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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)