Care Resource

Minority AIDS Initiative (MAI) Program Project

ADDRESSING HEALTH DISPARITY and VIRAL LOAD SUPRESSION in BLACK AA/HAITIAN FEMALE AND HISPANIC MMSC with one or more of three co-morbidities

(Heart Disease-Diabetes-Hypertension)

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Addressing Health Disparity and Viral Load Suppression

Care Resource researched HIV infection and co-morbidities and found the following relevant study below and decided to further investigate among the current Ryan White MAI population. In addition, Hispanic MMSC was also included due to having the same co-morbidities and increasing the sampling size.

- In the Clinical Infectious Diseases (CID) Journal, August 2020, study found that for women living with HIV is associated with a higher prevalence of various other chronic health conditions, including high blood pressure, diabetes, lung disease and cardiovascular disease.
- The CID analyzed data from a large electronic medical records system that included patients of multiple health systems and represented 15% of the U.S. population. They assembled a study cohort of 10,590 HIV-positive women and 14.6 million HIV-negative women (the control group) who were active in the database between April 2015 and April 2020.

Addressing Health Disparity and Viral Load Suppression

- Sixty-three percent of the HIV-positive women were Black, and 89% were younger than 65. Among the HIV-negative women, 77% were white, 14% were Black and 71% were younger than 65. HIV-positive women had a higher prevalence of various chronic health conditions compared with HIV-negative women: high blood pressure (49% versus 31%), diabetes (22% versus 12%), cardiovascular disease (13% versus 7%) All these conditions were more common among the HIV-positive women regardless of the age group.
- After adjusting the data to account for age and race, the investigators found that having HIV was associated with a greater likelihood of having high blood pressure, diabetes, cardiovascular disease and lung disease. The study also found that women with HIV are developing these chronic diseases at younger ages than women who don't have the virus.
- MAI clients who receive MCM and OAHS at Care Resource qualify for additional interventions with MCM and PCP services in order to maintain the client's viral load suppression and to track other health conditions affecting the patient such as heart disease, diabetes, or hypertension that are associated with their HIV status. A least 2 interventions per month with a MCM or PCP will be implemented to address client HIV health and co-morbidity.

Target Population

MAI MCM will be addressing Black AA/Haitian females and Hispanic MMSC with at least one or more co-morbidity (heart disease, diabetes, hypertension), and receiving outpatient ambulatory health services and medical case management at Care Resource.

- A total of 156 Black AA/ Haitian female and Hispanic MMSC participating in the MAI project.

Black AA/Haitian Female	HIV 42	Hypertension 10	Diabetes 25	Heart Disease 07	Black AA/Haitian With two co-morbidity Diabetes/Heart Disease 14	
Hispanic MMSC	HIV 114	Hypertension 36	Diabetes 23	Heart Disease 55	Hispanic Male With two co-morbidity Diabetes/Heart Disease 17	Hispanic Male With three co-morbidity Diabetes/Heart Disease/Hypertension 2

Innovative Approaches or Interventions that Differ from Usual Service

Care Resource MAI program is different than Ryan White Part A program by implementing the following two interventions:

- 1. I-ENGAGE intervention model: Evidenced based four-session strategy focusing on access, retention and medication adherence.
- 2. PRAPARE Social Determinants of Health Assessment: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences.

Addressing Health Disparity and Viral Load Suppression

1. Ryan White MAI Medical Case Managers are trained on I-ENGAGE and PRAPARE Interventions.

- The I-ENGAGE is a CDC evidence based intervention focusing on individuals retention in care or newly enrolled in HIV care to help support their efforts in achieving and maintaining viral suppression by a series of meetings with the RW MAI MCM, Using client-centered and motivational interviewing strategies. Clients in the intervention are engaged in exploring and building strengths needed to attend HIV care visits and also to adhere to medication once they start ART. The primary outcome is viral suppression.

2. I-ENGAGE Implementation:
    1) Retention in HIV care
    2) Adherence to prescribed antiretroviral therapy

These are two key interventions that lead to viral suppression.

Addressing Health Disparity and Viral Load Suppression

I-ENGAGE Four Section Protocols

- **Session Steps:**
- Welcome—Exchange Information –Adjustment Process—Strengths and Challenges—Implement Action Plan and Goals —Review goals and Document
- Patients enrolled will have 4 planned face-to-face or Telehealth, in-clinic (after primary care visit) clients have intervention sessions with MAI MCM, and will also have a series of reminder calls twice from MCM before each primary medical care visit, and as needed.
- **Session 1:** 0-6 weeks
- Objectives: Developed rapport with the client. What is HIV and how is it different than AIDS. What are Viral Load and CD4. Goal of HIV treatment and what to expect. Doctor appointment reminder calls, MCM also place reminder calls. Additional calls contacts. Any missed PCP visit, ADAP or specialist follow up. Structural Problem Solving and Referrals process. (Reassess clients' needs).
- **Session 2:** 6-12 weeks
- Identify: Strengths and Challenges of effectively communicate a common process of adjustment to medical crisis (including being diagnosed with HIV or another co-morbidity) and reassure patient that a process of adjustment can generally be expected. To assess the client's current strengths, concerns, and potential challenges to coming back to additional HIV-care visits. (Reassess clients' needs).

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- I-Engage Four Section Protocols
- **Session 3:** 12-18 weeks:

1. Monitor CD4
2. Monitor VL
3. Monitor for resistance
4. Monitor action plan and goals base on the clients' necessities.

- **Session 4:** 18-24 weeks: (Reassess clients' needs)
- SMART Plan Of Care: For each goal, the goal activities culminate in agreeing upon a related goal that could help the client to address issues discussed or maintain progress in a given area. All goals should meet the SMART criteria. The goal should be:
- Specific (formulate the plan in terms of actions)
- Measurable (something you could assess at the next session)
- Attainable (realistic to achieve before the next session)
- Relevant (the goal relevant to the client's situation)
- Time Bound (Set date for specific actions)

Addressing Health Disparity and Viral Load Suppression

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

- is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health, health centers and other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.

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- PRAPARE Assessment and Social Determinants of Health Measures:

PRAPARE Core Measures	
Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress

Addressing Health Disparity and Viral Load Suppression

- PRAPARE Social Determinants of Health Measures (con't)

PRAPARE Optional Measures	
Incarceration History	Safety
Refugee Status	Domestic Violence

Unique Barriers in Target Population

- Health disparities and viral load suppression are correlated to Some of the following Social Determinants of Health:
  1. Homelessness
  2. Income
  3. Ethnicity
  4. Stress
  5. Incarceration
  6. Transportation
  7. Immigration Status
  8. Language Barriers

Culturally Appropriate

Care Resource implements the following CLAS standards in addressing the MAI patient population

- Care Resource meets the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care in the following four main areas:
  - 1. Principal Standard
  - 2. Governance, Leadership, and Workforce
  - 3. Communication and Language Assistance
  - 4. Engagement, Continuous Improvement, and Accountability
- RW/MAI MCM and Medical Providers are a culturally diverse team.

THANK YOU

- Links:
- NACHC: PRAPARE
- https://www.nachc.org/research-and-data/prapare/#:~:text=The%20PRAPARE%20Team%20at%20NACHC%20will%20be%20hosting,started%20and%20workflow%20considerations%20for%20various%20staffing%20models.

- Clinical Infectious Diseases Journal:

1. Burden of Hypertension, Diabetes, Cardiovascular Disease, and Lung Disease Among Women Living with Human Immunodeficincy Virus (HIV) in the United States
   - https://academic.oup.com/cid/advance-article-abstract/doi/10.1093/cid/ciaa1240/5895966?redirectedFrom=fulltext

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Intensive Individual Level Intervention to Maintain Viral Suppression and Improve Health Outcomes Among HIV-positive Minority Populations Impacted by Social Determinants of Health (SDH)

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3/29/2021

MAI Target Population

Race/Ethnicity: HIV positive Black and Hispanic males and females regardless of gender or sexual orientation age 18 and over and expect to serve up to 75 clients using one (1) MCM and one (1) Peer. In addition OAHS includes 3 ARNP, and 1 Phlebotomist.

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Social Determinants & Systemic Poverty

- Low Level of Education
- Health Literacy
- High School Dropout/Under Resourced Schools & Neighborhoods/Crime Rates/Over Policing
- Low/No Income/Unemployment
- Homeless/Transient/or Unstable Housing
- Stigma (HIV/Homosexuality/Transgender)
- Poor Emotional/Family Support System
- Pregnancy (Teen/Young Adult)
- Underinsured/Uninsured
- No Insurance

Co-occurring Conditions & Morbidity

- Mental Health
- Substance Abuse
- Poor Oral Health (Dentition)
- Higher Death Rate
- Higher Rate of AIDS Dx
- Other population health Dx (HTN, DKA, Obesity etc.)

Service Delivery & Other Barriers

- Newly Dx with HIV Infection (less than 2 years)
- Previous Positive and Sporadic/Lost to Care
- Cultural Sensitive Providers
- Lack of Special Services Near Patient (ex. ADAP Location)
- Lack of private transportation

Quality Improvement Intervention

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One on one individual level intervention: Goal is to assist the client to achieve and maintain viral suppression throughout the course of HIV disease. Strategy is help client identify and develop coping mechanisms to deal with ongoing mitigating social determinants of health that impact HIV health outcomes.

- Individualized acuity assessment of adverse social determinants of health
  - Assessment: Develop a standardized acuity assessment of SDH (PE and SDH Acuity Tool)
    SDH: Scored Acuity levels based on SDH
    Support: Level of support needed for maintenance

    ✓ Acuity Level 1: Acute Intervention
    ❑ SDH has little to no impact (Need minimal)

    Limited intervention Assess, Enroll, Stabilize, (discharge to Ryan White Part A) once immediate need is met.

    ✓ Acuity Level 2: Moderate Intervention
    ❑ SDH has moderate impact on HIV health outcomes
    Limited intervention. Monitoring and periodic assistance

    ✓ Acuity Level 3: Intensive
    ❑ SDH has profound impact on HIV health outcomes
    Ongoing intensive intervention and monitoring required

QI Intervention Acuity Level 1:

One on one individual level intervention: Goal is to assist the client to achieve and maintain viral suppression throughout the course of HIV disease. Strategy is help client identity and develop coping mechanisms to deal with ongoing mitigating social determinants of health that impact HIV health outcomes.

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- ✓ Acuity Level 1: Acute Intervention
- ❑ SDH has little to no impact (Need minimal)

Limited intervention Assess, Enroll, Stabilize, (discharge to Ryan White Part A) once immediate need is met.

Case Study 1:
LM is a 49 year old white Hispanic male whose mode of transmission is MSM. He presented to C4U from another ASO who informed him that he could not be assisted because his insurance was terminated. LM is very concerned that w/o medication, he will have an increase in viral load and become sick. LM has 2 years of community college; is working part-time since CoVID (resulting in ineligibility for employer-paid health benefits); has stable housing, reliable personal transportation and a good social support system. Based on the C4U Acuity Scale for Social Determinates LM is Acuity Level 1.

Individualized Plan: Assist with ACA, ADAP enrollment, SNAP benefits, OAHS and Oral Health referrals.
Disposition: The client attends OAHS regularly, is taking meds as order ed by MD and is virally suppressed.
Monitoring***: Quarterly check-in*** with client to assess ongoing needs or changes in situation.

QI Intervention Acuity Level 2

One on one individual level intervention: Goal is to assist the client to achieve and maintain viral suppression throughout the course of HIV disease. Strategy is help client identity and develop coping mechanisms to deal with ongoing mitigating social determinants of health that impact HIV health outcomes.

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- ✓ Acuity Level 2: Moderate Intervention
- ❑ SDH has moderate impact on HIV health outcomes

Limited intervention. Monitoring and periodic assistance

Case Study 2

SW is a 39 year old African American female newly diagnosed with HIV at a C4U health fair. She has been in a monogamous relationship since high school and has disclosed to partner. She has a 10-year old son and a daughter who is a college freshman. She works part-time but is dependent on s/o income. She is "embarrassed of her diagnosis" and experiences frequent episodes of depression. She refuses mental health counseling. She is willing to discuss her feelings with HIV-positive female staff members. She attends appointment as scheduled. Her initial VL was 19,000 with CD4 less than 200. She acknowledges that she understands the importance of medication adherence and U=U but has decided "not to have sex" and refused condoms when offered. Her VL is currently undetected.

Individualized Plan: Provide RAAT, assist with ACA, ADAP enrollment, Medicaid/SNAP benefits, OAHS and oral health referrals.
Disposition: The client attends OAHS regularly, is taking meds as order by MD and is virally suppressed.
Monitoring***: Minimum q 60 Days*** check-in with client to assess ongoing needs or changes in situation.

QI Intervention Acuity Level 3

One on one individual level intervention: Goal is to assist the client to achieve and maintain viral suppression throughout the course of HIV disease. Strategy is help client identity and develop coping mechanisms to deal with ongoing mitigating social determinants of health that impact HIV health outcomes.

- ✓ Acuity Level 3: Intensive
- ❑ SDH has profound impact on HIV health outcomes

Ongoing intensive intervention and monitoring required

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Case Study #3

L.O-F. is a 41 Y/O African American female living in an inner-city low income, high crime and drug community. LOF presented to clinic for HIV testing and PrEP for prevention. The Orasure HIV test was reactive. Per DOH, the diagnosis was 2008. LOF adamantly denied being aware of her HIV status. LOF has stigma about being infected with HIV. She reports some level of college education, has chronic Hx of substance abuse, food insecurity despite access to food stamps, homeless by definition and, until recently, was living in an abandoned building. L.O-H prefers to earn money by "hustling" odd jobs and acting as a "runner," but occasionally exchanges sex for money/drugs. She has grandiose behavior and exhibits bi-polar traits. Recent physical trauma: gunshot wound to foot treated at JMH ER with successful OAH follow-up for dressing changes at C4U. LOH OAH service has included STD treatment ordered by OAH provider and FFE administration by OAH nurse in the community setting due to noncompliance. LO-F is at risk for medication diversion. Thus, the prescribing provider is ordering monthly dispensing vs 90 day supply. Currently enrolled in ADAP, non compliant with referrals for Mammogram, Dermatology, Oral Health, PAP. LO-F has distant support from her adopted father and is estranged from her minor child. VL is unstable since onset care at C4U since 12/2018 High VL 986,000 HIV RNA/ml Low VL 190,000. Current VL 1.2021 156,000. LO-F is always in a rush when she comes for appointments (e.g. " I need to get back to work").
Strategy: Allow walk-in appointments/Outreach Dispatch as needed ex: labs, referral appts/Harm Reduction/Treatment Readiness/with L-OF to reduce Viral Load/PfH

Individualized Plan: Assist with ACA, ADAP re-enrollment, SNAP benefits, OAHS and Oral and Mental Health referrals.
Disposition: Outreach for OAHS quarterly
Monitoring: ***Minimum monthly*** check-in with client to assess readiness and maintenance

SMART Objectives:

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Objective 1: Increase the number of MCM patients with suppressed viral by 80% by February 28, 2022

(Baseline measurement N=22 Suppressed=68 Unsuppressed 32%)

Objective 2: Retain a minimum of 90% of MCM enrolled clients in care by February 28, 2022

Objective 3: 100% of newly diagnosed and lost/returning to care clients, enrolled in MCM and OAH, will be prescribed HAART w/in 7 days of TTRA assessment

Objective 4: Complete POC at a minimum of 80% of MCM client every 6 months.

Objective 5: Provide contacts to 100% of MCM clients who scored a level 2 and 3 Acuity on a monthly basis (FFE/Outreach/TEL /telehealth) (assess treatment adherence, ADAP enrollment; readiness for residential/outpatient s/a treatment; food insecurity; homelessness and mental health) *Note: Level 1 Acuity clients will have the contacts based on the RWP standard.*

Objective 6: Coordinate a minimum of one quarterly OAHS medical appointment with 90% of clients from the last scheduled appointments. MCM clients regardless of acuity. (Data source is EMR)

CDC Evidence Based Practices:

HIV Treatment as Prevention

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- **RAAT/T&T:** People with HIV should take medicine to treat HIV as soon as possible. HIV medicine is called **antiretroviral therapy**, or **ART**.

- **Viral Suppression:** If taken as prescribed, HIV medicine reduces the amount of HIV in the body (**viral load**) to a very low level, which keeps the immune system working and prevents illness. This is called **viral suppression**—defined as having less than 200 copies of HIV per milliliter of blood.

- **Undetectable viral load**. Getting and keeping an undetectable viral load* is the best thing people with HIV can do to stay healthy.
- U=U (Treatment as Prevention) Another benefit of reducing the amount of virus in the body is that it helps prevent transmission to others through sex or syringe sharing, and from mother to child during pregnancy, birth, and breastfeeding. This is sometimes referred to as **treatment as prevention**. There is strong evidence about treatment as prevention for some of the ways HIV can be transmitted, but more research is needed for other ways.

CDC Evidence Based Practices:

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Partnership for Health (P*f*H)

Individual (one on one intervention to assist persons living with HIV/AIDS to achieve and maintain viral suppression throughout the course of HIV disease while developing coping strategies to deal with ongoing mitigating social determinants of health to improve HIV health outcomes.

- Support Plan :Client centered partnership to address individualized barriers
  CDC effective behavioral intervention: Partnership for Health (PfH)
  - Interactive HIV Health Education involves the entire staff
  - Increasing patient self efficacy
  - Identify individualized social determinants or barriers to successful adherence to HAART

MAI innovations Expected Outcome

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- Increase the number of MAI patients who have undetected viral loads
- Monitor and maintain viral suppression (VL) for clients with undetected viral loads
- Increase enrollment into treatment services for patients with S/A and/or Mental Health disorders; oral health; housing instability
- Of the clients identified with poor adherence, increase in adherence as evidenced by
  - reduced no show rates
  - labs monitored every 90 Days,
  - increase in CD4 counts
  - Decrease in viral load

MAI Program Evaluation Data Sources

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- Social Determinant (SDH) Acuity Assessment Scale
- PE Case Management Data
- PE OAHS Data Review
- Electronic Health Record eClinical Works (EcW)
- Excel Data Entry
- SPSS Analytic Software (Statistical Package for the Social Sciences)