Innovative Approaches to Engage People Living with HIV in Care Service

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John D. Bower School of Population Health
October 9, 2020
Reaching Viral Suppression

Opportunities

- Healthy fulfilling life
- Minimizing HIV morbidity and mortality
- Eliminate transmissions

Challenges

- Diagnosed HIV infection
- Receive care
- Engaged in regular HIV care
- Receive and adhere to ART

Challenges to HIV Prevention and Care in the South

- Rurality: Large distances and shortages of healthcare providers
- Racism
- Poverty
- HIV stigma and aggressive homophobia
- Education disparity
- Inadequate federal funding
- Healthcare infrastructure

Of 477 individuals newly diagnosed with HIV in 2018, 303 (64%) linked to HIV care in 30 days. Of 10,330 individuals living with HIV in Mississippi through the end of 2017 who were alive at year-end 2018, 64% had engaged in any HIV care and 44% had a suppressed viral load.

Source: MSDH, 2018 Mississippi HIV/AIDS Epidemiologic Profile
The MAX Clinic: A Structural Healthcare Systems Intervention Designed to Engage the Hardest-to-Reach Persons Living with HIV/AIDS

Julie Dombrowski, Matt Golden

MAX Clinic (“MAXimum assistance”) for patients who do not or can not engage in traditional HIV healthcare despite intensive outreach assistance
PATHways Program at Vanderbilt Comprehensive Care Clinic

- Advanced Practice Nurse-led program - interdisciplinary, individualized, intensive care for as long as the patient participates
  - Standard of Care = 15 minutes every 6 mons for HIV + Primary Care
  - PATHways = 1 hour/mon with clinician + 2 sessions/mon with therapist, daily case management and nursing support
  - We have 2 clinics/wk for this program - could see more pts. if we had time

- They developed an instrument (MDPSP) to identify patient strengths and concerns. Patients create individualized Care Plans based on strengths identified with this instrument
- > 80% viral load suppression in this group (~36 pts at any given time)
- Sustained viral suppression over time so long as pts remain engaged

Slide Credit: Robertson Nash, Ph.D., ACNP, BC, Director, PATHways Program
All-In at CIRCLE: who are we?

Cooperative for Innovation, Research and Clinical Engagement

HIV CARE CONNECT
Reducing Disparities in HIV Care

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
ADULT SPECIAL CARE CLINIC

UMMC™
Myrlie Evers-Williams Institute for the Elimination of Health Disparities

John D. Bower School of Population Health
Program Purpose

To provide client-centered HIV care and social services that reflect preferences, needs, and expectations of All-In at CIRCLE’s patients resulting in positive clinical outcomes by improving engagement, adherence, and durable viral suppression.
All-In at CIRCLE Team

- Dr. Leandro Mena - Director
- Dr. James “Ben” Brock - Co-Director
- Courtney Gomillia - Data Manager
- Dr. Kandis Backus - Clinical Pharmacist
- Jennifer Brumfield - Director of Clinical Operations CIRCLE
- Dr. Aubri Hickman - Ryan White Program Director
- Brandy Lucious - Lead Social Worker
- Vernessia Harbin - Social Worker
- Andrew Bates - Program Administrator
- Clinicians: 1FTE NP
- Hope Gilbert - Program Evaluator
- Sara Mason - Program Evaluator
**All-In at CIRCLE Logic Model**

**Inputs**
- Resources
  - Patients
  - Staff
  - UMMC
  - MS Dept of Health
  - Advisory Boards and Community Partners
  - Funding Source
  - Clinical partners
  - National evaluator
  - Consultants
  - Comparison group

**Activities**
- Clinical Services
  - Clinical visit
  - Lab testing
  - PRGs
  - Incentives
  - Implementation advisors
  - Telehealth
- Social Services
  - Intense care management/home visits
  - Food
  - Transportation
  - Housing
  - Childcare
  - Communication (telephone and APP)
- Education
  - Patients
  - Staff
  - Community partners
- Communication and Outreach
  - Patient tracking
  - Program participant recruitment, intake, reengagement
  - EPIC
- Program Evaluation
  - Education
  - Data management
  - Data analyses
  - Economic analysis

**Outputs**
- Appointments attended
- Encounters (clinical and non-clinical)
- ED visits
- Hospitalizations
- Deaths
- Viral load
- CD4 count
- Food vouchers provided
- Travel vouchers provided
- Social service referrals
- Social services provided
- Identification of super users
- Patient groups
- Staff meetings
- Advisory board meetings
- Workshops/Trainings
- Conferences
- Incoming calls
- Outgoing calls
- Call classification type
- Call date/time
- Reports
- Abstracts
- Publications
- Presentations

**Proximal Outcomes**
- Linkages to HIV care
- Reengagement to HIV care
- HIV care retention
- Medication adherence
- Patient care experience
- Social services
- Patient mental health
- Patient quality of life
- ED visits, hospitalizations & deaths
- Repetitive social services provided

**Distal Outcomes**
- Maintain durable viral suppression
- Retention in care
- Need for social support services
- Patient quality of life
- Patient transition to care as usual
- Impact of HIV stigma
- Healthcare costs
- Institutional and federal funding
- Low barrier access scaled up delivery model
Program eligibility criteria & recruitment

Eligibility:

- AIDS Diagnosis* and VL > 1000 copies/ml
- CD4 200-350 cells/ml and VL > 1000 copies/ml
- Syphilis, gonorrhea or chlamydia diagnosis in past 12 months and VL > 1000 copies/ml
- Identified by HIV healthcare provider as high risk for falling out of care

Recruitment:

- Hospitalized Patients - UMMC
- STD clinic walk-ins - Five Points, EPH
- STD/HIV program/DIS
- Emergency Departments - UMMC
- HIV Providers (ASCC, OAHCC, AHF, etc.)
- Jails Jackson MSA (Hinds, Rankin, Madison)

*AIDS Diagnosis: anyone with h/o OI or CD4 < 200 cell/ml or 14% of total wbc count
Program Evaluation

Advisory Committees

- Consumers
- Stakeholders

Evaluators

- CERE (University of Mississippi)
- UAB (HIV Care Connect PO)

Consultants

- Dr. Matt Golden (clinician/public health)
- Dr. Orgul Ozturk (health economist)
EVALUATION PLAN

Core Process: How are the core processes for All-In at CIRCLE impacting intended clients and staff?

Patient Related Outcomes: How are PROs changing over time for All-In at CIRCLE?

Mini-Study Focus, Year 1: Telehealth and All-In at CIRCLE – what is the impact and is there fallout?
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<td>Homophobia</td>
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<td>Social and emotional aspects of having HIV</td>
<td>TG AIM</td>
<td>Status of TG individuals in the process of transitioning</td>
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# REDCap® PRO Dashboard

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**Baseline Columns:**
- Out of Care Form - Demographics
- Out of Care - Survey
- Prepare
- ART Adherence
- PHQ 9
- AUDIT-C
- DAST
- Quality of Life
- Stigma
- Intimate partner violence
- Unmet Needs
- REALM-SF
- TG AIM

**2 Month Columns:**
- Intimate partner violence
- Homophobia

**4 Month Columns:**
- Intimate partner violence
- OAS
- Unmet Needs

**6 Month Columns:**
- Prepare
- ART Adherence
- PHQ 9
- AUDIT-C

**Other Month Columns:**
- Quality of Life
- Intimate partner violence
- Unmet Needs

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*All-In at CIRCLE*

University of Mississippi Medical Center
Timeline

March 1st, 2020
- Complete trainings
- Complete SWOTs

April 1st, 2020
- Soft launch
- NP 1 day/week
- Customize reports and dashboard for sites

May - July, 2020
- Increase NP coverage to 5 days/week
- Iterate and refine reports and dashboard

August - September, 2020
- Continue to add and tweak services through end of Year 1
- Perform Year 1 summary reports
- Year 1 local evaluation

COVID-19
Program Participants (N:30):

Who?
• Eligibility
  - CD4 < 200 with > 1000 VL (52%)
  - Provider (83%)
• African American 97%
In the past 6 months:
• Did not have working phone (50%)
• No access to working vehicle (73%)
• Incarcerated (14%)
• Unemployed (64%)
• Getting the HIV care they need (82%) on ART (73%)

What happened?
- Lack of transportation (73%)
- Unstable housing (68%)
- Money for medication (77%)
- Could not make/missed appointment (51%)
  ▪ Transportation (68%)
  ▪ Work (58%)
- Substance use (27%)
- Depression (47%)
- HIV not my priority (68%)
- Don’t feel comfortable in the clinic (68%)
- Don’t like doctor (46%)
- Missed RW cert (71%)
- Meds on restriction (57%)

What would help?
- Clinic characteristics:
  - Walking (95%) Weekends (73%)
  - Evening Clinic (73%) Telehealth (77%)
- A different doctor who I trusted more (41%)
- Help with transportation (64%)
- Having a SW/CM (60%)
  ▪ A different SW/CM (32%)
  ▪ Having them for available (82%)
- Peer support for appointments and meds adherence (54%)
- Incentives;
  ▪ $10 food voucher when I come to clinic (86%)
  ▪ $50 voucher when VL sup (90%)
- Substance use tx (23%)
- Depression tx (27%)
- Living in a different place (55%)
- Support group (46%)
Questions & Discussions