LINCS update 2018

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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

The number of infants born with **congenital syphilis** increased for the **5th year** in a row.

70 of those infants were stillbirths, with **30 stillbirths in 2017** alone.

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>33 cases</td>
</tr>
<tr>
<td>2017</td>
<td>278 cases*</td>
</tr>
</tbody>
</table>
What is the LINCS team?

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

- Syphilis or HIV case reported to DPH
- Locate patients
- Linkage to care and assure treatment
- Health education
- Partner notification and assure testing and treatment
- Link partners to PrEP or HIV care
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

HIV NAVIGATION OPTIONS IN SF
tiny.cc/HIVNavigationOptionsInSF

HIV CARE OPTIONS IN SF
A guide to clinics, providers, and the healthcare coverage they accept.
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
New initiatives to highlight

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

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

Intensive case management
Intensive support with medical & psychosocial;

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

Standard practices; clinic-based

Longer-term; Primarily clinic-based

Longer-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

Out of care HIV+ patients referred
Clinics (staff embedded at W86 and Tom Waddell)
HIV surveillance (no labs)
New dx, missed visit

90 days

Navigators work to locate patients
Located patients are offered Navigation services

Link to primary care with viral load drawn
Viral suppression at 6 months
Handoff to panel management or intensive case management
<table>
<thead>
<tr>
<th>Table 3.5 Care Indicators among persons who accepted and completed LINCS services in 2015 by demographic and risk characteristics, San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of referred to LINCS</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Trans Female</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Latino</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
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<tr>
<td>Other/Unknown</td>
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<tr>
<td><strong>Age in Years (as of 12/31/15)</strong></td>
</tr>
<tr>
<td>13-24</td>
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<td>25-29</td>
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<td>30-39</td>
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<tr>
<td>40-49</td>
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<tr>
<td>50+</td>
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<tr>
<td><strong>Transmission Category</strong></td>
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<tr>
<td>MSM</td>
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<tr>
<td>PWID</td>
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<tr>
<td>MSM-PWID</td>
</tr>
<tr>
<td>Heterosexual</td>
</tr>
<tr>
<td>Other/Unidentified</td>
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<tr>
<td><strong>Housing Status</strong></td>
</tr>
<tr>
<td>Housed</td>
</tr>
<tr>
<td>Homeless</td>
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</tbody>
</table>

<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?