IHP Workgroup Status Report

Treat Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression.

In Attendance: redacted
Meeting Date: 11/1/24
Submitted By: chairs

See updated goals. Red for proposed new language. Strikethrough for proposed to remove.

Objective	Data Updates	Successes	Problems	Next Steps
In five years, increase the number of healthcare systems prescribing rapid ART (as defined as ART medication at time of diagnosis) by two *and* increase the number of providers prescribing long-acting ART medications by two.	A team member has reached out to State of NH's Linkage to Care to see if we can find out how many health care systems are currently prescribing ART. Is it just ID? Anyone prescribing rapid ART? Awaiting this data as they were not present at this meeting.	Clarified definition of RAPID ART – **Immediate antiretroviral therapy** (ART) means starting HIV treatment as soon as possible after the diagnosis of HIV infection, preferably on the first clinic visit (and even on the same day as the HIV diagnosis). This strategy also is known as "rapid ART," "same-day ART," and "treatment upon diagnosis." Rapid (Immediate) ART Initiation & Restart: Guide for Clinicians | AIDS Education and Training Centers National Coordinating Resource Center	HIV Testing is performed at public health departments, Urgent Cares, EDs, Ob/gyn offices, Primary Care and then when someone has a positive dx they are referred to ID and therefore unable to provide rapid ART prescription due to length of time.	Do we like the definition in success column from AETC or the one below in the notes from the CDC? A team member is reaching out to a local ID MD to: Discuss option of making a rapid referral to increase time from dx to medication. Also, in this clinic the patient sees the Nurse first. What is the length of time until the patient gets to see MD and MD prescribes ART? A team member is reaching out to State of NH Surveillance to request data asking: What settings are we seeing positive diagnosis of HIV? Answer: mostly in the hospital inpatient settings as this is most likely the environment for people > 50 y/o, also some in primary care/MD offices/ telehealth, and through the health department.

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		(AETC NCRC) (aidsetc.org)		Also asked same question re AIDS, answer: more AIDS diagnoses through primary care/MD offices, and inpatient settings. Report increasing trend with telehealth where people send in specimens from the items sent to them and it leads to more diagnoses as opposed to those who do not come in at all. This is more seen for STIs but they have had a few cases of new diagnoses of HIV through telehealth. A team member heard in an HPG Advisory meeting that one of the health centers is starting a mobile clinic and looking into offering rapid ART. Need a rep from group to find out more.
~~**Increase PLWH who are in care**~~ **Decrease the number of PLWH who have not seen an HIV provider in 12 months, by 5% in five years.**		Clarified definition of what it means to see an HIV provider – in a 12-month period the patient will see a nurse with labs drawn with a follow up scheduled with a provider OR patient has an appointment with the provider. Team agreed a telehealth visit		Discussion, do we need to know how many people go to providers out of state. A team member will reach out to local ID MD to ask on outcomes of their meeting with State's Linkage to Care & Surveillance programs. Significant discussion re this goal, team decided to keep this goal in 11/1/24 meeting, see below. State's CARE program

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		counts as seeing a provider.		and surveillance team to follow up with data requested.
In five years, increase contracts and/or partnerships with wraparound service providers (dental, mental health, transportation, housing, substance use) in NH communities by 5%. ***Rewrite this goal into 2 separate goals?:** **1. In 5 years, increase *contracts* with wraparound service providers (dental, mental health, transportation, housing, substance use) in NH communities by 5%.** **2. In 5 years, increase *partnerships* with wraparound service providers (dental, mental health, transportation, housing, substance use) in NH communities by 5%.**	Data shared about NH RW CARE contracts		Contracts are easier to measure and clear. Partnerships are vague and need more clarity around what constitutes a partnership. Ideas to measure partnerships: warm handoffs. Ideas on ways to measure contracts: PHED Detailing, partnerships with ASO's.	Confirm the group wants to divide these goals into 2 separate goals. More discussion re how to measure contracts and partnerships. More discussion re is there an opportunity to connect with 211 to bring cohesive resources to the table and therefore increase partnerships? Do we want to explore data re how many PLWH in NH are not in NH RW Care.

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Next meetings:

Friday, January 10th 3:00 – 4:30

9/13/24 Meeting, Notes from chat:

CDC: Rapid ART is defined as initiating ART within 7 days or as soon as possible for those newly diagnosed with HIV. Implementation of rapid ART differs depending on the setting and resources available. Programs will need to identify processes that work best for their populations or setting.

In response to question raised on why rapid ART is important: In comparison to standard/delayed treatment, rapid ART can reduce the incidence of TB and severe bacterial infections in HIV patients. Our findings suggest that rapid ART should be utilized when clinical conditions and the patient's physical state allow.

Additional plan for discussion at next meeting: State Chair would like to share most recent 5-year surveillance report. 5-Year STI/HIV Surveillance Report, Current | New Hampshire Department of Health and Human Services (nh.gov) Should we add goals to reflect this data esp. 26% of people dx w HIV had a concurrent dx of AIDS. Should we have a goal to decrease this number? Does increase in testing support this? Does PHED Detailing on HIV prevention/asking providers to test more help to further support this effort?

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11/1/24 Meeting, Minutes:

Guest speaker from DHHS Surveillance. Also works with the IHP Respond group. She is here to help answer questions from a previous meeting and show some data. She is an HIV epidemiologist for the state, and she tracks surveillance data for every HIV case in New Hampshire including new diagnosis and connecting to linkage to care team. She imports labs including unsuppressed VL (greater than 200 mL copies). Some of the questions that we posed are out of her scope so she cannot answer them, primarily questions 3 through 6. Questions below:

1. What settings are we seeing positive diagnoses of HIV?
    a. Let's please move forward with this data as it sounds like this is quite feasible on your end.
2. What settings are we seeing positive diagnoses of AIDS?
    a. Let's please move forward with this data as it sounds like this is quite feasible on your end.
3. How many health care systems are prescribing ART?
4. Who is prescribing ART, is it just ID?
5. How many heath care systems are currently prescribing **rapid** ART?
6. Who is prescribing **rapid** ART?
7. Is there any data on your end around people who have not seen an HIV provider within 12 months? (RW CARE may be able to assist with this as well.)
    a. The group does not have any particular details about this so it is open to interpretation and how you think this would be best supported by the data. The goal we are trying to support with data is: Decrease the number of PLWH who have not seen an HIV provider in 12 months, by 5% in five years. The team clarified the definition of what it means to see an HIV provider: in a 12-month period the patient will see a nurse with labs drawn with a follow up scheduled with a provider OR patient has an appointment with the provider. The team agreed a telehealth visit counts as seeing a provider. We trust that you would know best so whatever feels appropriate to support this is helpful. We can define what data we are using so it is reproducible in the future.
8. We have the data from the 5 year surveillance report. Is there any current data for HIV/AIDS that you are able to share?
    a. Let's plan for you to please email me the slides following the HPG meeting so you do not have to recreate anything and the group can mull them over at the following meeting.

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HIV epidemiologist wanted to discuss question 7 in detail; what would be use and do with that data and what is the purpose of providing this data?

A member's response was because we were charged with keeping/bringing people into care we would like to have a sense if a particular population is more likely to be out of care or targeted to need more linkage to care. Other similar characteristics to folks not staying in care? Who are we missing?

A member also mentioned wanting to see where the gaps are.

A chair reiterated goal C which is to decrease the number of people living with HIV who have not seen an HIV provider in 12 months x 5% in 5 years.

HIV epidemiologist questioned if using HRSA's definition of lost to care was the best way of wording will see. She gave an example that if a lab draw in 12 months may be from an ER visit but that does not mean the patient is truly in care. But other people might see their doctor a month late and still be considered in care but the definition makes it seem like they are not. What do we do with this info? "Our challenge [The state] is that we are having difficulty implementing mobilizing resources. The state has information and wants to make the best use of everyone's time.

A member said that goal C is very challenging. She has 25 years worth of experience and trying to address goal C. There is not a ton of outreach to folks not connected to care. Another member said that we do not know what has been done because a lot of us are new to this group and the response was not much has been done.

A chair mentioned that she has found that a lot of providers are unaware of the linkage to care team in the state. She and her team are trying to educate more individuals.

A member made a point that it is difficult to go to the doctor because there are issues with things not getting billed correctly and having to connect with billing and still having issues. A member would like as part of Detailing and or CARE to educate the billing departments from the state level if allowed. Just finishing up a detail educating providers.

HIV epidemiologist spoke about the CDC 5-year grant cycle that has just restarted. They are focusing on Data to Care which is an Ending the Epidemic Initiative. She and her team statewide have to work on this as part of the grant but finding resources to reach people has been difficult. The linkage to care people are overwhelmed as they cover all surveillance throughout the state not just HIV. They are hoping to contract with outside partnerships like DH and the ASO's to try to utilize them to help bridge these gaps. Is this something that they can utilize? Who is doing the work and who has capacity to do the work?

A member said if the CDC is pushing the subject that we should keep this as a goal. What is the CDC offer for resources and support for these approaches? HIV epidemiologist said that the CDC has a Not in Care Program and they can find people not in care with viral loads in 12 months by running it through their system.

A member said the goal may be hard but it is critical to know of where things are going. A chair suggested that perhaps this is the barrier to achieving this goal and that is what we should focus on; ways to address the barriers.

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A member said that NHCare also has data to care items written within their grant and can help.

What are these barriers? The group decided that billing issues was one of the barriers. Perhaps changing the 5-year goal to reduce barriers. It may keep folks in care because it is easier to access. A member said that these are great action steps, but everyone already tries to connect with patients before they are lost to care.

A chair said that we could be looking at ways partnerships are interacting, maybe making communication clearer. A member asked if we could identify a group of people to help. She said that if there was training and scripting that she would be able to and put some time to help make calls. A member made the point that we lose folks to care and cannot call due to things like lack of phone or the number being changed.

A member explained that there is a data base called Accurint that can compile data from utility bills using contracts etc. to help find folks, but that also has limits. For example, if someone's recently out of incarceration or if they are unhoused, and the resources there to find people are limited as well.

HIV epidemiologist explained her process for finding people who are lost to care. She can pull a list and can see if someone has moved out of state or is deceased. She removes the individual and the list is given to outreach for folks who can be “reasonably” contacted. For security and confidentiality laws she cannot give this list out unless there is a mutual patient. For example, she can only give NHCare program people who have been in NHCare.

HIV epidemiologist briefly spoke about a project she was working with DH where DH gave her a list and then she pulled people off the list who moved out of state or were deceased and gave it back to her linkage to care team. DH has a meeting soon to cover processes with Linkage to Care for more efficient outreach. If DH cannot reach these individuals the list then goes back to the linkage to care team to do a deep dive search.

A member also asked to use this team to set up more frequent follow-ups with patients to check-in when a patient misses an appointment or just check in overall between appointments. A member mentioned that this is something that DH does already, but she cannot speak for other hospitals. A member said that all hospitals do it differently and asked why all hospitals do not follow the same guidelines. He also asked why there were no other hospitals represented at this meeting. A member stated that DH made commitment to this because they have an HIV program, and other hospitals might not see it is a top priority. A chair encourages open dialogue to collaborate and make integration seamless.

A member said that she was struggling with an advisory board that she is part of where there are ID doctors from different hospitals. She notes that there is lack of participation because things seem “stable and boring”. She is trying to think about how to get these members into this group and revive the advisory board. She wonders if emergent groups would be a good idea so that way people with lived experience can communicate needs and issues directly to the providers.

A chair's recap so far is that we will keep the goal as written at this time. It would be difficult, but we feel strongly about the data on the processes.

HIV epidemiologist at this point said it makes no sense to “fish” for information if we do not have a project to use the data. If we have a project/people/capacity it would be beneficial to run data.

A member spoke on a few reasons why people might be lost to care including substance use disorder, mental health issues, poverty, and homelessness as some priorities that keep people from coming in to get blood work and to their appointments.

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Another member said another set of people that we might not think about being lost to care are people who were frustrated with services and choose not to go because they do not like the services being provided or how the services are being provided. She also reiterated that some people go 14 months between appointments, not exactly 12 months and strictly looking at the 12 months can skew data even though these individuals are still in care.

HIV epidemiologist addressed question 1; what settings are we seeing new diagnosis of HIV? Her response was that she sees new HIV diagnoses most in hospital inpatient settings where most of those more likely over the age of 50, primary care/doctors offices/ telehealth, and through the health departments.

She also addressed question 2; what setting are we seeing new diagnosis of AIDS? sees more AIDS diagnosis through primary care/doctors offices, and inpatient settings. She spoke on the increasing trend with telehealth where people send in specimens from the items sent to then and it leads to more diagnoses as opposed to those who do not come in at all. And this is more seen for STIs but they have had a few cases of new diagnosis of HIV through telehealth.

A member also briefly told us that the Manchester mobile health van might be going away. We touched briefly on the new SSP ordinance in Manchester and the difficulties that that is presenting us. She also sent out an email to those who are interested in reading the ordinance.

Next steps:

-Discussed keeping goal C

-State chair will follow up with billing departments and CARE to try to lessen barriers to care

-A CARE member will think about how to get more providers/entities to this group

-DH representatives will report back on how the meeting with DH and DHHS went.

-HIV epidemiologist will circulate the SSP Ordinance Letter (attached)

IHP Workgroup point person also told us that our meetings will be changing from Zoom to Teams and they are working on developing instructions on how to get onto Teams, as their contract is ending with their logistic support agency. She will send updates once that is finalized

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