RE-LINKAGE TO CARE OF HIV AND HEPATITIS C CO-INFECTED PATIENTS IN NEW YORK CITY

HIV EPIDEMIOLOGY AND FIELD SERVICES PROGRAM

FIELD SERVICES UNIT

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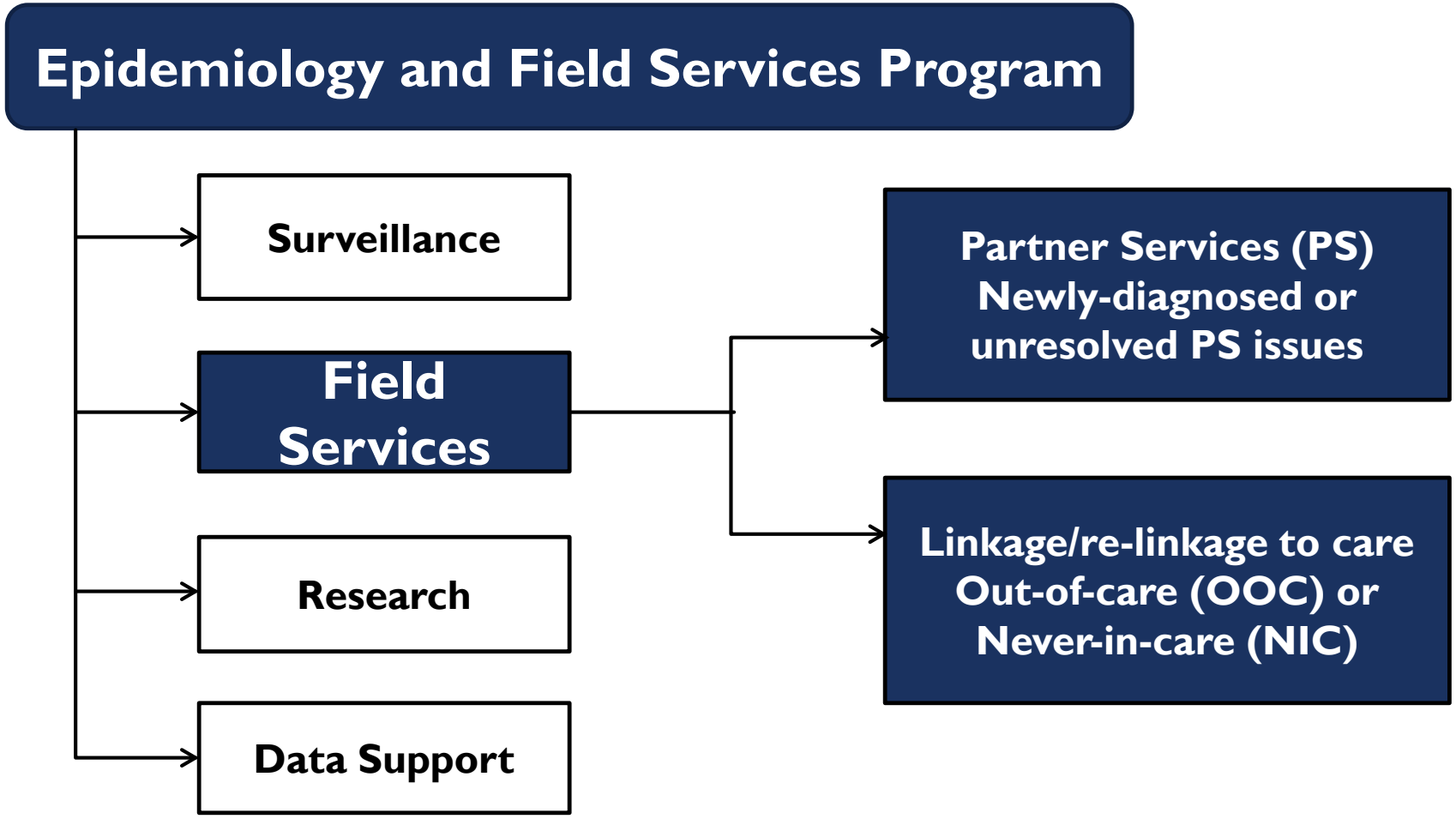
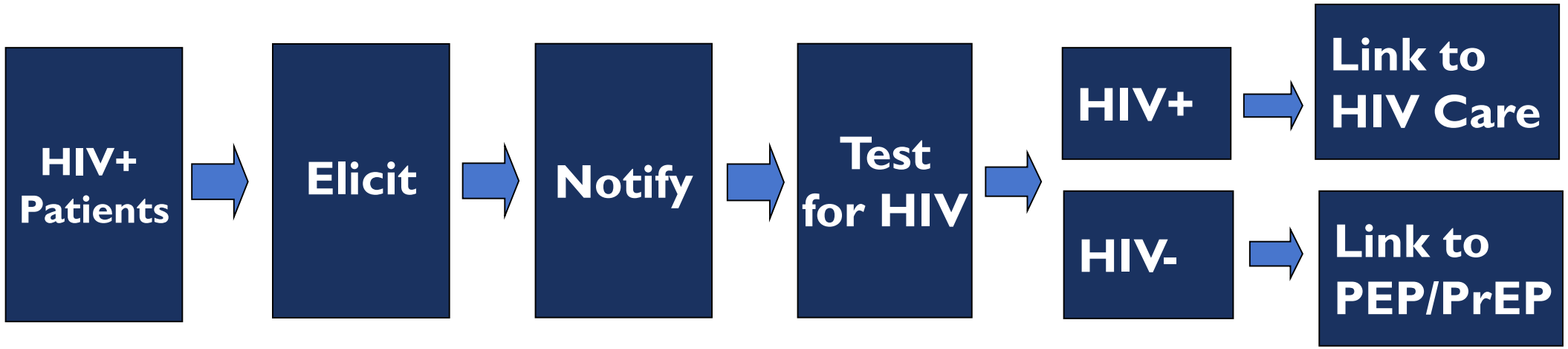
NYC BUREAU OF HIV PREVENTION



FIELD SERVICES UNIT AIMS ESTABLISHED 2006

- Persistent problem of late HIV diagnosis
  - NYC partner services (PS) outcomes lagged behind NYS and other national benchmarks
- Missing surveillance information
  - 30% of cases with no transmission risk identified
- Delayed linkage to care (LTC)
  - ~25% with no VL/CD4 1 year after initial diagnosis
  - Elevated risk of morbidity/mortality and onward HIV transmission

FSU WORK FLOW



- Disease Intervention Specialists assist HIV-diagnosed persons with PS and LTC

OUT OF CARE WORK FLOW

- In 2007, FSU began outreach to patients on the basis of CD4 or HIV viral load (VL) results reported to HIV surveillance registry as proxy measures of engagement in care
- This information was used to identify PWLH presumed out of care (OOC) (no labs ≥ 13 months)
- Once identified, OOC clients were assigned to Disease Intervention Specialists for return to care (RTC) for HIV and for HCV evaluation and care if indicated
- In 2013, FSU began matching names of OOC-PLWH with the HCV surveillance registry to **prioritize** HCV co-infected OOC-PLWH for RTC and HCV linkage to care and treatment

WORK FLOW

Step 1: **Presumed** OOC HIV/HCV co-infected cases selected from the surveillance registry

Step 2: Pre-field Checks

Other databases: HASA, BCD MAVEN, New York State Electronic HIV Management System (NYEHMS)

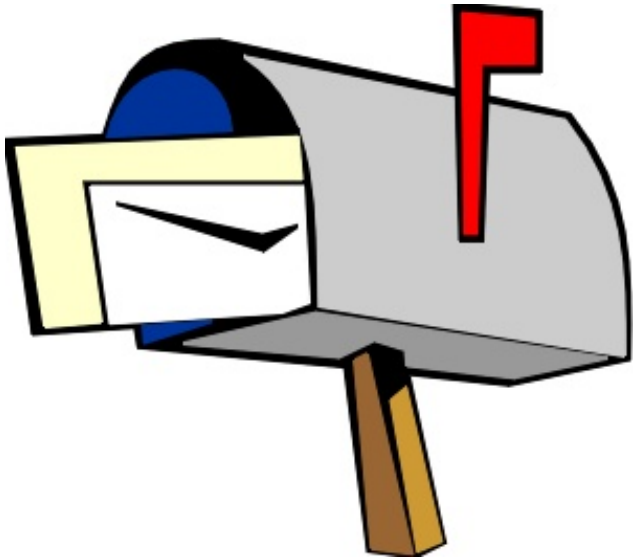
Step 3: Assign, investigate, and link to care

Search engines: - Worker Connect, Parole system check

People search - Lexis-Nexis, USPS, Google, etc.

Electronic Clinical Data – Healthix, NYCIG, Bronx RHIO

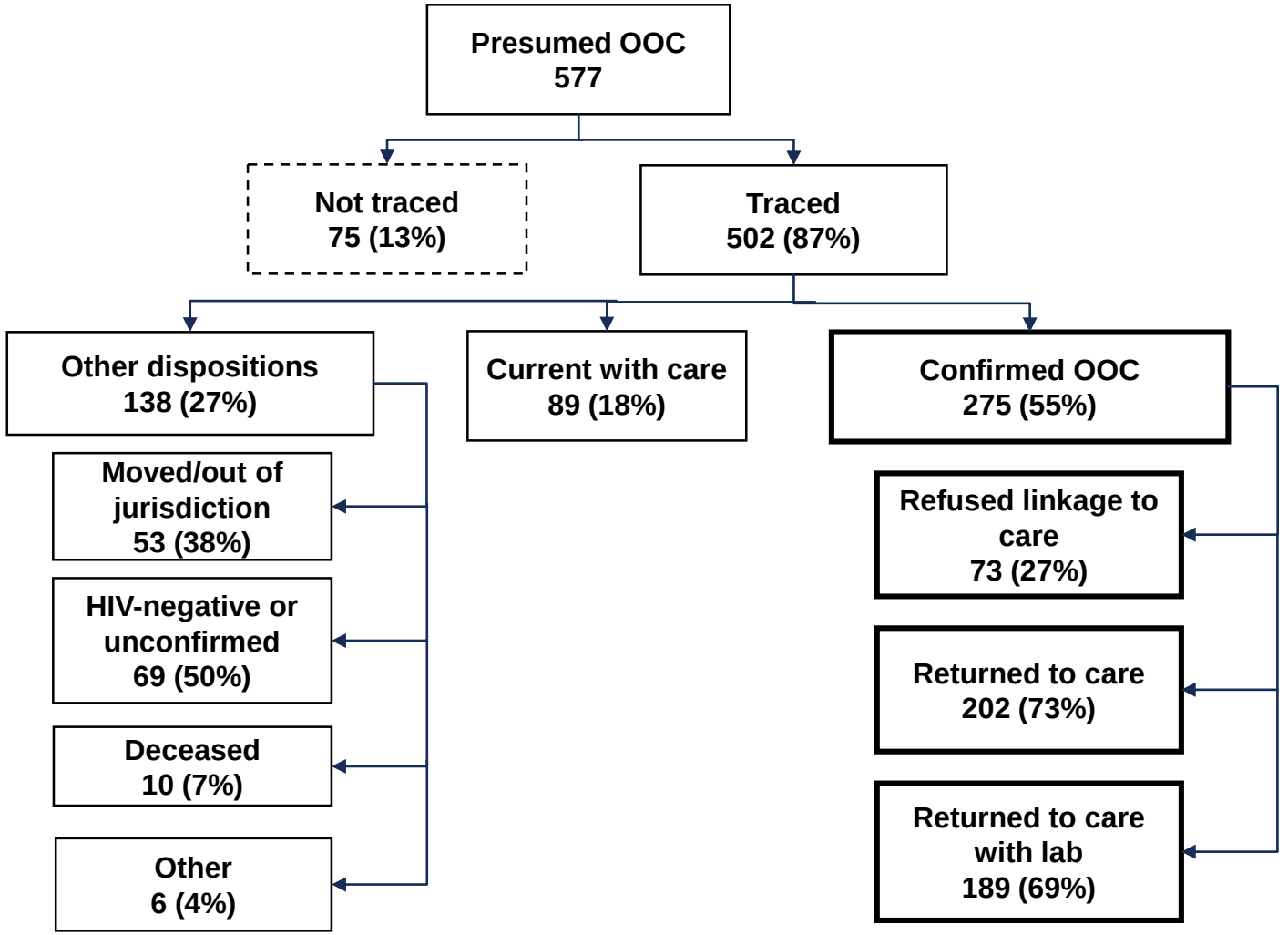
FIELD INVESTIGATION



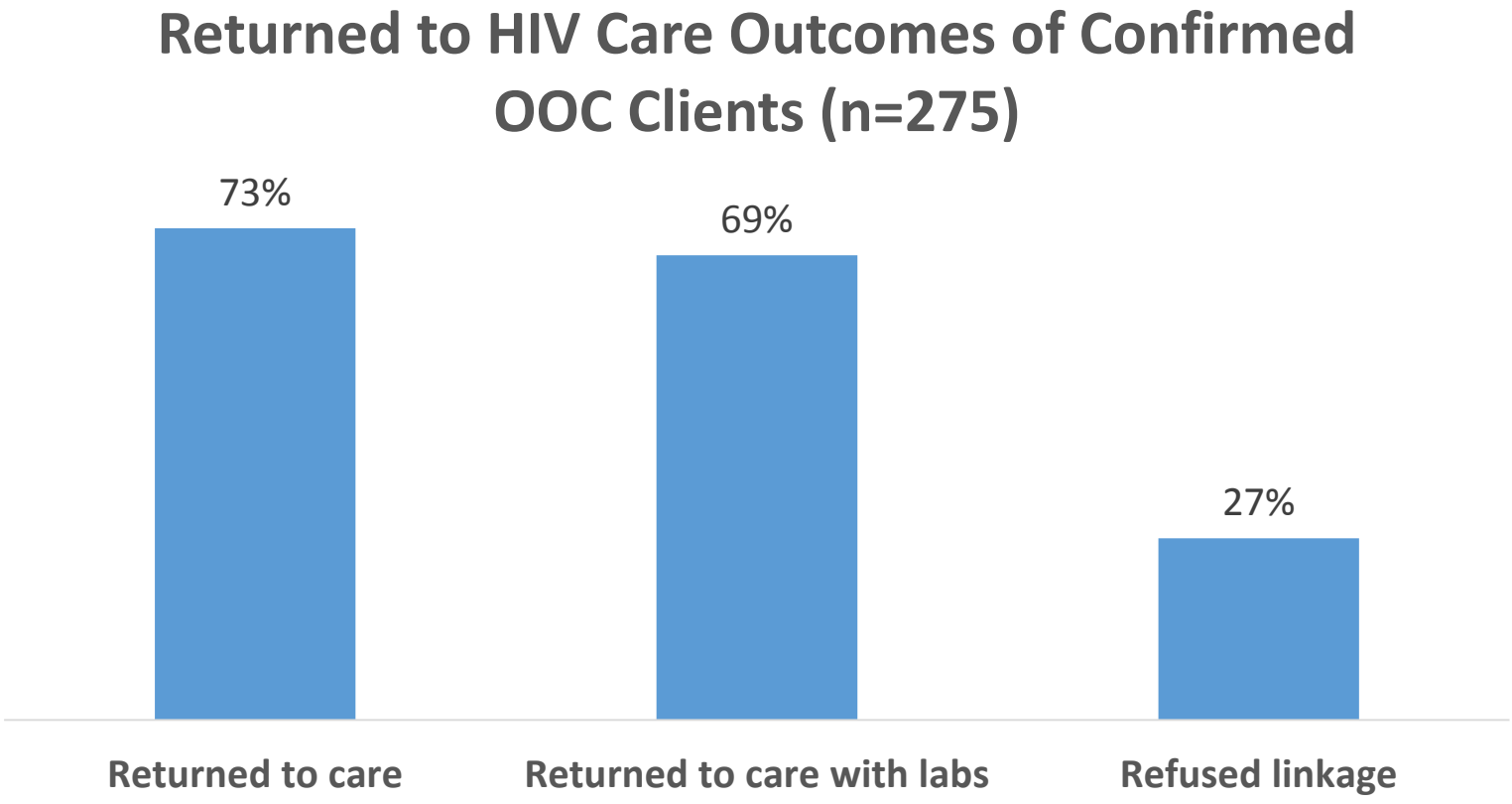
FSU HIV/HCV CO-INFECTION OUTREACH OUTCOMES

CASES ASSIGNED FROM 2016 TO 2017

FLOW CHART OF HIV AND HCV CO-INFECTION PRESUMED OUT OF CARE (OOC) ASSIGNED FOR LINKAGE TO CARE OUTREACH IN NYC, 2016 – 2017



RETURNED TO HIV CARE OUTCOMES, 2016-2017



Returned to care: patient kept the appointment
Returned to care with labs: patient kept the appointment and had CD4/VL labs done
Refused linkage: patient refused FSU linkage service

HCV EVALUATION AFTER RETURNED TO CARE, 2016-2017

Returned to HIV Care (N=202)	N	%
Hepatitis C (HCV) Screening		
Total number screened for HCV (Preliminary or Confirmatory)	93	46%
Preliminary HCV Positive (AB^+)	28	14%
Confirmed HCV Positive ($NAAT/RNA^+$)	68	34%
Confirmed HCV Negative ($NAAT/RNA^-$)	25	12%

HCV TREATMENT

Confirmed HCV Positive (NAAT/RNA+) (n=68)	N	%
Currently on treatment	14	21%
Referred to treatment	17	25%
Treatment deferred due to medical conditions	19	28%
Insurance issue	3	4%
Other reason not on treatment -		
Patient refused treatment	10	15%
Incarcerated	1	1%
Don't know/Missing	4	6%

CHALLENGES & LESSONS LEARNED

CHALLENGES

- Client -
  - Clients lack of HCV knowledge and do not think HCV is their top priority (e.g. other medical conditions)
  - Concerns about side effects of the medication
  - Many clients also had substance, alcohol, or mental health issues
- Provider -
  - Lack of communication between provider and client
  - Providers do not want to initiate treatment immediately (e.g. too high HIV viral load, not compliant to the follow-up appointment)
- Administrative & Data -
  - Some insurance does not cover the medication - high cost of the medication
  - Substantial number of clients subsequently tested HIV negative during case investigation (e.g. misreported HCV viral load as HIV viral load)

LESSON LEARNED

- Build relationship with clients
- Reduce stigma and increase willingness to care by educating clients about HCV
- Methadone program can be helpful to link people to HIV care and HCV evaluation
- Work with HCV care coordinators (Project INSPIRE: NYC Hep C Care Coordination Program)

THANK YOU

QUESTIONS?