



# LINCS update 2018

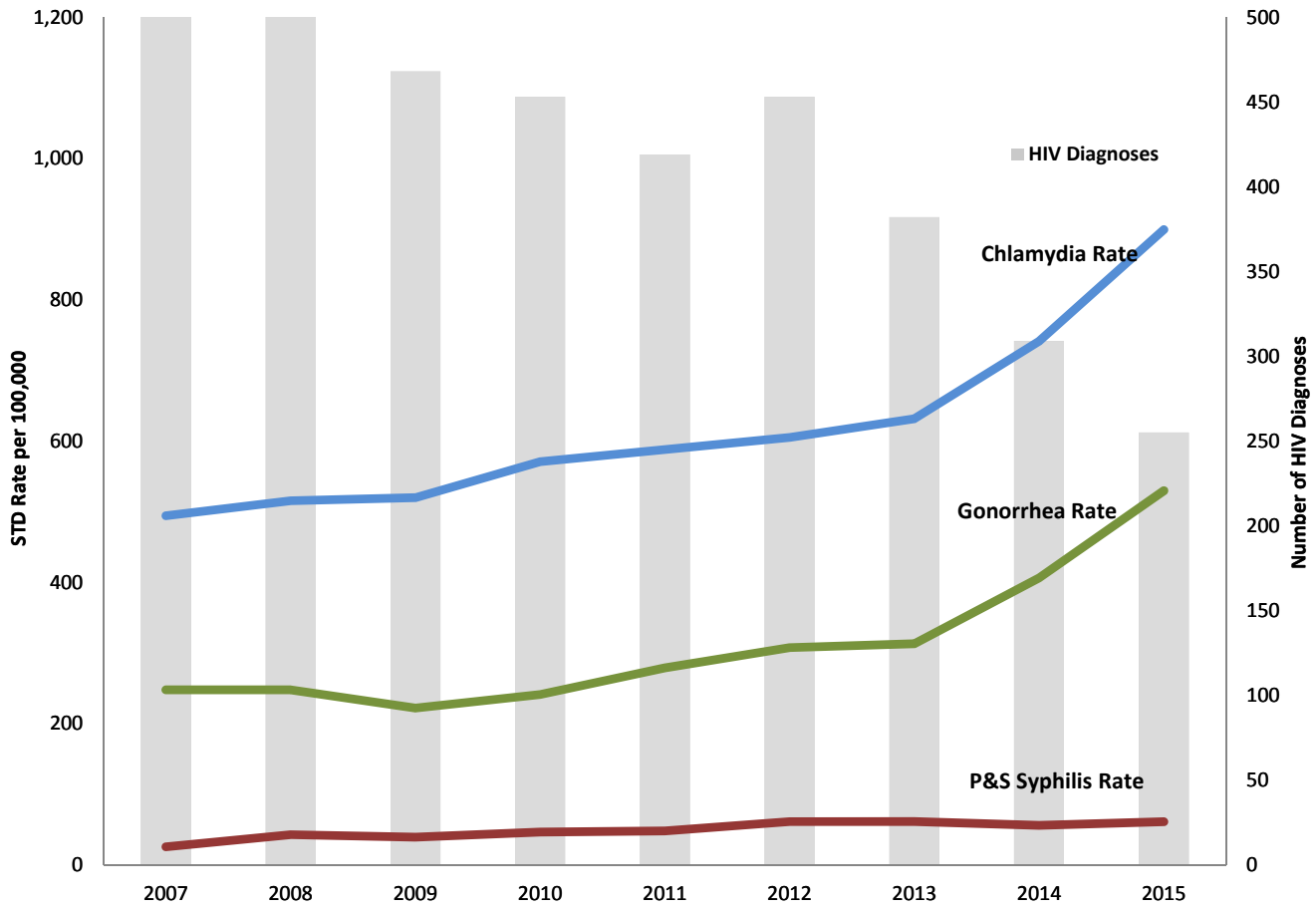
May 21, 2018

Susan Philip, MD, MPH, Darpun Sachdev, MD

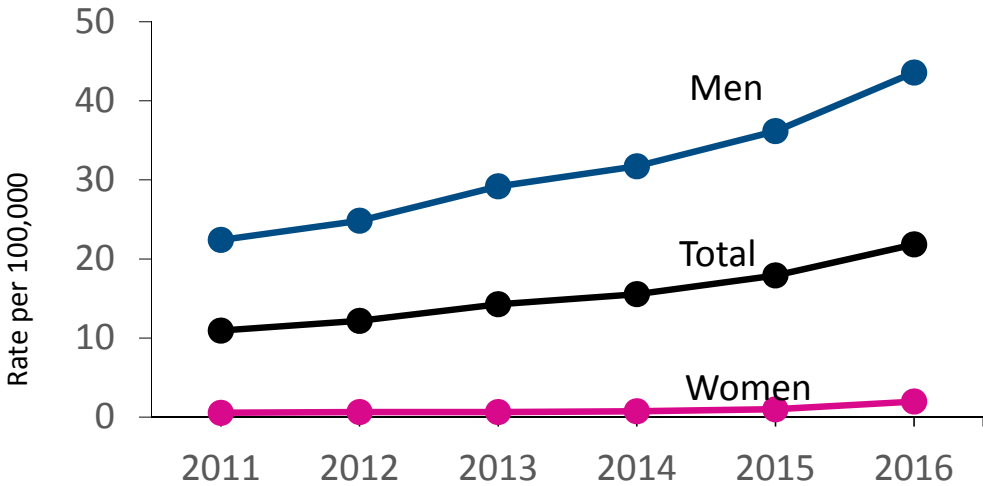
Erin Antunez, MA, Rebecca Shaw, Mark O'Neil

Panelists: Jason Chadderdon, Hugh Gregory, Patrick Kinley, Julianne O'hara

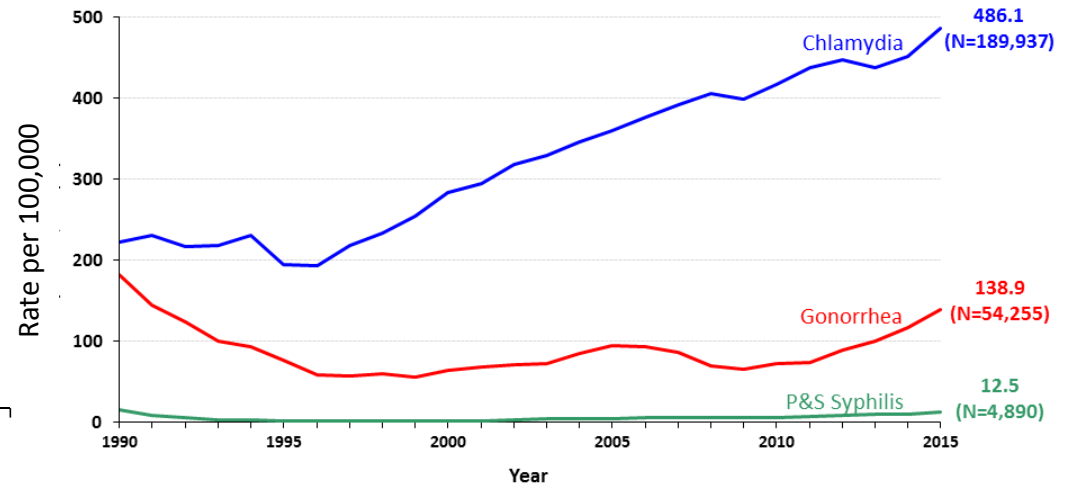
# In SF, STD Increases are Occurring Even as HIV Diagnoses Decline



# STD Increases are Occurring in other Cities and States



Primary and Secondary Syphilis Rates in NYC

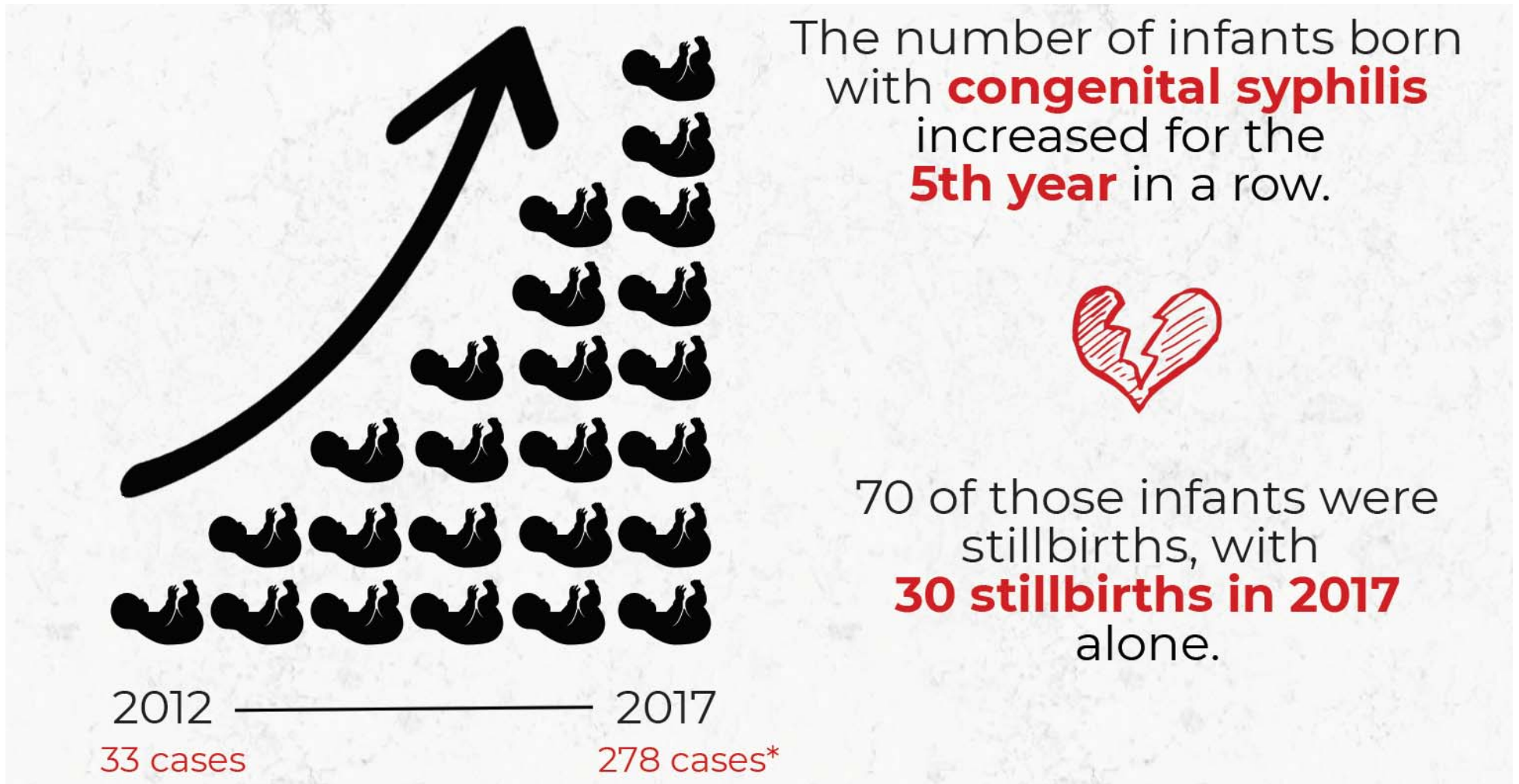


Chlamydia, Gonorrhea, and Syphilis Rates in CA

# Priority Populations are Those at Highest risk for STDs or Severe Complications of STDs

- Gay and Bisexual Men and other Men who have sex with Men (MSM)
- Adolescents and Young Adults of Color
- Transgender persons
- Pregnant women (preventing congenital syphilis)

## Syphilis in California: A focus on women



# What is the LINCS team?

**LINCS is your link to sexual health**

**Have you been tested for syphilis?**

- If you have syphilis, getting treated today will help keep you healthy, and will prevent the spread to your partners
- We recommend testing for STDs every 3 months

**Are you or your partners interested in PrEP?**

- PrEP is a daily pill that prevents HIV by more than 90%
- We have a team who can help you get PrEP regardless of insurance status

**Living with HIV and haven't seen a doctor in 6 months?**

Our team can help you:

- Get into HIV care
- Stay healthy on medications to keep your viral load low so you don't transmit HIV

**WHAT IS PARTNER SERVICES?**

It can be difficult to tell your partners you have HIV or an STD. Our specialists can contact partners and get them free testing and treatment, while protecting your privacy.

To get LINCed, call us at 415-487-5536 | [www.sfcityclinic.org](http://www.sfcityclinic.org)

*LINCS is the city's team ensuring comprehensive sexual health.*

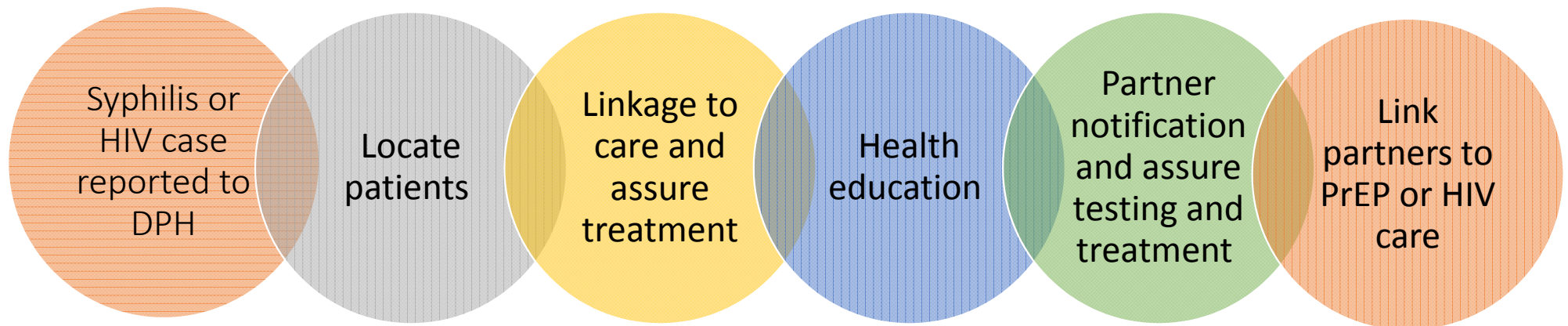
**LINCS is the city's team ensuring access to free and confidential sexual health services**

Syphilis and HIV partner services and navigation to care

# What does the LINCS team do?

## **Disease intervention and navigation to health services**

**We work closely with clinical providers and surveillance data to ensure patients and partners are linked to sexual health services**



## Who do we work with?

- All people diagnosed with syphilis or HIV or at City Clinic
- Homeless and marginally housed
- Injection drug users
- Pregnant women

## How do we do it?

- Prioritize!
- Field outreach
- High standards of confidentiality
- Client centered
- Motivational interviewing
- Harm reduction
- **Tenacity**



# New initiatives to highlight

- Developing standard work (“best practices”) on how to locate and link clients
- Field-based Navigation



## Creating a standard work of locating homeless clients



- Gather more detailed contact info from clients during every interaction
  - Phone
  - If homeless, where they stay/tent color
  - Emergency contacts
- Reviewing clinical notes and records
- Emergency room searches
- Pharmacy records for medication pickups
- Jail records
- Lexis-Nexis (addresses) and DMV
- New pilot: Consent clients to contact via facebook messenger!

# Standardizing city-wide resources for HIV linkage to care



**RAPID CARE OPTIONS IN SF**

[tinyurl.com/RapidOptionsInSF](https://tinyurl.com/RapidOptionsInSF)



**HIV NAVIGATION OPTIONS IN SF**

[tiny.cc/HIVNavigationOptionsInSF](https://tiny.cc/HIVNavigationOptionsInSF)



**HIV CARE OPTIONS IN SF**

A guide to clinics, providers, and the healthcare coverage they accept.

[tiny.cc/HIVNavigationOptionsInSF](https://tiny.cc/HIVNavigationOptionsInSF)



**HIV BENEFITS OPTIONS IN SF**

How to pay for health care and medication so you can stay in care and undetectable

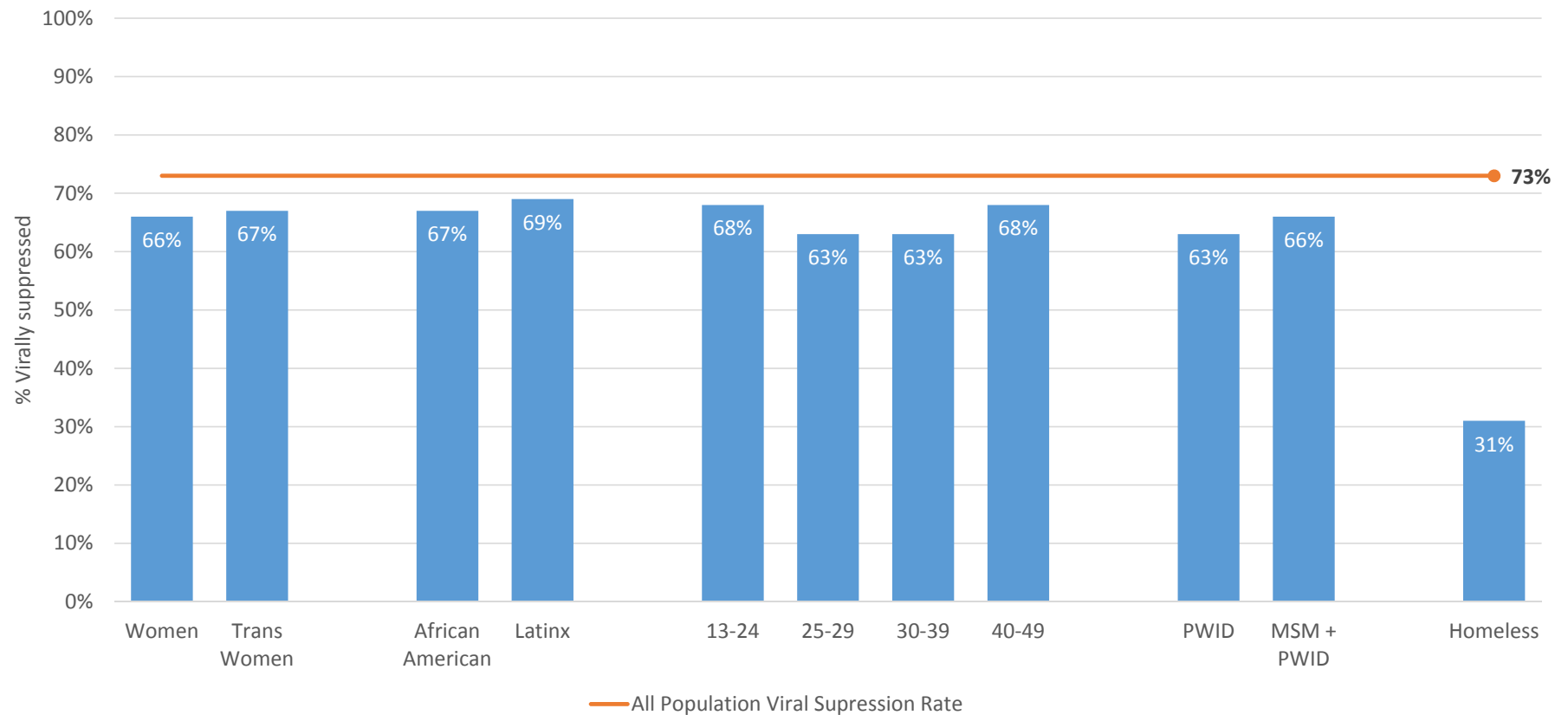
[tiny.cc/HIVNavigationOptionsInSF](https://tiny.cc/HIVNavigationOptionsInSF)

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- Developing standard work (“best practices”) on how to locate and link clients
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# Still More Work to Do: Disparities in Viral Suppression



Source: SFDPH HIV Epidemiology Section

# Levels of HIV Care Available to Our Patients

## SF Model – Meeting People Where they Are



Panel management  
Appointment reminders  
Missed visit follow-up  
Routine review of panel to ensure engagement

*Standard practices;  
clinic-based*



Centers of Excellence (CoE)  
Focus on mental health, substance use, stigma, and other barriers

*Longer-term;  
Primarily clinic-based*



Intensive case management  
Intensive support with medical & psychosocial;

*Longer-term  
Community-based*

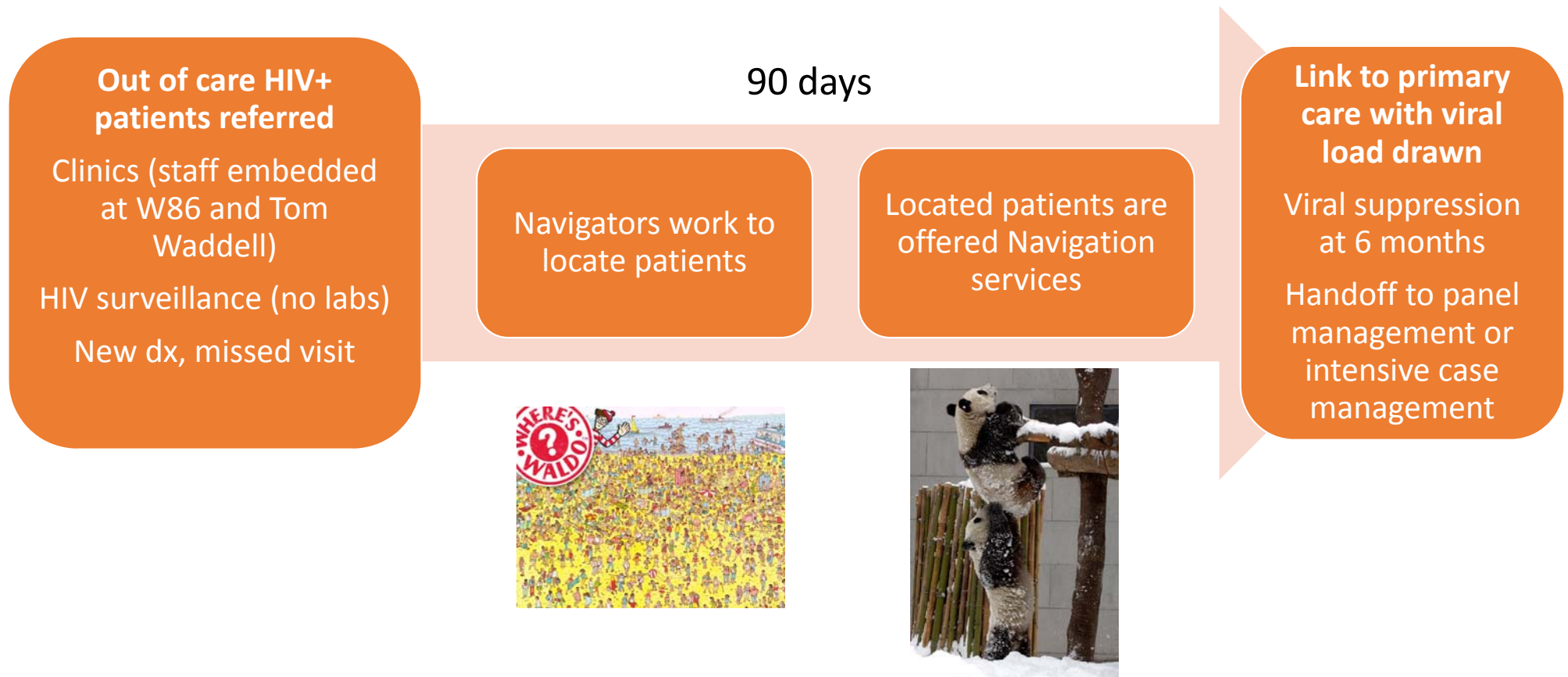


Mobile Medical and Case Management  
Directly Observed Therapy program  
HHOME, Health at Home

*Short-term;  
Community-based*

**LINCS Navigation: Provide time-limited and field-based outreach to re-link patients to care**

# LINCS Navigation=direct outreach for re-linkage



**Table 3.5 Care Indicators among persons who accepted and completed LINCS services in 2015 by demographic and risk characteristics, San Francisco**

	Number of referred to LINCS	Number of accepted and completed LINCS	% Linked to care within 3 months of LINCS initiation <sup>1</sup>	% Retained in care 3-9 months after linkage <sup>1</sup>	% Virally suppressed at most recent test in 12 months after LINCS initiation <sup>1</sup>
<b>Total</b>	<b>209</b>	<b>106</b>	<b>90%</b>	<b>64%</b>	<b>68%</b>
<b>Gender</b>					
Male	172	83	89%	66%	72%
Female	23	16	94%	56%	56%
Trans Female	14	7	86%	57%	43%
<b>Race/Ethnicity</b>					
White	84	41	88%	59%	61%
African American	58	32	88%	59%	88%
Latino	47	27	96%	78%	52%
Asian/Pacific Islander	11	3	100%	67%	67%
Other/Unknown	9	3	67%	67%	100%
<b>Age in Years (as of 12/31/15)</b>					
13-24	8	5	100%	60%	100%
25-29	24	10	90%	70%	80%
30-39	55	28	79%	64%	54%
40-49	71	37	97%	62%	65%
50+	51	26	88%	65%	77%
<b>Transmission Category</b>					
MSM	98	51	92%	67%	73%
PWID	29	16	100%	69%	63%
MSM-PWID	72	32	81%	59%	63%
Heterosexual	7	5	80%	40%	60%
Other/Unidentified	3	2	100%	100%	100%
<b>Housing Status</b>					
Housed	158	76	89%	62%	64%
Homeless	51	30	90%	70%	77%

<sup>1</sup> Percent of persons accepted and completed LINCS.



Why would we relink them  
to the same system where  
they failed to engage in  
health care to begin with?

Julie Dombrowski MD (UW Max Clinic)

## LINCS for life?

- LINCS is focused on short-term navigation to reconnect patients to system of care
- Patients need varying levels of ongoing support to STAY in care
  - Panel management
    - Reminder calls
    - Rapid follow up on missed visits
  - Case managers who conduct regular field-based outreach

# Lessons learned and Planning Council opportunities

- **Field-based navigators** who worked closely with clinical teams were able to **effectively identify, locate and re-link and virally suppress** patients who had fallen out of care. **Warm hand off** to case management is critical.
- The Council has an opportunity to ensure that **all COEs include field-based navigators**. **Field-based navigators need access to the clinical record system** to ensure labs are drawn and check for viral suppression and to **document within that system** (so that the care team communicates with them)
- The Council has an opportunity to **ensure all Health Network clinics streamline care re-entry** and **offer drop-in HIV care primary care** if indicated (low barrier access to antiretrovirals and STD screening!)

## LINCS Panel

Jason Chadderdon, Hugh Gregory, Patrick Kinley, Julianne O'hara

- What is your role and how long have you been working with LINCS?
- Tell us about a success story
- What is the hardest part of your work?
- How do you stay motivated when there are so many barriers to link people to care and prevention services?
- What do you want to see change for your clients in the next 5 years?