Integrating Prevention, Care and ADAP
Beyond Cultural Competency: Strategies to Meaningfully Engage Black MSM Across the Care Continuum

Thursday, July 30, 2015
Omoro Omoighe, Associate Director, Center for Engaging Black MSM Across the Care Continuum (CEBACC), Health Equity/Health Care Access, NASTAD

Dr. Ifeoma Udoh, Director Monitoring and Evaluation, Pangaea Global AIDS
Center for Engaging Black MSM Across the Care Continuum NASTAD (CEBACC)
Estimated HIV Incidence in the United States 2007 – 2010

0.2% of the US population comprises 23% of new infections

Interventions for HIV screening, linkage and retention for positive Black MSM

less emphasis on prevention, behavioral modification

Peer reviewed studies/articles published between 2008 – 2014

*Multiple study designs considered

Primary Study population – Black MSM residing in the US
Center for Engaging Black MSM Across the Care Continuum (CEBACC)

CEBACC Goals
Develop, Design, and Disseminate

Two Year HRSA Cooperative Agreement

- Identify, Evaluate and Highlight Promising Care Models that Advance HIV Care Linkage and Retention Among Black MSM
- Design CME Units to Accelerate Delivery of High Quality HIV Care for Black MSM Patients
- Disseminate Technical Assistance and CME training to Provider and Patient Audiences
Patient/Provider Relationship

• Bi – directional opportunities to address the communication gap
• Black MSM patients and health care providers must be willing to educate and inform one another
• Successful care engagement is a partnership!
Behavioral Clinical Community Advisory Panel

Clinicians
- Patrick Wilson
- Sheldon Fields
- Michael Mugavero
- Orlando Harris
- David Malebranche
- Christopher Watson
- Mitchell Wharton

Researchers

Policy Experts

NOT PICTURED
- Dr. Leo Moore
- Dr. Quintin Robinson
- Leandro Mena
- Elijah Robinson
- Daniel Driffin
- Greg Millett
- Kali Lindsey
- Anton Bizzell
# BCCAP Care Model Rating Tool

## OVERALL DESIGN & APPROACH

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Excellent</td>
</tr>
<tr>
<td>3</td>
<td>Good</td>
</tr>
<tr>
<td>2</td>
<td>Adequate</td>
</tr>
<tr>
<td>1</td>
<td>Poor</td>
</tr>
</tbody>
</table>

- a. How well does this model/program address the needs specified (e.g., social determinants/barriers existing in the built environment, care access)?
- b. How well does the design enhance the program’s effectiveness? How well do the activities support the overall goal(s) of the model/program?
- c. How innovative is the program/model?
- d. How well does the model/program address long-term outcomes/goals?

### SCORE FOR IMPACT ON CARE CONTINUUM

- (Answer a & b ONLY for care continuum models)
- a. How well does this program/model address linkage, retention, and/or viral suppression?
- b. What is the potential of the program for moving BMSM toward viral suppression?

- (Answer c & d ONLY for prevention/bar-before-the-bar models)
- c. How well does the model/program address HIV prevention and HIV testing?
- d. What is the potential of the program for preventing HIV among BMSM?

## DATA & EVALUATION

- a. How rigorously has the program been evaluated (i.e., use of quasi-experimental design, pre-post tests, qualitative data, etc.)?
- b. Given the timeline for implementation, what is the potential impact for meaningful change in addressing different strata of the care continuum?
- c. What is the quality of the data available to evaluate the model/program for efficacy?
- d. How strong is the framework/plan to evaluate the model/program (whether or not it has been formally examined for efficacy)?

## SCALABILITY & TRANSFERABILITY

- a. How well does this program/model engage BMSM OR how easily is the program/model transferable to other subpopulations of BMSM?
- b. How easily can the model/program be implemented in different settings (i.e., to reach the largest number of BMSM)?

## DISSEMINATION

- a. How capable is the program/model in reaching a significant number of BMSM (i.e., nationally or within a particular community/geographic area)?
- b. How well has this model/program been (taken up/ramped up/absorbed) by the target population?

## COST & SUSTAINABILITY
<table>
<thead>
<tr>
<th>Care Model</th>
<th>Institution Funded</th>
<th>Budget</th>
<th>Funder</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRUSH (Alameda County, CA)</td>
<td>CBO/Academic</td>
<td>$1,000,000</td>
<td>California HIV/AIDS Research Project (State)</td>
</tr>
<tr>
<td>Connect to Protect/SMILE (Memphis, TN)</td>
<td>CBOs/Hospitals/Local Health Department</td>
<td>$300,000</td>
<td>National Institute Health/NICHD ATN (Federal)</td>
</tr>
<tr>
<td>Howard Brown/Broadway Youth Center (Chicago, IL)</td>
<td>ASO</td>
<td>$500,000</td>
<td>HRSA Ryan White Part D (Federal)/CDC (Federal)</td>
</tr>
<tr>
<td>Project Silk (Pittsburgh, PA)</td>
<td>Academic/CBO</td>
<td>$467,000</td>
<td>AIDS United (Federal)</td>
</tr>
<tr>
<td>Linkage To Care (L2C) (Indianapolis, IN)</td>
<td>ASO</td>
<td>$400,000</td>
<td>CDC (Federal)</td>
</tr>
<tr>
<td>Us Helping Us – Ties that Bond (Washington, DC)</td>
<td>CBO</td>
<td>$300,000</td>
<td>CDC (Federal)</td>
</tr>
<tr>
<td>Retention Through Enhanced Personal Contact (REPC)</td>
<td>ASO/CBO (multisite)</td>
<td>$241,565</td>
<td>CDC/HRSA (Federal)</td>
</tr>
<tr>
<td>CLEAR Program (Norfolk, VA)</td>
<td></td>
<td>$83,000</td>
<td>NASTAD, DC HAHSTA, Gilead</td>
</tr>
<tr>
<td>Project Healthy Living: ManDate (Washington, DC)</td>
<td>Local host house (varies)</td>
<td>$60,000</td>
<td>Adolescent Trials Network (Federal)</td>
</tr>
<tr>
<td>SMILE - Fenway Institute (Boston, MA)</td>
<td>FQHC</td>
<td>$55,000</td>
<td></td>
</tr>
<tr>
<td>AIDS Foundation Chicago HIV-VIP Program (Chicago, IL)</td>
<td>NGO</td>
<td>$14,500</td>
<td></td>
</tr>
</tbody>
</table>
What’s Working?
Characteristics of selected care models

– Care is client - centered
– Care is client- driven
– Assets based vs. Deficits based
– Program design addresses health systems/targets multiple stakeholders
– Promise for maximum utilization by Black MSM
– Significant impact on HIV care across one or more strata of the care cascade, including prevention
– Program is currently ongoing
What’s Working?
CEBACC Key Concepts

- **Intersectionality** – Black, gay, male, youth
- **Community Engagement** - Designed closely with the target population – e.g. CRUSH
- **Leveraging Partnerships** – linking black MSM patients with support services, strong referral networks for partner services, (mental health/substance use, employment) – C2P
- **Innovations + Refreshing Traditional Strategies** - recreational space AND affiliation with medical clinic, support and counseling groups: Project Silk, UHU Ties that Bond, Kaiser Speakout 25 under 25
What’s Working?
CEBACC Key Concepts

– Prioritizes patients’ immediate concerns, needs and desires
– Patient navigation, case management, individualized attention
– Not rushing patients into first appointment – readiness check
– Assisting black MSM patients with additional structural and psycho-social barriers to care (mental health/substance use, employment)
– Programs meet clients where they are at
HIV Campaigns & Messaging

Black MSM want to see messages that:

• Affirm who they are
• More positive reinforcement around staying healthy
• Feature faces of Black love
• Utilize social media and digital technology
CEBACC CME/CNU Development

1. Describe health care challenges for black MSM

2. Address misinformation, knowledge gaps, and ignorance among provider communities

3. Develop skills in offering high quality and nuanced culturally appropriate sexual health services
CME/CNU Development

Dr. David Malebranche
STD/STI Screenings

Dr. Leo Moore
Sexual Health Intake History

Dr. Quintin Robinson
Vaccinations
• Local Context
• Goals and Implementation
• CRUSH overview: Updates on Progress
• Community Engagement
• Lessons Learned
• Next Steps

Presentation Outline
• As nationally, new cases are increasing among MSM, and in particular African Americans young MSM/MSM of color
  – MSM between 18-29 made up 81% of new cases between 2010-2012
• Health Depart. and the AIDS Office not funded for prevention federally; Ryan White Oakland TGA
• ACA/Covered CA meant push to get younger people enrolled in health services…
• NO municipal/public supported STI clinic in Alameda County

Why a sexual health clinic for young MSM? What would the model be?
Newly Diagnosed HIV Cases by Sex and Race/Ethnicity, Alameda County 2010-2012

Sex (n=656)

- Male: 84.3%
- Female: 13.9%
- Trans*: 1.8%

Race/Ethnicity (n=656)

- White: 23.9%
- African-American: 41.5%
- Latino: 21.5%
- API: 10.2%
- Other/Unknown: 2.9%

Credited: Epidemiology and Surveillance Unit, HIV/AIDS, Alameda County PHD, September 2014
Newly Diagnosed HIV Cases by Age Group and Mode of HIV Transmission, Alameda County 2010-2012

### Age Group (n=656)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-12</td>
<td>0.2%</td>
</tr>
<tr>
<td>13-17</td>
<td>0.9%</td>
</tr>
<tr>
<td>18-24</td>
<td>18.6%</td>
</tr>
<tr>
<td>25-29</td>
<td>13.3%</td>
</tr>
<tr>
<td>30+</td>
<td>67.2%</td>
</tr>
</tbody>
</table>

### Mode of HIV Transmission (n=656)

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>68.4%</td>
</tr>
<tr>
<td>IDU</td>
<td>3.4%</td>
</tr>
<tr>
<td>MSM + IDU</td>
<td>4.7%</td>
</tr>
<tr>
<td>Hetero Contact</td>
<td>9.8%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>13.7%</td>
</tr>
</tbody>
</table>
• Truvada® as PrEP became FDA approved 2012: Moving from efficacy trials to demonstration/implementation

• California HIV/AIDS Research Project: Epidemiological Interventions Initiative (EII)

• Novel approaches to addressing the HIV prevention care and treatment continuum (PrEP-TLC +)

• Funded April 2013, 4 years, 3 sites in CA: $20 million state investment

• Goal of CRUSH:
  – To integrate routine sexual health services for Y/MSM within the setting of an existing HIV primary care clinic

Establishing a Model Sexual Health Clinic
• Established in 1997
• Clinical, treatment, psychosocial, and peer treatment based services for HIV + youth (13-29 yrs)
• “Clinic without walls”: To support linkage and retention, peer advocates GO TO clients- at their homes, at other agency sites, at coffee shops; clinic cellphones and communicate with clients via text messaging
• Enhanced access: Flexible drop in provider availability; non punitive if missed appointments; food and transportation vouchers
• Approx. 220 HIV Positive youth <29 accessing clinic
  – Over 80 % MSM
  – 70 % African American, 12% Latino; 12% White; 6% API
  – 70% virally suppressed

EBAC and Downtown Youth Center
CRUSH: Specific Aims

Aim 1: Test & link >400 young MSM of color to sexual health services
- Expand referrals to include high risk HIV-
- Engagement of ASO and non ASO partners
- Youth outreach “corps:” staff assigned at all three partners
- Social network testing: RYSE, HEPPAC, AHS, EBAC

Aim 2: Enhance & evaluate engagement & retention strategies for young HIV+ MSM of color
- Outreach & engagement to identify out of care HIV + youth
- Peer mentoring for newly diagnosed/out of care youth
- Optimize current HIV care & treatment services at DYC
- Clinical case management/psychosocial support for program staff
CRUSH: Specific Aims (cont’d)

Aim 3: Engage & retain HIV- young MSM of color in sexual health preventive services, including PrEP

- Integrate SHS for HIV- into HIV care setting
- DYC model:
  - developmentally appropriate
  - culturally sensitive
  - individually tailored
- Combination HIV prevention strategy, including:
  - Community based warm-hand off for high risk HIV-
  - Risk reduction counseling
  - HIV testing & early detection
  - STI testing & treatment
  - Pre-exposure prophylaxis (PrEP)
  - Post-exposure prophylaxis (PEP)
Connecting Resources for Urban Sexual Health (CRUSH)

**Aim 1: Testing and Linkage**

**Downtown Youth Clinic (DYC)***
- Existing model/services
- *Social network HIV testing and linkage*

**Existing clinical organizations serving youth**
- Continuing referrals

**Community engagement with new partners**
- Youth corps, embedded outreach and testing coordinators
- Internet outreach

**CRUSH**
- **HIV Positive**
  - *Intake*
  - *Triage*
- **HIV Negative**
  - **Aim 3: Sexual Health Services for High-Risk HIV Negative Youth**
    - *Warm handoff to prevention case manager*
    - *Repeat testing (HIV, STI) every 3-6 months*
    - *PrEP*
    - *nPEP*
    - *Risk reduction counseling*
    - *Youth focused and youth run workshops***

**Aim 2: Enhanced HIV Primary Care for Youth**

**DYC + Enhancements**
- Assisted disclosure and warm handoff
- Existing services*
- *Peer mentoring*
- *Linkage/Retention specialist*
- *Staff support*

**Seroconversion**
Building on the DYC Model: Sexual Health Services for Positives and Negatives

**DYC/TLC Cohort**
- Peer advocacy
- Peer Mentoring
- HIV Primary Care
- ARV access
- Social support from MSW
- Mental Health/Substance Use
- DEBIs
- ADAP and RW services

**Negative Cohort**
- Retention Specialist
- HIV testing, including NAT
- Pre-exposure prophylaxis (PrEP)
- Post exposure prophylaxis (PEP)
- Primary Care referrals
- Benefits counseling
- Social Support activities
CRUSH: Community and Scientific Partners

Gladstone Institute of Virology and Immunology

Pangaea Global AIDS Foundation

La Clínica

East Bay AIDS Center

downtown YOUTH CLINIC

HEPPAC

Asian Health Services

RYSE CENTER
Progress to Date

Began implementation February 2014

- 282 (70.5% of target) total enrolled

PrEP Access: 175 have ever accessed (160 currently on)
  - 48 weeks of free access
  - 29 continued on via access to insurance

TLC Cohort
  - 75 HIV positive:
    - 17 newly diagnosed
    - 12 re-engaged into care by CRUSH
Race and Ethnicity

HIV+ (n=61)
- API
- Black
- Hispanic / Latino
- Mixed
- Other
- White

HIV- (n=165)

PrEP (n=135)
Gender and Age

Age:
- HIV+ (n=61): 24.6 ± 2.7
- HIV- (n=165): 24.6 ± 2.8
- PrEP (n=135): 24.8 ± 2.7
Cumulative Testing/Screening Numbers

**STI Testing & Treatment Numbers**

- 282 individuals screened baseline visit:
  - 50% presented/tested positive for at least 1 STI at baseline visit

- Preliminary STI Status Results
  - 20+ cases of Syphilis
    - 1/3 early latent/late latent

**HIV Testing Numbers**

- Over 1000 HIV tests conducted
  - Negative participants on PrEP tested every 3 months

- Rapid (Oral) HIV Ab: ~800 tests
  - Moved from 3rd generation testing (state mandated) to 4th generation Alere test

- HIV NAAT: The Early Test
  - 1 positive/seroconverstion
STI incidence

Percent of entire cohort

Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan

Total GC | Total CT | Total Syphilis

Legend:
- Blue: Total GC
- Red: Total CT
- Green: Total Syphilis
Prelim. PrEP adherence

- **Daily dosing**
- **4-6 doses per week**
- **2-3 doses per week**
- **< 2 doses per week**

Weeks after initiation:
- 4 weeks (n=99)
- 12 weeks (n=70)
- 24 weeks (n=36)
- 36 weeks (n=4)
- 48 weeks (n=7)
Integrating Sexual health for HIV –’s into a HIV Clinic of for HIV-’s : Early Lessons

Clinical:
- 25% at baseline seeking PrEP actually need PEP:
- Many young HIV negatives have no insurance coverage but qualify for Medi-Cal/Covered CA
  - Utilize benefits counselor
- Solidify warm hand-off for primary care services for HIV negatives

Community Level
- A lot of discussion with partners “What does sexual health mean? What are the outreach messages for Y/MSM?”
82.7% of PEP users rolled onto PrEP (38/46)

2.8% of PrEP users were given PEP after nonadherence (4/140)

12.0% of PrEP seekers were determined to require PEP (15/125)

97.6% of PrEP seekers eventually did receive PrEP (122/125)
Lessons Learned: Integration into HIV Clinic of Services for HIV negatives/Sexual Health for Y/MSM

- Administrative challenges working within a hospital system: EPIC; new registration procedures
- Developing & documenting clinical flow is crucial & ever changing
- Cross-training staff: HIV testing, intake, consent, lab processing, referrals, etc.
- Strengthening intra-agency collaboration ultimately helps with clinic flow
  - Developing assessment tools for clinical and program staff to address the PrEP to PEP interplay
  - Increased STI treatment 3 fold: Nurses were like “WHAT????”
  - Increased unstable room utilization: managing the clinic flow with youth schedules
• Working with community partners
• Establishing a robust Community Advisory Board

Community Engagement for Sexual Health of Y/MSM of color
CRUSH
Community Collaborations

Major outreach partners (referrals in):

- RYSE Youth Center (non-ASO partner)
- HEPPAC (Casa Segura): Oakland’s needle exchange program
- Asian Health Services

Referral network of Primary Care Providers for Negatives “warm hand off” (referrals out)

- Asian Health Services
- La Clinica de la Raza
Establishing a Robust CAB

- **Meetings monthly (9/year)**
- **Key activities**
  - Developing media & outreach tool language & messaging
  - Website & webisodes
- **Investing in their development: Trainings and In Services**
  - PrEP (Bob Grant)
  - Affordable Care Act
  - Trans*-specific outreach strategies
- **CAB as “CRUSH ambassadors”: Media Liaison; Scientific Liaison, Education Director**
  - Youth Radio/media coverage
  - Community outreach
  - Participation in community forums
CAB Activities

- Culturally appropriate materials - HEAVILY vetted

- CRUSH Website: www.CRUSH510.org

- Plan for 2 short videos “Webisodes”, developed by RYSE and the CAB
  - Sexual Health
  - PrEP
Lessons Learned in CAB implementation and management for Youth based Clinical Programming

- CAB management takes a lot of time and effort
  - Regular calls/reminders; routine meeting establishment
  - CAB recidivism is normal! Process for routine recruitment and training is via ongoing CAB members
  - Youth CAB engagement needs to be social and active or they get bored
  - Trans* reps on staff have increased from 1 to 3 this year
  - CRUSH CAB instrumental as referral partner: Many referral chains from CAB members
  - CAB input into project development has been critical
Lessons Learned in Engagement for Youth Based Clinical Programming

- Youth focused in-reach more effective as a recruitment tool vs traditional outreach, for “digging deep” into Social Networks
- Clinical staff, current existing clients, word of mouth about CRUSH has higher yield for enrollment
- Contacts they way they need: text messages, cell phone access vs. clinic phones
- Shifting outreach to be community education driven, versus recruitment driven
  - Community Forums
  - Online Outreach Coordinator
Discussion

Cultural Implications for Youth Based Clinical Programming
Telling the Story
Insights for Youth based clinical services

• Providing options for youth for STI testing (self rectal swabs, etc.)
• Emphasizing benefits of routine HIV testing
• Rethinking clinic retention for youth engagement
  – Missed visits vs. late visits
  – Youth come in when they want to
• Long clinic visits are a deterrent
• Front line staff critical in retention and engagement
  – Importance of Alfonso, JD, Maurice
Considerations

Sustainability: Many participants want to continue on PrEP beyond 48 weeks of free PrEP:

- Benefits counseling support needed for Y/MSM: ACA Access
- Clinical Capacity for integration PrEP access at an HIV clinic- Considerations for EBAC; integration for all providers

- Need to address frequent PEP users
- Challenges of implementing a youth based/run implementation program- they all know each other!
- Lots of training around professional development, boundary setting, leadership
Considerations

- Addressing Health Literacy for youth: “Quick Touch” education

- CAB driven community forums: RYSE to implement
  - On going community based education: Addressing the need for sexual health at all levels, clinical and community based

- Culturally Competent means constantly checking in

- Recurrent STIs: Youth need more info/training

- Health Education Specialist

- Webisode that is STI/PrEP focused
  - Ongoing Linkage to care and support for accessing insurance coverage
www.CRUSH510.Org

Thank you’s:

- Our Funder: CHRP
- State Office of AIDS
- The CRUSH and DYC Team: Michael, Kristin, Alfonso, Maurice, Jaime, Jessica, Jeff, LaTanya, Jose, Alex, Kathryn
- Our CAB and community partners
Q & A
Thank you!

- Omoro Omoighe, oomoighe@nastad.org

- Dr. Ifeoma Udoh, iudoh@pangaeaglobal.org