# 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).

# Addressing Health Disparity and Viral Load Suppression

- 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.

# Addressing Health Disparity and Viral Load Suppression

- 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