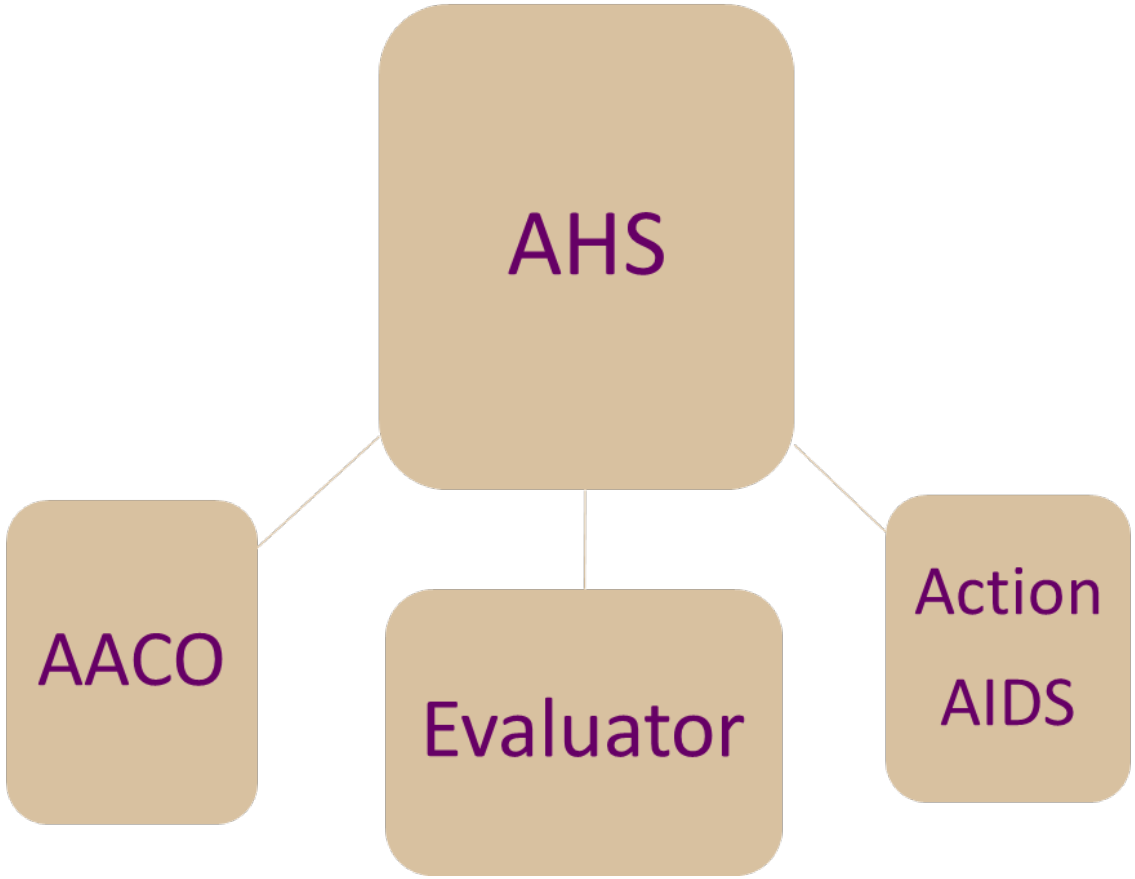
Project Implementation

HCC Project At A Glance



Key Partners of Philadelphia HCC

AIDS Activities Coordinating Office – a division of the Health Dept



ActionAIDS CBO, the largest case management provider in Philadelphia.

HCC Retention Intervention

Navigation

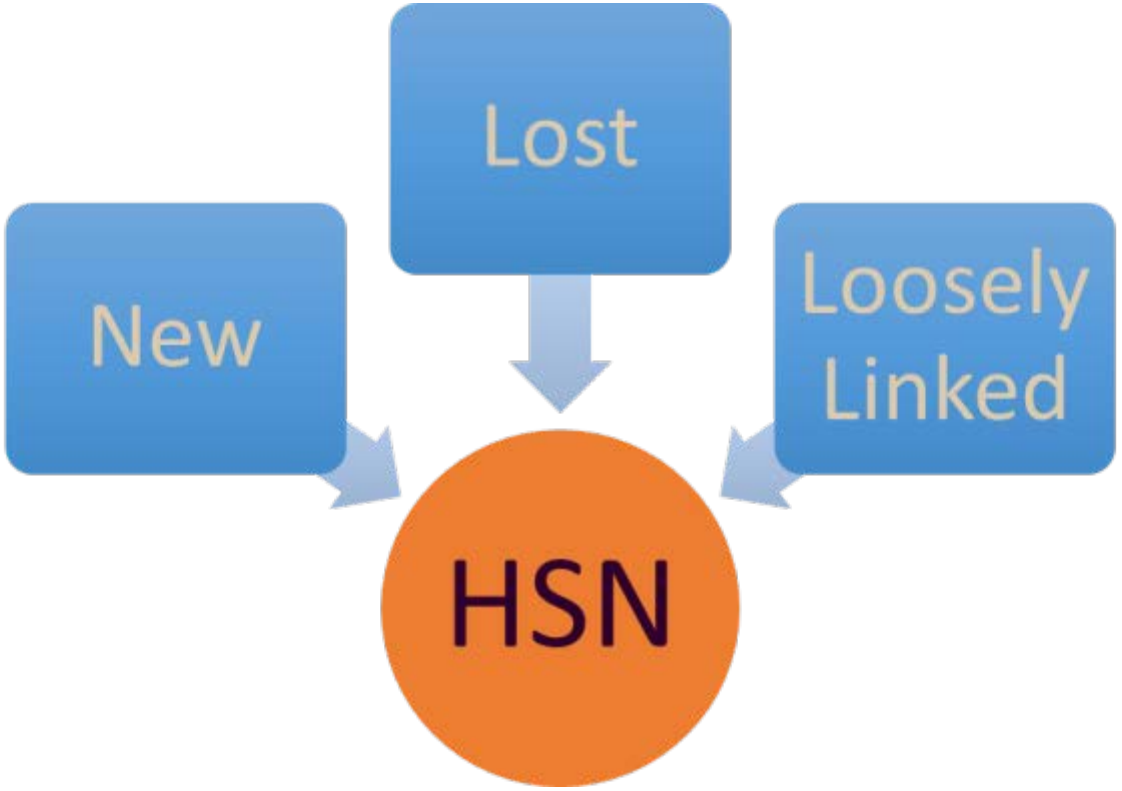
- Health center system
- Systems external to health center

Linkage

- Case management
- Other services as needed

Intervention was limited to an average of 90 days

Patients Referred to Health System Navigators (HSN)



Data Results

Methods

- Analysis focused on 77 HSN enrollees who received services 3/1/13 through 9/30/13; two enrollees were excluded as CAREWare data was not available
- Outcomes examined included:
  - Time required to link/re-engage patients to care
  - Retention in care (evidence of two medical visits at least 90 days apart over 12 months)
  - Viral suppression (HIV1 RNA<200 copies/ml closest to the end of the measurement period)
- HSN patient demographic and outcome data was compared to data for non-HSN HIV patients seen in the Health Centers
- 12 month pre-intervention data was compared to 12 month post-intervention data for 66 patients who were previously diagnosed and in care at the HCs

Patients Referred, Eligible, and Enrolled in HSN, March through September, 2013

	Number	Percent
Referred	304	
Eligible*	135	44.5% of Referred
Enrolled	77	57.0% of Eligible

** Excluded those who had died, were incarcerated, had moved out of Philadelphia or had evidence of care elsewhere in Philadelphia*

Referral Categories of HSN Enrollees, March through September, 2013

	Number	Percent
Total	77	100.0%
Newly Diagnosed	11	14.3%
New to Health Center	1	1.3%
Loosely Linked to Care**	64	83.2%
Lost to Care	1	1.3%

***Deemed by Health Center staff to be at risk for falling out of care, or failed to have two medical visits at least 90 days apart in past year*

Demographic Comparisons

	Enrolled (2 Missing); n=75	Referred, Not Enrolled (11 Missing); n=47	Remaining HC HIV Population; N=1006
RACE/ETHNICITY			
Black	88.0%	74.5%	84.9%
Hispanic	5.3%	6.4%	7.5%
White (non-Hispanic)	2.7%	10.6%	4.7%
Other	4.0%	8.5%	2.9%
GENDER			
Male	68%	72.3%	65.2%
AGE (20+ Eligible) (p<.05)			
20-44	52.0%	40.4%	32.1%
45+	48.0%	59.6%	67.6%
HIV STATUS			
CDC AIDS criteria	32.0%	34.0%	37.7%

Demographic Comparisons, Continued

	Enrolled (2 Missing); N=75	Referred, Not Enrolled (11 Missing); N=47	Remaining HC HIV Population; N=1006
EXPOSURE			
Heterosexual	61.3%	66.0%	70.3%
MSM	26.7%	21.3%	19.0%
IDU	5.3%	4.3%	4.7%
Other	6.7%	8.4%	6.0%
HOUSING (p<.05)			
Stable/Permanent	85.3%	87.2%	93.0%
INSURANCE STATUS			
No Insurance	36.0%	57.5%	40.4%
POVERTY LEVEL			
100% or Less FPL	82.7%	78.7%	83.2%
>100% - 300% FPL	16.0%	21.3%	16.1%
>300% FPL	1.3%	0.0%	0.7%

Linkage to Care

- Newly diagnosed HSN patients (n=11):
  - 18.2% received care within 1 month
  - 90.9% had received care within 3 months, which exceeds the NHAS target of 85%
- Other HSN patients (n=66)
  - 74.2% received care within 1 month
  - 84.9% had received care within 3 months

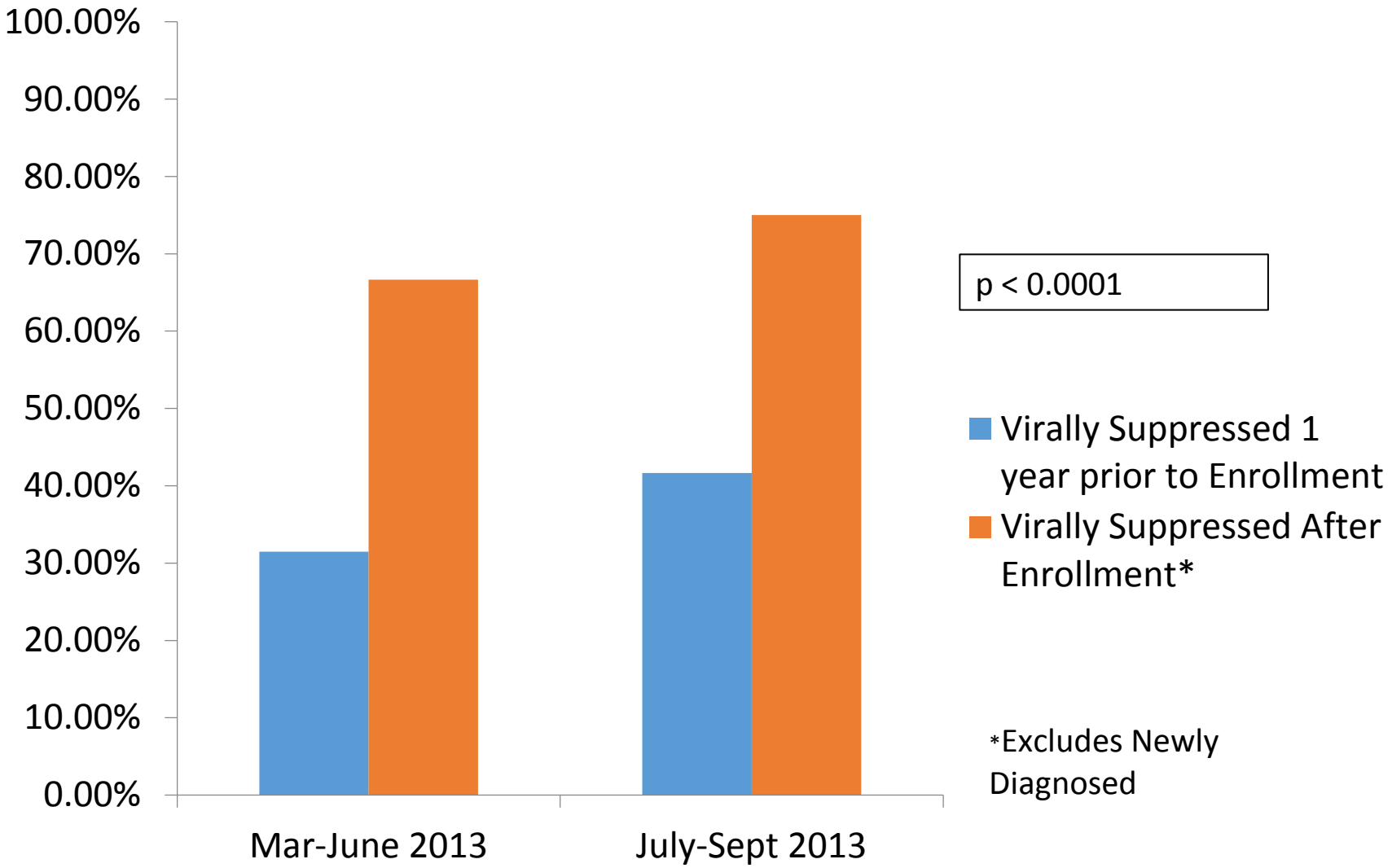
HSN vs. Non-HSN Patient Results

	Non-HSN*	HSN	Odds Ratio	p-value
RETENTION IN CARE			1.89	0.28
Not Retained	66	3		
Retained	863	74		
% Retained	92.3%	96.1%		
VIRAL SUPPRESSION			0.44	.00013**
Not Suppressed	154	24		
Suppressed	775	53		
% Suppressed	83.4%	68.8%		

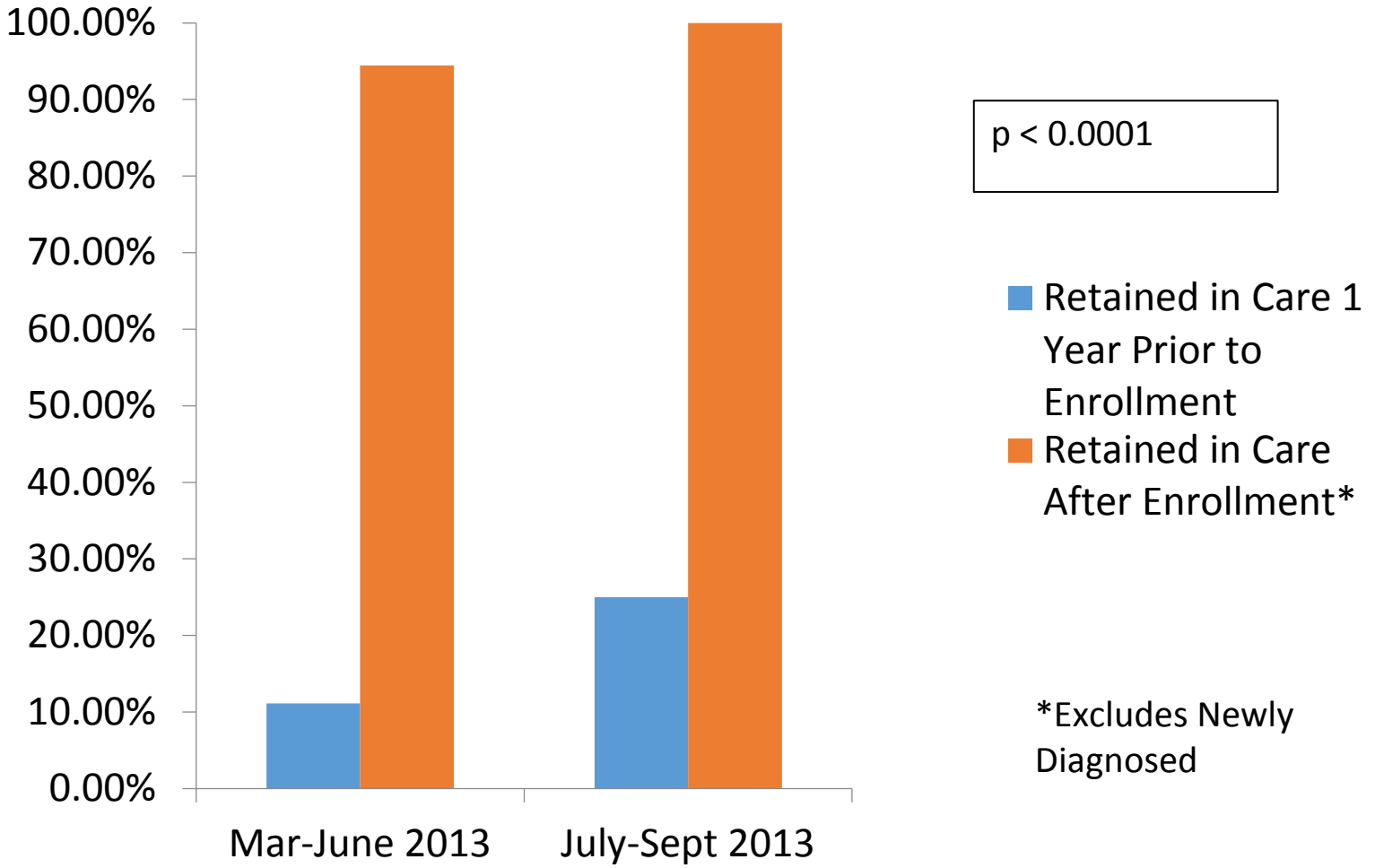
*Includes those referred to HSN but not enrolled

**Those enrolled in HSN were 56% less likely to be virally suppressed as compared to the remainder of the clinic population.

Viral Suppression Before vs. After Enrollment



Retained in Care Before vs. After Enrollment



Results summary

- HSN enrollees were younger and less stably housed than non-HSN enrollees
- Linkage to care:
  - 90.9% of newly diagnosed HSN enrollees were linked to care within 3 months
  - 84.9% of other enrollees were linked to care within 3 months
- Retention in care:
  - There was no statistical difference between HSN enrollees and non-HSN enrollees
  - 95.5% of HSN enrollees (excluding newly diagnosed) were retained in care versus 13.6% pre-enrollment ($p<.0001$)
- Viral suppression:
  - HSN enrollees were less likely to be virally suppressed compared to the remainder of the clinic population at 1 year post enrollment ($p<.0001$)
  - 68.2% of HSN enrollees (excluding newly diagnosed) were virally suppressed versus 33.3% pre-enrollment ($p<.0001$)

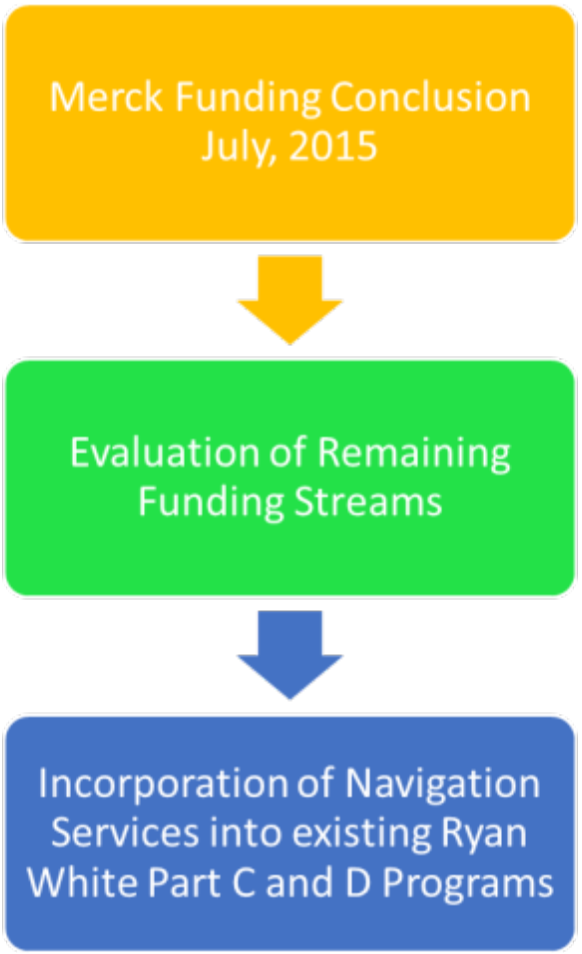
Case Studies

Sustainability

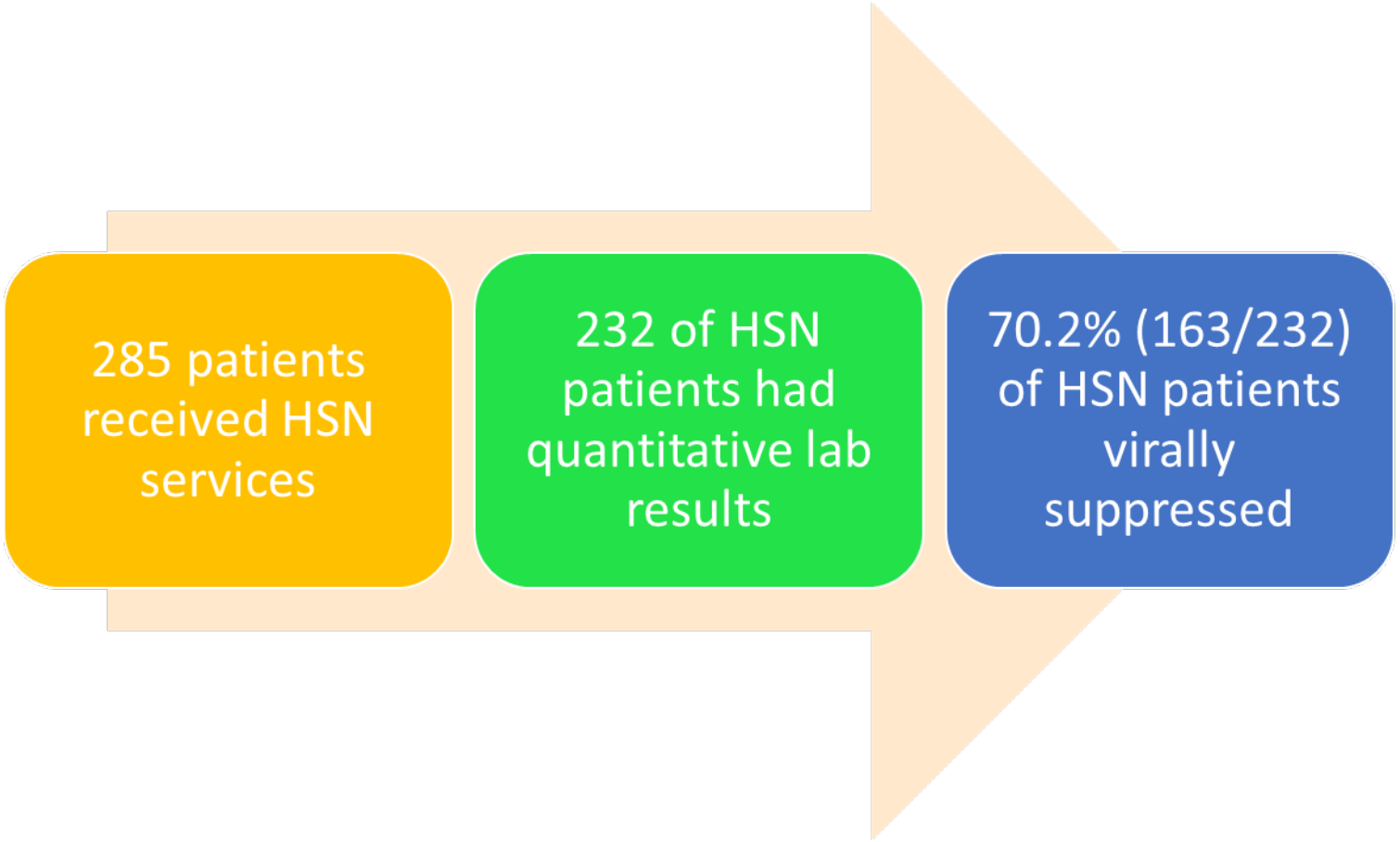
Lessons Learned

- Delineating roles
- Defining eligibility
- Staff turnover
- Collaboration
- Time limitation of intervention
- Appropriate comparators for data interpretation

Program Funding Transition



Preliminary Data Updates,
July 2015 - July 2016



Conclusions

- Health System Navigation improves retention and viral suppression for HIV positive patients facing numerous barriers to care

- Health System Navigation can be implemented in a large public health system

- Health System Navigation can be successfully implemented as a collaborative effort

Questions?

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