RAPID* ART Initiation in San Francisco

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*Rapid ART Program Initiative for New Diagnoses
Presenter Disclosure

• Presenter: Oliver Bacon, MD, MPH

• Relationships with commercial interests
  • Gilead Pharmaceuticals provided study drug for the US PrEP Demonstration Project (not related to this talk)
Roadmap

• “Getting to Zero” in San Francisco
• RAPID: Immediate ART
  • Rationale
  • RAPID Pilot at UCSF/San Francisco General Hospital
• Taking RAPID citywide
  • Implementation strategy: Linkage, Care, Evaluation
  • RAPID Clinical Basics
  • Lessons learned in 2016
Case

• 26 y.o. MSM
• Referred to you after (+) lab-based 4th generation Ag/Ab test and multispot yesterday afternoon while screening for PrEP
• CBC, transaminases normal; CrCl 80 mL/min
• CD4, HIV RNA pending
• Resistance genotype, HLAB5701 not sent
• Makes $14,000/yr as a bike messenger, supplements with odd jobs, sex work
• No Insurance
would you....

1. **Wait** 2 weeks for results of baseline testing, then start antiretroviral therapy with DTG/3TC/ABC or EVG/COBI/FTC/TAF

2. **Start antiretroviral therapy today?**

3. Ask him about recent sex partners, contact them for HIV testing and, if uninfected, **offer them PrEP (Pre-exposure prophylaxis)?**
SF getting to Zero (G2Z): By 2020
- 90% fewer HIV Infections
- 90% fewer HIV Deaths
- Zero stigma and discrimination
New HIV Cases and HIV-related Deaths, by Year: 2006-2015

- **2006:** HIV test w/o written consent
- **2008:** PHAST
- **2009:** 2006: HIV test w/o written consent
- **2010:** ART at diagnosis; HIV test scale-up
- **2011:** LINCS
- **2012:** PrEP
- **2013:** RAPID Pilot
- **2015:** 2013: RAPID Pilot

**Notes:**
- **2005:** PHAST
- **2006:** HIV test w/o written consent
- **2010:** ART at diagnosis; HIV test scale-up
- **2011:** LINCS
- **2012:** PrEP
- **2013:** RAPID Pilot

SFDPH HIV Epidemiology Annual Report 2015
HIV Care Cascade in San Francisco

1: confirmed HIV test
2: latest VL<200 c/ml within 12 mo of diagnosis

SFDPH HIV Epidemiology Annual Report 2015
## Table 3.2: Care indicators among persons newly diagnosed with HIV in 2014 by demographic and risk characteristics, San Francisco

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of diagnoses(^1)</th>
<th>% Linked to care within 1 month of diagnosis(^2)</th>
<th>% Linked to care within 3 months of diagnosis(^2)</th>
<th>% Retained in care 3-9 months after linkage(^2)</th>
<th>% Virally suppressed within 12 months of diagnosis(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>334</td>
<td>84%</td>
<td>91%</td>
<td>73%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>313</td>
<td>85%</td>
<td>90%</td>
<td>72%</td>
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<tr>
<td>Female</td>
<td>14</td>
<td>64%</td>
<td>93%</td>
<td>93%</td>
<td>79%</td>
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<tr>
<td>Transfemale</td>
<td>7</td>
<td>71%</td>
<td>100%</td>
<td>86%</td>
<td>71%</td>
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<tr>
<td><strong>Race/Ethnicity</strong></td>
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<tr>
<td>White</td>
<td>143</td>
<td>87%</td>
<td>94%</td>
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<td>76%</td>
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<tr>
<td>African American</td>
<td>36</td>
<td>67%</td>
<td>81%</td>
<td>64%</td>
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<tr>
<td>Latino</td>
<td>96</td>
<td>81%</td>
<td>88%</td>
<td>71%</td>
<td>78%</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>42</td>
<td>88%</td>
<td>93%</td>
<td>76%</td>
<td>86%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>17</td>
<td>94%</td>
<td>94%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Age at Diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-24</td>
<td>37</td>
<td>76%</td>
<td>84%</td>
<td>65%</td>
<td>73%</td>
</tr>
<tr>
<td>25-29</td>
<td>54</td>
<td>93%</td>
<td>98%</td>
<td>81%</td>
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<tr>
<td>30-39</td>
<td>101</td>
<td>75%</td>
<td>85%</td>
<td>63%</td>
<td>67%</td>
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<tr>
<td>40-49</td>
<td>81</td>
<td>89%</td>
<td>91%</td>
<td>79%</td>
<td>78%</td>
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<tr>
<td>50+</td>
<td>61</td>
<td>87%</td>
<td>97%</td>
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<td><strong>Transmission Category</strong></td>
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<tr>
<td>MSM</td>
<td>253</td>
<td>84%</td>
<td>91%</td>
<td>75%</td>
<td>78%</td>
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<tr>
<td>PWID</td>
<td>19</td>
<td>79%</td>
<td>95%</td>
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<td>63%</td>
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<tr>
<td>MSM-PWID</td>
<td>37</td>
<td>86%</td>
<td>89%</td>
<td>65%</td>
<td>57%</td>
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<tr>
<td>Heterosexual</td>
<td>11</td>
<td>82%</td>
<td>100%</td>
<td>82%</td>
<td>91%</td>
</tr>
<tr>
<td>Other/Unidentified</td>
<td>14</td>
<td>79%</td>
<td>86%</td>
<td>57%</td>
<td>57%</td>
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<tr>
<td><strong>Housing Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Housed</td>
<td>298</td>
<td>83%</td>
<td>90%</td>
<td>73%</td>
<td>77%</td>
</tr>
<tr>
<td>Homeless</td>
<td>36</td>
<td>89%</td>
<td>94%</td>
<td>69%</td>
<td>53%</td>
</tr>
</tbody>
</table>

\(^1\) Includes persons diagnosed in 2014 based on a confirmed HIV test and does not take into account patient self-report of HIV infection.

\(^2\) Percent of total diagnoses.
Universal ART = better care and prevention

• Delivering ART as early as possible after a new diagnosis of HIV:
  • improves morbidity and mortality in all stages of infection (START INSIGHT Team NEJM 2015)
  • in acute/recent HIV infection: limits reservoirs and hyper-infectivity (Jain et al. JID 2013; Saez-Cirion et al. VISCONTI team, PLoS Pathog. 2013)
  • reduces transmission by 96% (HPTN052--Cohen et al. NEJM 2011)

• Typical interval of weeks to months between diagnosis, ART, and virologic suppression=lost opportunities
  • Delayed or dropped linkage, retention
  • More immunologic dysfunction
  • More onward Transmission
Pilot: RAPID at San Francisco General Hospital HIV Clinic
UCSF HIV/AIDS DIVISION – San Francisco General Hospital
Clinic Statistics
FY 2013-2014

Started in 1983
2,700 Primary care patients
14,000 Primary care visits/yr

CLINICS

HIV Primary Care
HIV Specialty Care
(Psych, GYN, Derm, Pulmonary, Anal dysplasia)
HIV Urgent Care
Hep C Coinfection
Women’s Clinic
SALUD Clinic
(Hispanic/Latino patients)
RAPID/PHAST Clinic
(HIV testing and Linkage to Care)
PrEP – Pre-Exposure Prophylaxis

GENDER
11% women
85% men
4% TG

RACE/ETHNICITY
6% Asian/PI
22% African American
21% Hispanic/Latino
49% White

AGE
Average age: 44
Range: 18-84
<30: 16%

INSURANCE STATUS
Public 78%
Uninsured 21%
Private 1%

RISK FACTORS
Homeless 6%
Mental Illness/Active Substance Use 33%
Hep C 40%

ART
93% prescribed ART
84% virologic suppression (<200)
RAPID Demonstration Project
July 2013-December 2014

• Overall feasibility of a health systems intervention for **same-day outpatient ART for newly diagnosed HIV infection**

• Deployed in context of extensive existing services for navigation, linkage and retention

• Select ART regimens, flexible scheduling

• Initially targeted to new patients with acute HIV infection (HIV Ab – within 6 months)

• Extended in 2014 to include active 0I, CD4<200

Pilcher, IAS 2015
Milestones of care: SFGH, 2006-2013

2006-2009
CD4-guided ART

2010-2013
Universal ART

Days since Referral

Pilcher, IAS 2015
The SFGH RAPID Model

HIV+ Diagnosis
- Disclosure
- Referral
- Scheduling

1st Clinic Visit
- Registered
- Insured
- Housing/SU/MH
- Counseling
- Labs

1st PCP Visit
- Medical evaluation
- ART criteria met

ART start
- Pills taken

Viral load suppressed
- VL monitoring
- Adherence
- Retention

RAPID visit: ART start
- Disclosure, counseling
- Registration
- Insurance
- Housing/SU/MH
- Labs
- Counseling
- Medical eval

PCP Visits
- VL monitoring
- ART management
- Adherence
- Retention

Pilcher, IAS 2015
New SFGH patients, RAPID era: 2013-4

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAPID Cohort (n=39)</th>
<th>Universal ART (n=47)</th>
<th>P-value</th>
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<tbody>
<tr>
<td><strong>Sociodemographics</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Age: mean(range)</td>
<td>32 (21-47)</td>
<td>35 (19-68)</td>
<td>NS</td>
</tr>
<tr>
<td>Male: n (%)</td>
<td>39 100%</td>
<td>43 92%</td>
<td>NS</td>
</tr>
<tr>
<td>Non-white ethnicity</td>
<td>23 59%</td>
<td>34 71%</td>
<td>NS</td>
</tr>
<tr>
<td>Homeless</td>
<td>11 28%</td>
<td>13 25%</td>
<td>NS</td>
</tr>
<tr>
<td>Uninsured</td>
<td>39 100%</td>
<td>47 100%</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Staging</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute (Ab- &lt;6m)</td>
<td>21/30 70%</td>
<td>8/31 26%</td>
<td>0.001</td>
</tr>
<tr>
<td>$\log_{10} VL$</td>
<td>4.9 (2.8-6.6)</td>
<td>4.5 (1.6-6.1)</td>
<td>NS</td>
</tr>
<tr>
<td>CD4 mean (range)</td>
<td>474 (3-1391)</td>
<td>417 (11-1194)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Pilcher, IAS 2015
## RAPID program era 2013-4: acceptability and safety

*Pilcher, IAS 2015*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAPID (n=39)</th>
<th>Universal (n=47)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptability</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall ART uptake</td>
<td>39 (100%)</td>
<td>40 (85%)</td>
<td>NS</td>
</tr>
<tr>
<td>Engaged in care (appt &lt;6 mos)</td>
<td>35 (90%)</td>
<td>40 (85%)</td>
<td>NS</td>
</tr>
<tr>
<td>Transferred care</td>
<td>8 (21%)</td>
<td>11 (23%)</td>
<td>NS</td>
</tr>
<tr>
<td>Provider switched</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ART simplification</td>
<td>10 (26%)</td>
<td>0 (0%)</td>
<td><strong>0.001</strong></td>
</tr>
<tr>
<td>ART Toxicity</td>
<td>2 (5%)</td>
<td>0 (0%)</td>
<td>NS</td>
</tr>
<tr>
<td>Genotype-driven modification</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>NS</td>
</tr>
</tbody>
</table>

*all outcomes determined as of last followup (up to 18 months post referral)
Engagement Timeline, SFGH

CD4-guided (2006-9)
- Referral
- 1st Clinic Visit
- 1st PCP Visit
- ART Prescribed
- Viral load suppressed

Universal (2010-3)
- Referral
- 1st Clinic Visit
- 1st PCP Visit
- ART Prescribed
- Viral load suppressed

RAPID
- Referral
- 1st Clinic Visit
- 1st PCP Visit
- ART Prescribed
- Viral load suppressed

Pilcher, IAS 2015
Patients want same day ART.

Acceptance of same day ART

Proportion of patients on ART

Days after ART offer

RAPID

Universal

Pilcher, IAS 2015
“There was about 10 seconds of so many thoughts. She (the doctor) pulled out the 5-day starter pack, and I saw the future rolling down the strip of pills in front of me......meaning, this is how I’m going start, and I really didn’t see an end to it. It was a reality check. This was going to be my future, like, what have you done, why did you do it....and, for a few seconds, what’s going to happen, and what if I can’t afford these pills? .......... And then all of a sudden, you come to terms with it, and you’re ok, you feel like you’re going to be ok, you’ve gone through the worst of it, the uncertainty: it’s shortened to only 10 seconds, and then you’re sure you’re going to take those two pills every day, and there’s no second guessing. Short and sweet. You’re in, and oh my God, then you’re done and you walk out and it’s done: a new day, and you can focus on getting better, finding a job, protecting your health, putting a roof over your head, and know that you will be ok. So then, there’s nothing to think about. And basically that was it.”
Qualitative Lessons from Interviews with RAPID Pilot Team Members: Keys to Success

1. Single point-of-contact for referrals activates the team (e.g. PHAST Pager)
2. Committed team is essential (Counseling, Benefits Navigation, Clinical): roles more important than titles
3. Avg. RAPID intake 2 hours
4. Minimize handoffs: Every handoff is a warm handoff
5. Have a plan for medication access
   - Emergency ADAP
   - Presumptive Medi-Cal
   - Pharma Patient Assistance Cards
   - Starter packs?
6. Schedule follow-up in 5-7 days and check in with patient in the 1-2 days after he/she leaves the appointment
Taking RAPID Citywide
The Goal of RAPID is to improve the health of newly diagnosed patients by eliminating delays in ART and access to high-quality HIV care. This means:

• Starting ART the same day as someone is newly diagnosed with HIV (or within 5 days if same-day start is impossible)
• Their first follow-up visit with HIV 1° care within a week after starting ART
• Sometimes RAPID patients will be referred to you at Step III, having already started ART.
• Sometimes RAPID patients will undergo all Steps I-III or II-III at your clinic (especially if they were your patients when they were HIV-uninfected.)
Mapping the City for RAPID: Where do New Cases Test, Link

Testing Sites

RAPID PROCESS: within 48 hours of Diagnosis
- Disclosure
- Counseling
- Partner Services
- Medical Evaluation
- Benefits/Insurance Navigation and Rapid Enrollment
- Linkage to HIV Primary Care within 5 Days
- Immediate ART (Starter Pack or Prescription)

HIV Primary Care Sites

Insurance Status: 46% Private  38% Public/Uninsured
Plan for Taking RAPID ART Citywide

**Capacitating Testing/Linkage Sites**

*Goal: ≤ 5 days to*
- Disclosure
- Counseling
- Benefits navigation and enrollment
- Linkage to ART/HIV 1° care intake

*Approach*
- Buy-in from Leadership at testing, linkage sites
- In-service training
- Linkage Protocol
- RAPID Provider Directory

**Capacitating ART Providers**

*Goal: at intake*
- Medical evaluation
- Baseline testing
- Offer immediate ART

*Approach*
- Protocol
- Outreach
  - HIV prevalence
  - Special populations
- In-services
- Academic Detailing
- Ongoing Support

**Data**

*Goals:*
- Mapping the Landscape of testing, linkage, care
- Interviews w Patients, Care Teams
- Collection of performance data
  - Uptake
  - Time to ART start
  - Regimens used
  - % linked
  - Sites of care
  - Retention
  - Time to viral suppression
  - Durable suppression

*Approach*
- Local Surveillance data
- LINCS data
- Sentinel sites?
Clinical Management Issues:
Who is eligible for immediate ART?

- Anyone with a new, confirmed HIV diagnosis unless there is a clear contraindication to starting immediate ART.

Who is not eligible for immediate ART?

- Patients for whom immediate ART might be medically dangerous and who should undergo a thorough evaluation and stabilization before ART:
  - Untreated cryptococcal meningitis (defer ART for 5 weeks after the diagnosis, antifungal treatment initiation)
  - Pulmonary or gastrointestinal kaposi sarcoma before chemotherapy (usually Doxil) has been started

Who might be eligible for immediate ART?

- Patients re-engaging in care with clear, uncomplicated ART history, low likelihood of resistance?
Laboratory Evaluation for RAPID Patients

- Confirmatory HIV testing (if needed)
- HIV RNA
- HIV genotype
- Integrase genotype (if available)
- CD4+ T cell count
- HLAB5701 polymorphism testing
- RPR, HAV IgG antibody, HBsAg, HBeAb, HBsAb, HCV antibody
- CBC
- Renal
- Liver
- Lipids
- QFT
- Toxo
# Recommended RAPID Treatment Regimens

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Pill Burden</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| dolutegravir 50 mg once daily tenofovir-DF 300mg/emtricitabine 200mg once daily | 2 pills once daily | • Rapid drop in VL with INSTI class  
• DTG well tolerated  
• DTG appears to have high genetic barrier to resistance  
• once daily dosing                                                      | • Limited experience                                                                  |
| darunavir 800 mg once daily ritonavir 100 mg once daily tenofovir-DF 300mg/emtricitabine 200mg once daily | 3 pills once daily | • PI class has high genetic barrier to resistance  
• clinical experience suggests efficacy even if M184V present  
• once daily dosing                                                      | • Drug interactions (ritonavir a CYP3A4 inhibitor)                                      |
| raltegravir 400 mg twice daily tenofovir-DF 300mg/emtricitabine 200mg once daily | 1 pill BID + 1 pill daily | • Rapid drop in VL with INSTI class  
• RAL well tolerated                                                      | • BID dosing for RAL                                                                  |
| Once daily coformulated TAF 10mg/emtricitabine 200mg/elvitegravir 150mg/ cobicistat 150mg | 1 pill once daily | • Rapid drop in VL with INSTI class  
• Lowest pill burden  
• once daily dosing                                                      | • Drug interactions (cobicistat a CYP3A4 inhibitor)  
• possibility of INSTI, NRTI resistance with failure seen in licensing trials  
• Not for use if CrCl<30 mL/min                                             |

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FTC/TDF can be replaced by FTC/TAF when used with an integrase inhibitor. The combination of FTC/TAF plus a boosted PI was studied with TAF 10mg. The renal effects of TAF 25mg (the dose available in the US) when given with a boosted PI are uncertain.
ARVs to AVOID until results of genotype, HLAB5701 are known

• 1st, 2nd generation NNRTIs (efavirenz, nevirapine, etravirine, rilpivirine): NNRTI class most associated with transmitted drug resistance; efavirenz neuropsychiatric side effects; nevirapine associated with hepatotoxicity; rilpivirine less potent if baseline VL>100,000 c/mL

• Abacavir-containing regimens (including abacavir co-formulations such as Epzicom® and Triumeq®): high risk of fatal abacavir hypersensitivity reaction if HLA-B5701(+).
Prevalence of Drug Resistance Mutations in Treatment-Naive Patients, 2000-2013

- Baseline plasma samples from 4 phase III trials (GS 903, 934, 104, 111, N = 2531)
  - 1617 samples analyzed for integrase mutations
  - 2531 analyzed for protease or RT mutations
- Substantial \( \uparrow \) in prevalence of NNRTI resistance, modest \( \uparrow \) in PI resistance
- Stable prevalence of NRTI resistance (mostly TAMs)
  - M184V/I \( \leq 0.2\% \); K65R \( \leq 0.2\% \)
- Little evidence of transmitted INSTI resistance over period
  - Mostly T97A polymorphism

RAPID Pilot: transmitted resistance by Class

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAPID (n=39)</th>
<th>Universal ART (n=47)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transmitted resistance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>8/32 25%</td>
<td>18/43 42%</td>
<td>NS</td>
</tr>
<tr>
<td>Major NNRTI-R</td>
<td>7 22%</td>
<td>11 26%</td>
<td>NS</td>
</tr>
<tr>
<td>Major PI-R</td>
<td>1 3%</td>
<td>2 5%</td>
<td>NS</td>
</tr>
<tr>
<td>Major NRTI-R</td>
<td>0 0%</td>
<td>1 2%</td>
<td>NS</td>
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<tr>
<td><strong>Regimen</strong></td>
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<tr>
<td>INI-based</td>
<td>35 90%</td>
<td>31 83%</td>
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</tr>
<tr>
<td>PI-based</td>
<td>4 10%</td>
<td>5 10%</td>
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Pilcher, IAS 2015
# RAPID Insurance Issues

<table>
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<th>Insurance</th>
<th>Income</th>
<th>Resolution</th>
<th>+/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>&lt;138% FPL*</td>
<td>Medicaid</td>
<td>Rapid (0-2 d) enrollment/linkage</td>
</tr>
<tr>
<td>Uninsured</td>
<td>&gt;138% FPL*</td>
<td>Subsidized Commercial Plan (ACA/”Obamacare”)</td>
<td>Difficult enrollment/linkage</td>
</tr>
<tr>
<td>Uninsured, ACA/Medicaid ineligible</td>
<td>&lt;400%FPL</td>
<td>Ryan White Funding Sliding Scale Self-Pay “Healthy SF”</td>
<td>Rapid (0-2 d) enrollment/linkage</td>
</tr>
<tr>
<td>Insured: Medicaid</td>
<td></td>
<td>Meds/Labs/Care Covered, no assistance needed</td>
<td></td>
</tr>
<tr>
<td>Insured w high copay**</td>
<td></td>
<td>Public and Pharma Copay Assistance (rapid activation in 0-2 days)</td>
<td></td>
</tr>
</tbody>
</table>

*FPL=Federal Poverty Limit
$16,395 = 138% of FPL for a single person (2016)
**including ACA (subsidized) plans
Lessons Learned in 2016:
2016: Outreach to HIV 1° Care Sites

Strategy
1. Outreach to Clinic Leadership
2. All-staff discussion/In-service
3. Individual provider detailing
4. Follow-up

Implementing RAPID
- UCSF/SF General (W86)
- Kaiser SF
- San Francisco City Clinic
- Larkin (youth)
- Family Health Center

In-Process
- Castro Mission
- Southeast
- Tom Waddell
- Mission Neighborhood

47% Of new HIV+s

On the List
- Private Practices
- UCSF University Hospital
- St Mary’s
- SFVAMC
- One Medical
- Community Consortium Clinics
2016: Lessons Learned

1. Provider acceptance high

2. Greatest challenge: linkage/insurance navigation
   1. Medi-Cal/eligible: easy
   2. Insured (incl Kaiser): easy
   3. ACA-eligible or enrolled/not established in care most difficult: drug studies fill a gap, for now.....
   4. Student visas: more difficult

3. Disparities a challenge

4. New HIV infections “on” PrEP
   1. Determine last dose (>1 week before likely infection?)
   2. Consider PI/r + DTG + FTC/TDF until baseline genotype results
Goals for 2016-17

• Implement, evaluate systematic RAPID detailing
• Detail all HIV providers on RAPID
• RAPID linkage navigation “bootcamp” for navigators/test sites
• “Bridging” RAPID ART site to care for difficult-to-link patients using Government funds while they are being navigated?
• Evaluation metrics
Evaluation Goals

• Working with Surveillance to refine citywide RAPID Metrics: for new outpatient HIV diagnoses
  - Days from diagnosis to first care visit
  - Days from first care visit to ART start
  - Days from ART start to virologic suppression
  - % with ART start within 1, 3, 5, 7 days of diagnosis
  - 6, 12 month retention

• Patient experience of RAPID
• Provider experience of RAPID

Qualitative Interviews
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Extra Slides
Persons Living with Diagnosed or Undiagnosed HIV Infection
HIV Care Continuum Outcomes, 2012 — United States and Puerto Rico

N = 1,218,400

2012

Diagnosed Received medical care Prescribed ART Viral Suppression

87.2 39.1 36.2 30.2

National HIV Surveillance System: Estimated number of persons aged ≥13 years living with diagnosed or undiagnosed HIV infection (prevalence) in the United States at the end of 2012. The estimated number of persons with diagnosed HIV infection was calculated as part of the overall prevalence estimate.

Medical Monitoring Project: Estimated number of persons aged ≥18 years who received HIV medical care during January to April of 2012, were prescribed ART, or whose most recent VL in the previous year was undetectable or <200 copies/mL—United States and Puerto Rico.

United States Centers for Disease Control and Prevention
RAPID

Intervention Components

• Facilitation of same day appointments (PHAST* Team)
  • paged with any new confirmed HIV+ patients on SFGH campus
  • paged by testing sites in SF with any new HIV+ with no/public insurance (i.e., SFGH eligible)

• Flexible scheduling for providers (on-call back-up)
• ART regimens pre-approved for use prior to genotyping or lab testing
• Available as 5 day starter packs
• Accelerated process for health insurance initiation (PHAST Team)
• Recommendation for 1st dose to be taken observed in the clinic

*Positive Health Access to Services and Treatment

Adapted from Pilcher, IAS 2015
Median Time to VL suppression by ART initiation strategy: SFGH 2006-2014

Pilcher, IAS 2015
Antiretrovirals used in RAPID Pilot

- FTC/TDF + DTG  26 (67%)
- EVG/COBI/FTC/TDF  7 (18%)
- FTC/TDF + DRV/r  4 (10%)
- FTC/TDF + RAL  1 (2%)
- DTG/3TC/ABC  1 (2%)