2022
NATIONAL
HIV & HEPATITIS
TECHNICAL ASSISTANCE MEETING

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Thinking Outside the Box: Partnering with Non-Traditional Partners to Increase Client Engagement

Agenda

- Introductions
- Session Objectives
- Overview of the Link-Up Rx Intervention
- Overview of the Mobile Outreach, Retention and Engagement (MORE) Intervention
- Question and Answer

Session Objectives

- Describe the key components to implement the Detroit Department of Health's Link-Up Rx intervention
- Describe the key components to implement Whitman Walker Health's MORE intervention
- Identify and describe strategies to engage non-traditional partners to increase engagement in care for PLWH

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Link-Up Rx
Detroit Department of Health (Detroit, Michigan)

Lindsey Kinsinger, MPH

Date to Care Rx Consultant

Katrease Hale, MPH

Data to Care Rx Consultant

Program Overview: What is Link-Up Rx?

- Link-Up Rx is a data to care (D2C) program that aims to increase retention in care and viral suppression among people with HIV by using prescription refill information to decrease the length of time between refills and reduce antiretroviral therapy (ART) interruption.

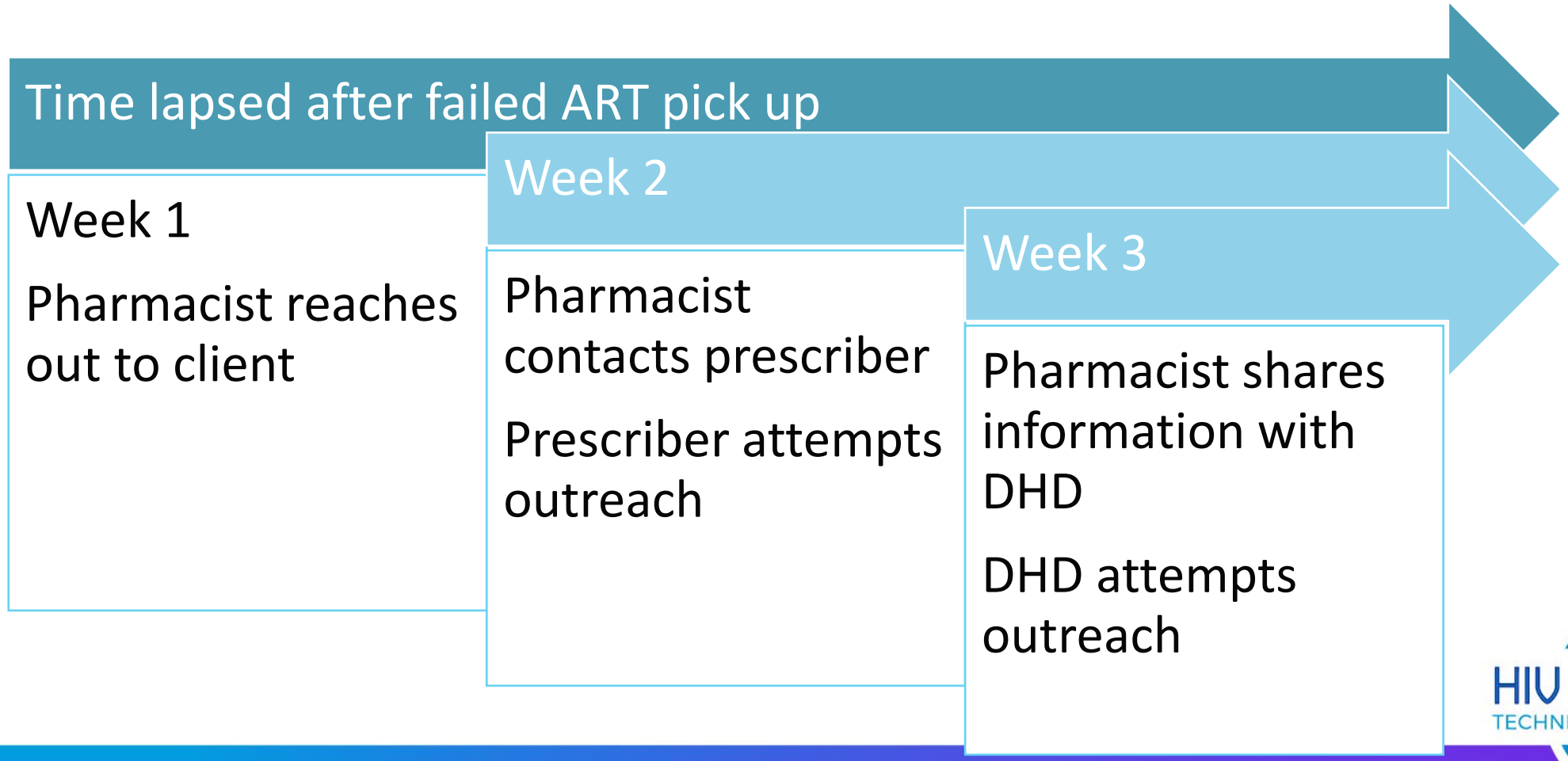
Link-Up Rx in Detroit: Background

- Link-Up Rx started in June 2018 as a partnership between the Detroit Health Department (DHD), Michigan Department of Health and Human Services and Metro Detroit Pharmacies
- Rebate funding from MDHHS's RWHAP Part B supports the implementation of Link-Up Rx
- The program used the building blocks (outreach strategy, data and documentation framework, staffing) from their established Data to Care Program

Link-Up Rx in Detroit: Goals

- There are two main goals:
  1. Increase the level of involvement of pharmacists in the current care model for PLWH and
  2. Increase viral suppression amongst PLWH

Link-Up Rx in Detroit: Model



In 2021, NASTAD performed an evaluation of the the Link-Up Rx intervention in Detroit

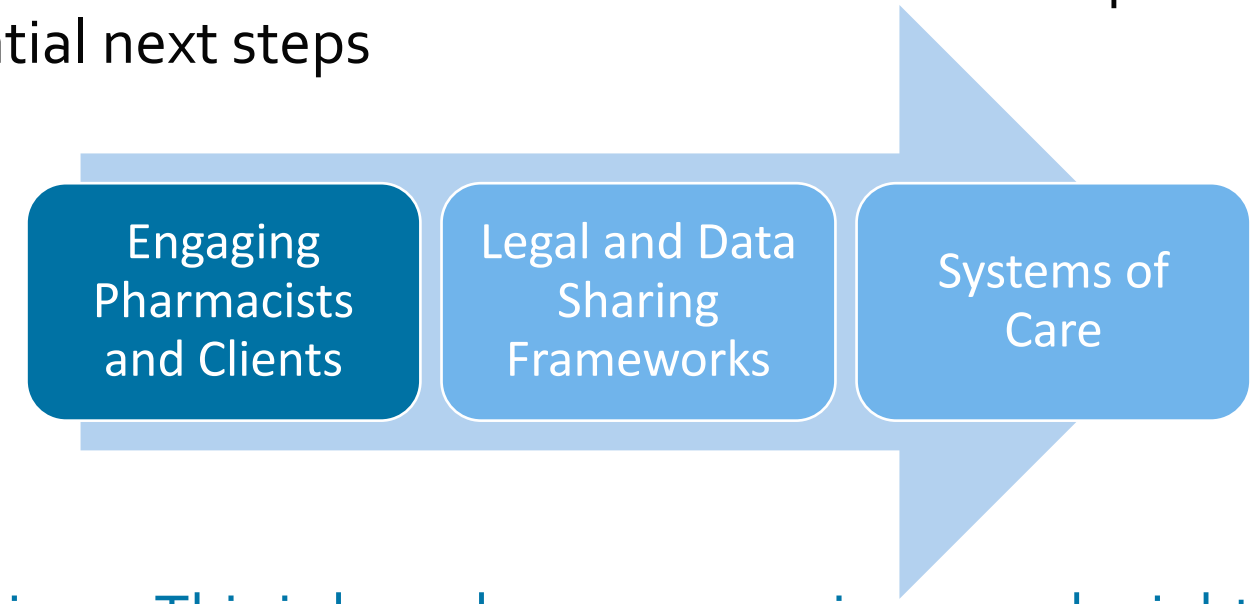
Relevant Findings

- **Evaluation of 393 Link-Up Rx Clients between January 2019 and June 2020**
  - **33%**: The intervention team relinked about one-third of clients back to the pharmacy (n=111).
  - **20%: ** were relinked to either their medical provider (n=24), RWHAP services (n=29), or received their medications (n=28).
  - **33%**: one third of clients were unable to be located since their last appearance on the Link-Up Rx list.

How to start a D2C Rx program, including strategies to engage consumers and pharmacy partners

Tips for Starting a Data to Care Rx Program

- We would like to touch on three main areas and provide some potential next steps



- Disclaimer: This is based on our experience and might look differently in other jurisdictions

1a. Engage People Living with HIV early on, and continually

- At DHD, the D2C Rx program built off the successful engagement strategies from D2C.
- Facilitated a "road show" and met with as many consumer groups as we could to roll out the potential strategies for re-engagement and the pharmacy partnership.
- Later we went back to these groups to share updates and continue building trust within the community.

1b. Engage Pharmacists, early on and continually

- Pharmacists are integral members of the care team.
- Pharmacists are often underutilized.
- Willing pharmacies and pharmacists are critical stakeholders who guide the implementation of the intervention in your jurisdiction.

Questions We Asked to Assess Outreach Capacity of Pharmacists

1. What steps do pharmacists take to connect with people who do not pick up their medication?
2. How long do pharmacists hold medications?
3. What is the ideal timeframe for pharmacists to conduct outreach with clients?
4. How can the role of Linkage Specialists enhance outreach efforts?
   - Do you have lessons learned from traditional data to care?
5. How do you think your clients would feel about receiving outreach from health department staff on your behalf?

What We Learned

- Pharmacists experienced limitations in accessing client-level HIV data (CD_4 and viral load data).
- Pharmacy teams often act as case managers.
- Insurance is a constant battle.
- Pharmacy feedback was needed to inform the Link-Up Rx logic model and program design, for example we originally planned on 30/60/90-days instead of the 1/2/3-week model.
- Pharmacists want to see data and information returned to them and stay in communication on program success or shortfalls

Additional Strategies to Increase Buy-in from Community Members

- Hold multiple meetings with pharmacists, PLWH, Ryan White providers, and others in the HIV care community to understand their role in engaging people with HIV.
- Provide food and transportation to community meetings.
- Be transparent.
- Build a website for ongoing and consistent communication.
- Hire members of the community.

Engagement Strategy: Questions to Ask Yourself

- How do you currently engage with pharmacists and consumers in your jurisdiction?
- Do you currently have a Data to Care program?
- What is the landscape for accessing medications in your area (delivery, mail, walk-in, big chains, small or local pharmacies)?

Tip: Starting with 340B contract pharmacies:

- Many RHWAP and HIV prevention providers already have established business agreements with 340B contract pharmacies.
- These relationships include sharing patient-level information about prescriptions filled.

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Show of Hands:

Who engages with pharmacies in the same way you engage with clinics?

Other considerations & next steps for bringing non-traditional partners into the HIV care plan

2. Legal and Data-Sharing Frameworks

Key Takeaways

- Understand your local public health code
- In Michigan, our public health code is written broadly.
  - *It states that we can use surveillance information for two purposes, to care for an individual or to prevent the transmission to others. In Michigan, we have tried to define this in more concrete ways including who is viewed as a provider of care (pharmacists are considered providers).*
- Pharmacists should also start engaging their legal team(s)

Legal Frameworks: Where to Start?

Steps to clarify what your state's public health statute allows

- Do you currently know what your health code/state law allows?
- Does your model of care/health department recognize pharmacists as providers of care?

Steps to successfully share data

- Do you have access to surveillance information, including CD_4 and viral loads?
- Do you currently exchange data with pharmacists or providers?

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3. Systems of Care

Key Takeaways

- Insurance is constantly an issue for clients so be prepared to address this or have referral mechanisms in place
- The ability of clients to remain in care is heavily impacted by social determinants of health (e.g., housing, socioeconomic status).
- The intervention team tailored client engagement strategies and developed community partnerships to provide referrals to supportive services (e.g., employment, housing, transportation).

System of Care: Where to Start?

- Health Insurance Enrollment
  - Do you already have insurance navigation?
  - If not, can you fund an agency or hire one FTE to do navigation?

- Referral Mechanisms to Address Life Needs
  - Do have strong relationships with the following:
    - Ryan White Providers
    - Pharmacists
    - Medicaid
    - Utility and Housing Assistance
    - HOPWA

If not, start creating and strengthening these partnerships because they are crucial.

Summary & Next Steps for Interested Programs

1. Sit down with pharmacists in the area and discuss the potential partnership. Specifically ask the following questions:

    a) What do you do when someone doesn't pick-up their medication?
    b) What does this outreach look like?
    c) How long do you hold medications?
    d) Do you think there would be value in trained linkage specialist reach out to clients that do not pick up their medications?
    e) There are various ways to facilitate the timing of outreach. What time frame makes the most sense to you?

Next Steps for Interested Programs

1. Sit down with consumers and discuss what this program could look like. Run through the stages of outreach and see what suggestions they have, where hesitations and concerns are and how you could strengthen your program.
2. Start engaging experts (Surveillance, Health Department, public health lawyers) in your area to understand the public health code and laws around data sharing and use.
3. Have a thorough understanding of the unmet need and population(s) out of care in your area. If possible, seek to hire linkage specialists that are from these communities or have extensive experience working with them.

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Mobile Outreach and Retention (MORE) Program for People Living with HIV at Whitman Walker Health (Washington, DC)

Megan Dieterich MPH, MMSc, PA-C, AAHIVM

Physician Assistant/Research Clinician

Whitman Walker Health

Whitman Walker Health

1525 14th St NW

MRC 2301 MLK Jr Ave SE

Our mission is to be the highest quality, culturally competent community health center serving greater Washington's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in LGBTQ and HIV care.

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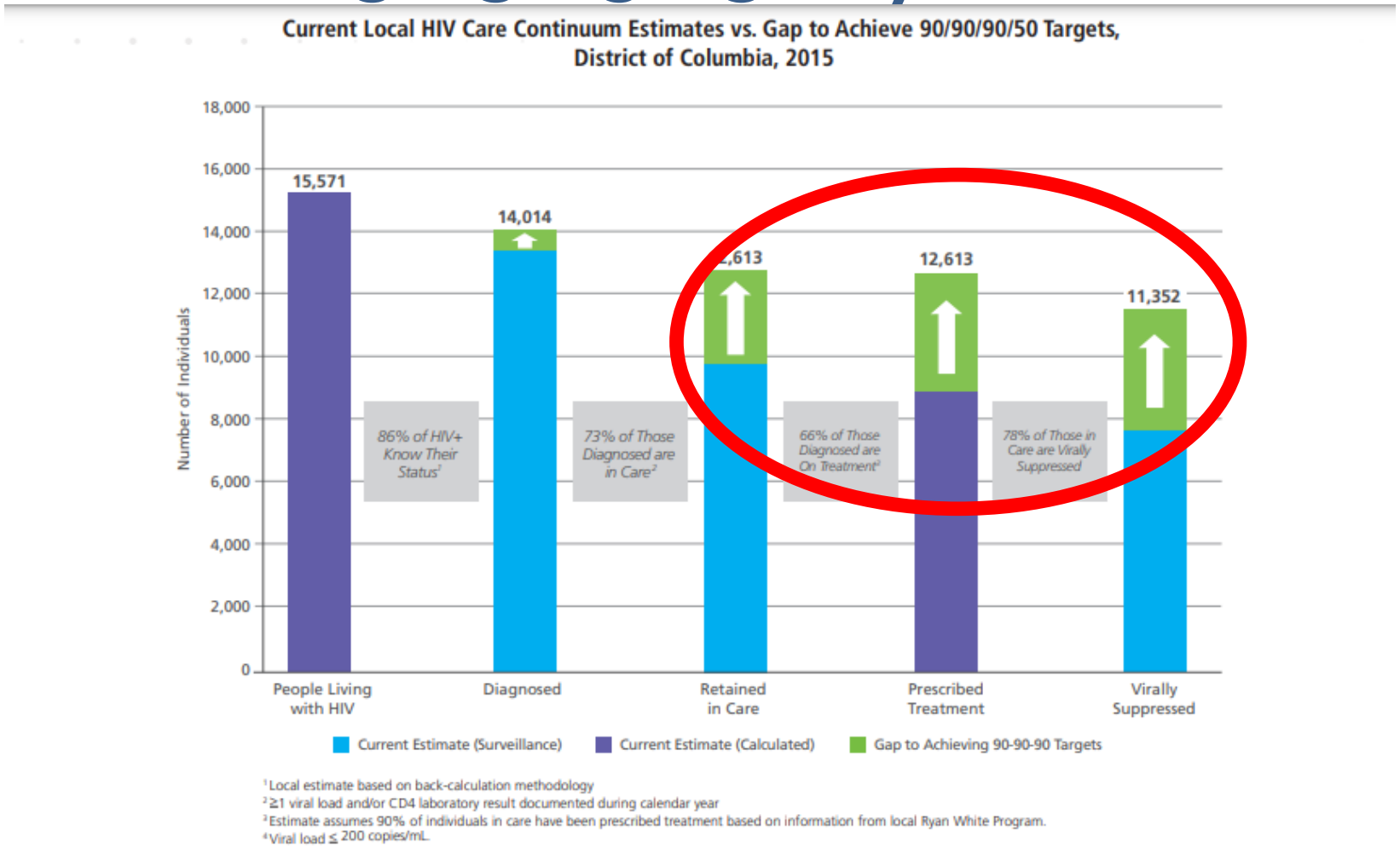
Scope of the Problem

- In 2015, over 15,000 or 2.0% people living in Washington DC were living with HIV/AIDS

- Mayor Bowser's 90-90-90-50 goal for 2020
  - -90% diagnosed
  - -90% of those diagnosed on ARVs
  - -90% of those on ARVs virally suppressed
  - -50% decrease in new HIV infections

HIV Care Continuum 2015 in the context of the 90/90/90/50 by 2020



Treatment as Prevention

- PLWH who are engaged in care have improved ARV access, increased viral suppression rates (VS%) and decreased all-cause mortality
- PLWH not retained in care (RIC) with viremia account for 67% of all HIV transmission
- PLWH who are undetected are 94.0% less likely to transmit HIV
- In 2017, DC DOH officially endorsed the scientific and stigma-reducing evidence of U=U (undetectable equals untransmittable) underscoring that persons living with HIV can live long lives without worrying about passing HIV to others or perceiving themselves as carriers of disease
- Therefore, interventions aimed at improving RIC and VS are essential in improving health outcomes for PLWH and reducing HIV transmission

Barriers to Care

GW Milken Institute, DC

Top reported barriers:

- Transportation
- “Didn’t feel like it”
- Forgot Appointment
- Competing priorities

Baligh et al, Philadelphia

HIGH	**-Competing Life Activities** **-Feeling Sick** **-Stigma** **-Mental Illness** **-Transportation** **-Insurance issues**
MED	**-Forgetfulness** **-Negative experience with clinic** **-Scheduling challenges** **-Difficult relationships with staff**
LOW	**-Unstable housing**

WWH's Response: MORE

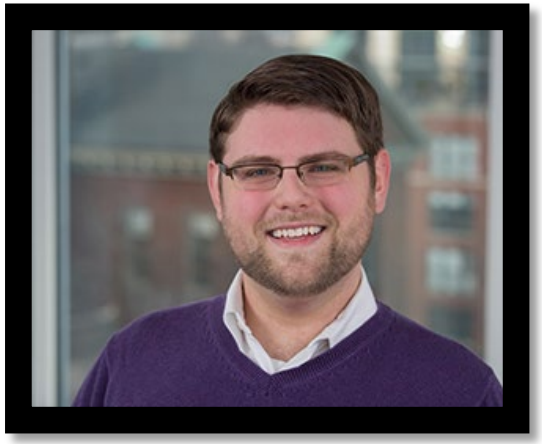
The Mobile Outreach Retention and Engagement Program (MORE)

- Initially a Public/Private Partnership
  - DC department of health
  - Washington AIDS partnership
  - Bristol Myers Squibb Foundation (initial 2y funding)
  - MAC AIDS Fund (initial 2y funding)
  - Additional funding from ViiV Healthcare
  - Now integrated into Standard of Care at WWH

- A comprehensive intervention to offer expanded support services and medical care **outside** of the clinic in response to identified barriers to care

The MORE Team

Megan Dieterich (she/her)-Provider



Bobby Bangert (he/him)-Manager

- 2 mobile advance practice practitioners (MAPP) PA-C/NPs with expertise in HIV (AAHIVS)
- 2 mobile care navigators (MCN)
  -aid in coordination of care
  -adherence counseling
- Manager of Retention and Engagement

Brandon Warren (he/him)-MCN

Chris Kubaska (he/him)-MCN

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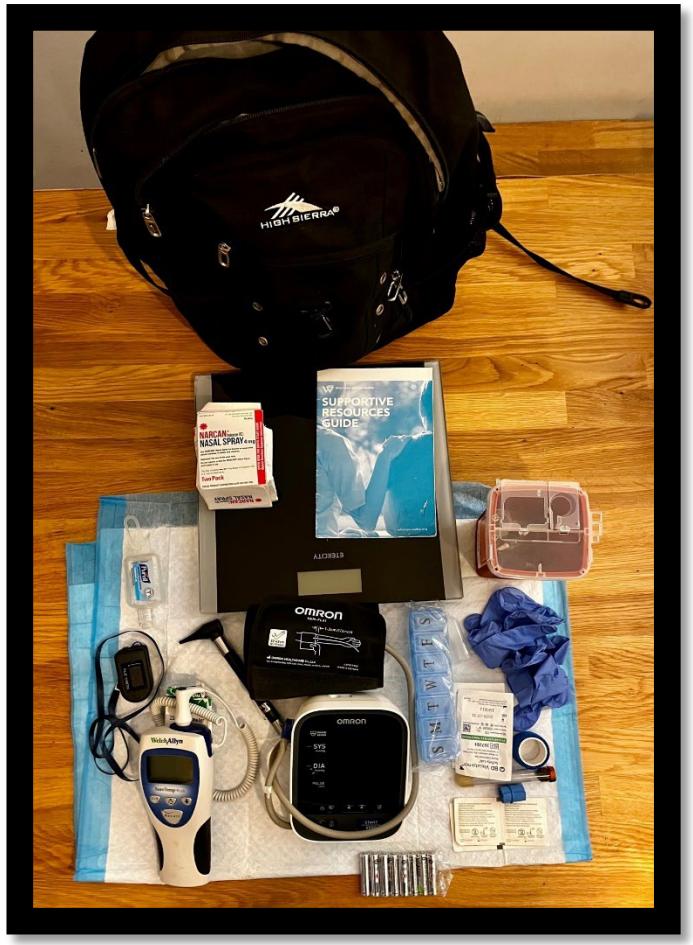
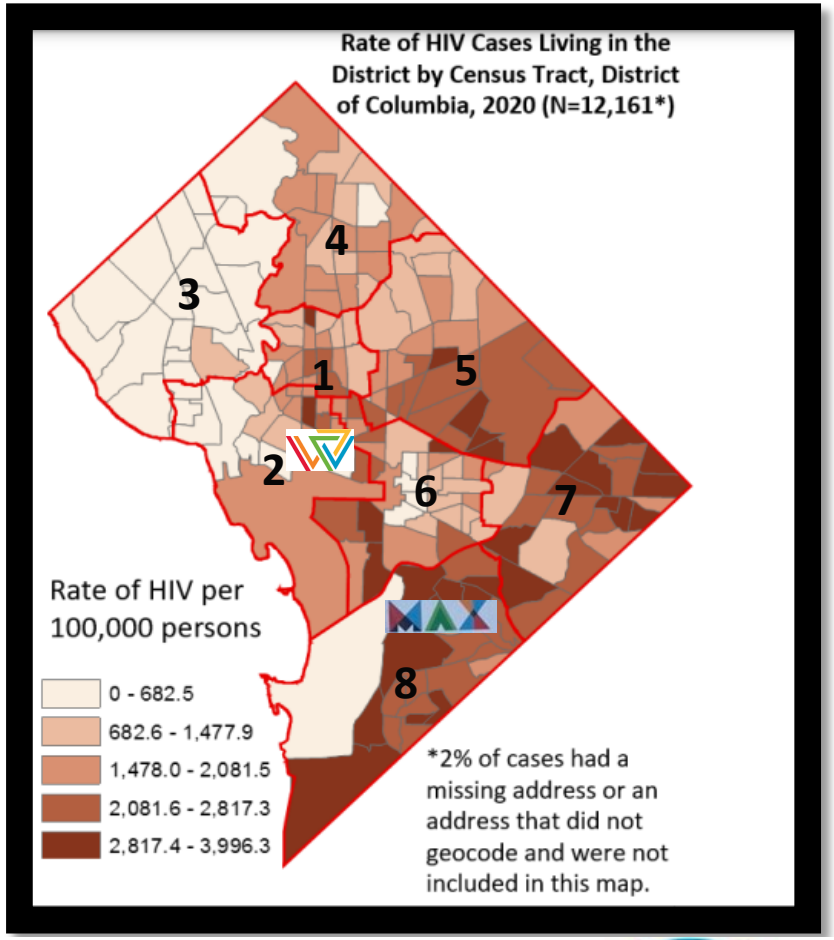
Response by Specific Barrier

Figure 1. Barriers to Care	MORE Team Response Service
Transport	➢ Medical and lab visits in home ➢ Ride Share services and help with MTM transport through insurance
Forgetting	➢ Care Navigation Support/reminder calls
Stigma	➢ Medical and lab visits in the home
Feeling Sick	➢ Medical and lab visit at the home
Scheduling	➢ Care Navigator scheduling ➢ Home visits ➢ Extended/flexible in-office appointments
Insurance	➢ Internal Public Benefit services
Competing Priorities	➢ Home visits and flexible hours ➢ Care Navigator support
Housing	➢ Connection to Housing Counselling Services or Core Service Agencies
Mental Health	➢ Connection to In-house services ➢ Transportation to psychiatry visits ➢ Connection to Core Service Agencies
Substance Use	➢ MAPP able to prescribe suboxone ➢ Connection to In-house services
Negative Experience at Clinic	➢ Home Visits ➢ Direct access to MAPP and MCN
Access to Food	➢ Food Cards
Unreliable Phone Access	➢ Ability to add Phone minutes

The MORE Home Visit



- Travel team of provider/MCN w/ “med bag” and phlebotomy supplies
- Drive to home or meeting place of choice
- Call before to confirm
- Home visit can include:
  - Vital signs
  - HPI
  - Limited PE
  - Phlebotomy/specimen collection
- Return to clinic with specimens



*Currently unable to deliver treatments (injections)

Recruitment

- **Inclusion Criteria**: 18+ WWH PLWH who:
  - had a detectable viral load (VL < 200 copies/ml) in the last 6 months

    and/or
  - no medical visit in the last 6 months

    and/or
  - specific barrier to care as identified by a provider

- **Re-engagement Blitz**: Periodic data pulls from EMR to identify eligible patients

Enrollment

- Care navigators call patients on list or have a “warm hand-off” from provider to conduct a brief the baseline interview

- The baseline interview includes:
  - a brief “pitch” on the MORE intervention
  - discussion around the client's willingness to participate
  - assessing the client's self-reported HIV medical care, barriers to care and supportive service needs (level of MORE).

- Interview is based on the structured Ryan White intake interview for CNs

Self-Selected Level of Need

LOW	MEDIUM	FULL
Low MORE participants receive: • Medical visits at the health center • Phlebotomy at the health center during standard hours • Insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards which can be accessed by individual	**Medium** MORE participants receive: • Medical visits at the health center • Phlebotomy at the health center during standard hours • **Internal Care navigation support** at the health center • Insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards with **CN support** • **Connection to food programs through CN support**	**Full** MORE participants receive: a MORE team • **Mobile medical visits in-home** or at a location of the client's choice with a Mobile Care Provider (MPP) • Medical visits at the health center with **flexible hours** with an MAPP, or during regular hours with an internal primary care physician • **Mobile phlebotomy** services at home, location of the patient's choice, or at Health Center during standard hours • Insurance sponsored transportation, tokens**, rideshare services (Uber/Lyft),** or SmarTrip (metro-rail) cards • **Food Cards** and connection to services • **Phone minutes** • **Weekly team (MCN/MAPP) care planning**

MORE Patient "Make it Work" Moments

I can't afford transportation to clinic

There is a stigma surrounding MRC, if I go in people will know I am HIV+

I can't get through to schedule my appointment, my minutes will run out if I wait on hold

I can't leave my grandbaby to come in

I can't take my medications because I don't have food

I can't get off work to come in because I don't have PTO

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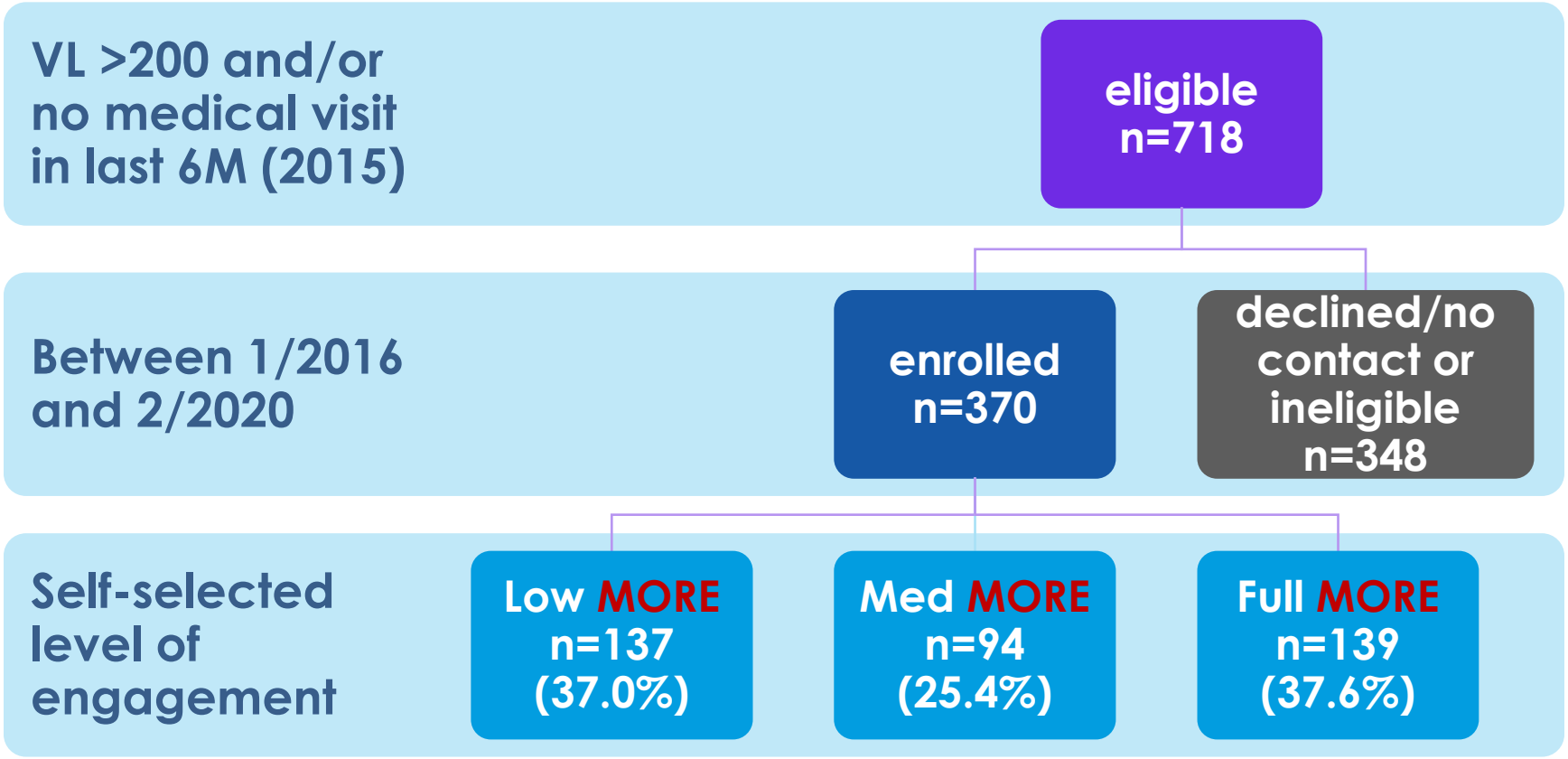
Results: Enrollment



Results: Demographics

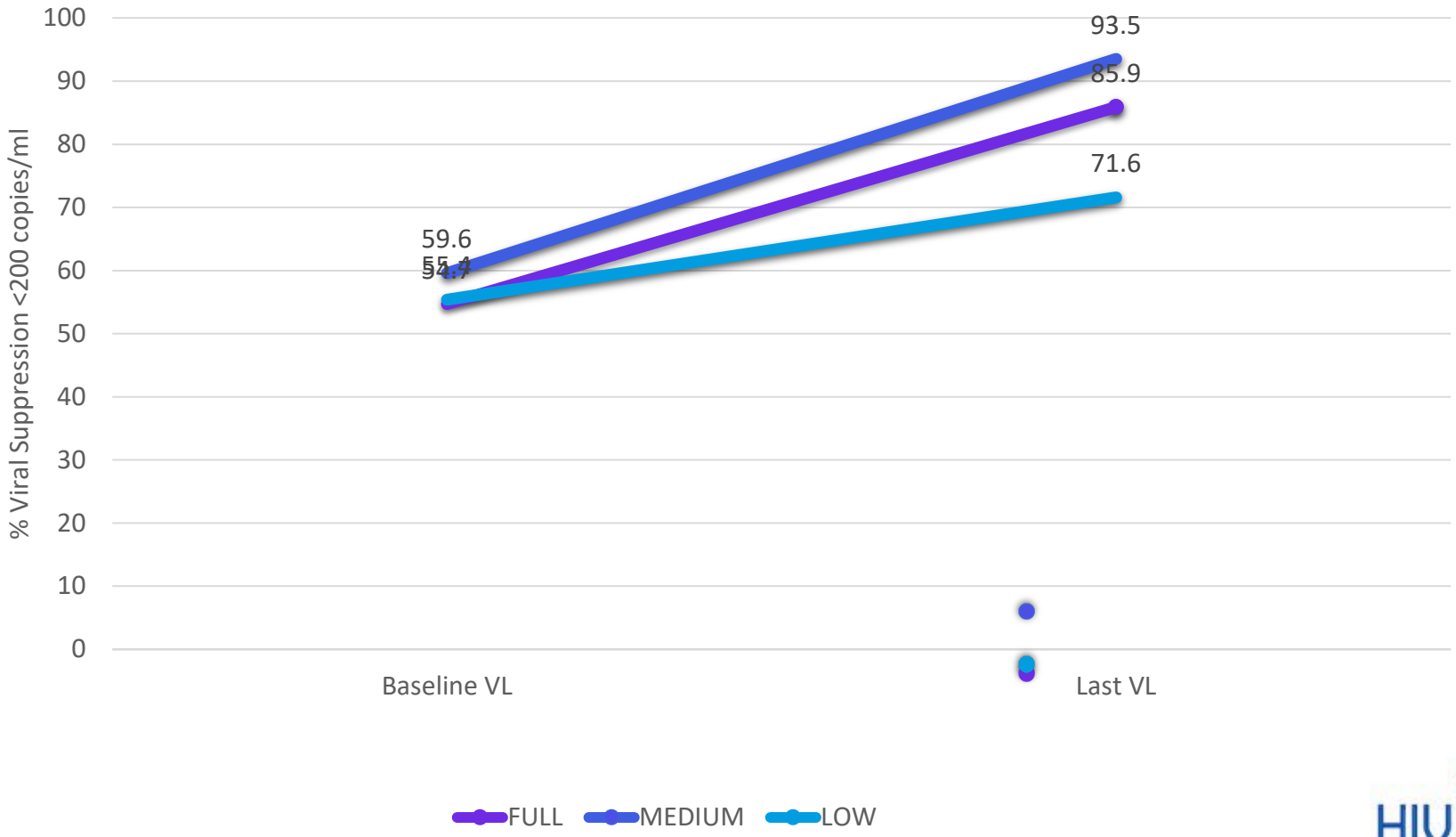
Table 1. Demographic Characteristics among varying levels of MORE participants

	Full MORE n=137 (%)	Medium MORE n=94 (%)	Low MORE n=139 (%)
Age Mean (SD)	45.8 (13.0)	47.7 (12.8)	47.7 (12.1)
Sex Assigned at Birth			
Female	51 (37.2%)	13 (13.8%)	30 (21.6%)
Male	86 (62.8%)	81 (86.2%)	108 (77.7%)
Transgender Identity			
Yes	30 (21.9%)	11 (11.7%)	18 (12.9%)
No	107 (78.1%)	83 (88.3%)	121 (87.1%)
Race			
Black/African-American	128 (93.4%)	79 (84%)	106 (76.3%)
White	6 (4.4%)	9 (9.6%)	20 (14.4%)
Other	3 (2.2%)	6 (6.4%)	13 (9.4%)
Ethnicity			
Hispanic	4 (2.9%)	8 (8.5%)	12 (8.6%)
Non-Hispanic	127 (92.7%)	81 (86.2%)	123 (88.5%)
Sexual Identity			
Gay/Lesbian	46 (34.3%)	49 (35.3%)	66 (47.5%)
Heterosexual	61 (45.5%)	30 (21.6%)	43 (30.9%)
Bisexual	13 (9.7%)	6 (4.3%)	14 (10.1%)
Other	14 (10.2%)	8 (8.5%)	16 (11.7%)
Insurance Category			
Medicaid	97 (70.8%)	48 (51.1%)	63 (52.5%)
Medicare	28 (20.4%)	15 (16.0%)	32 (26.7%)
Private	8 (5.8%)	19 (20.2%)	12 (10.0%)
None	4 (2.9%	12 (12.8%)	13 (10.9%)

Results: Co-Morbid Conditions

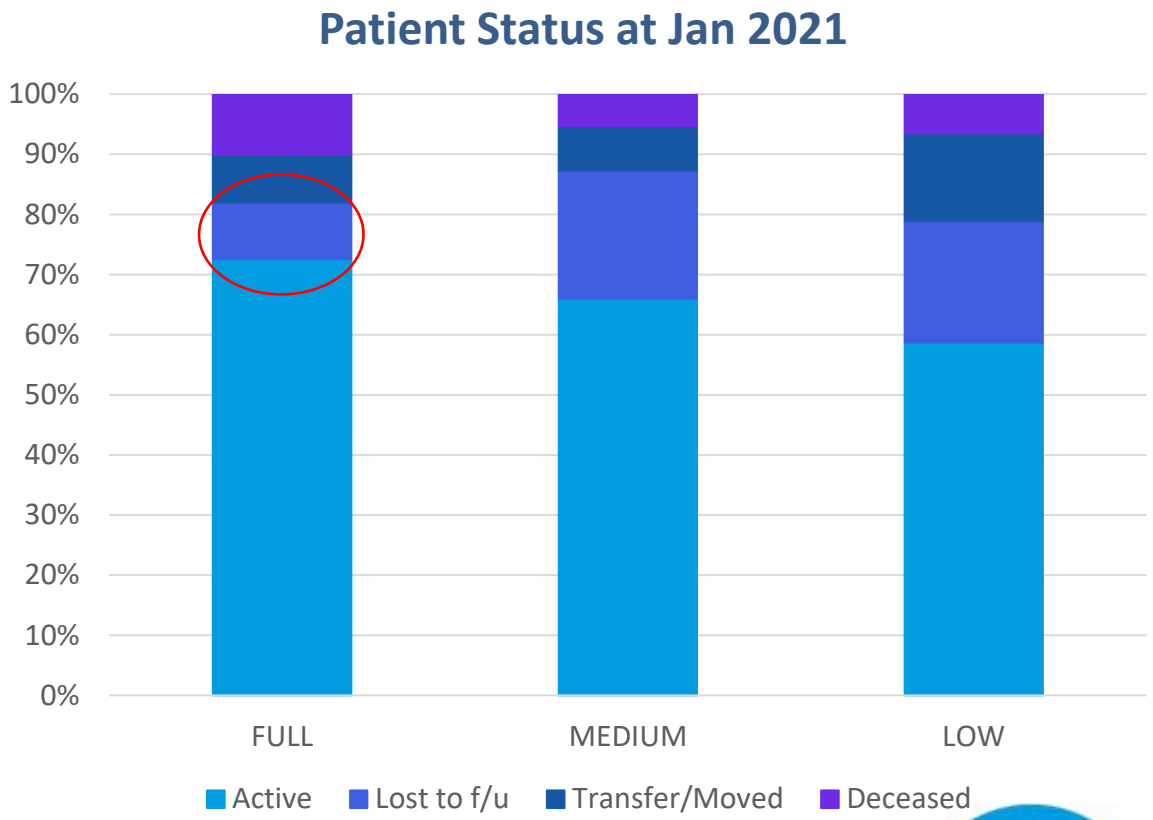
Table 2. Co-morbid Conditions by level of MORE			
	FULL	MEDIUM	LOW
Hypertension	57 (41.6%)	34 (36.2%)	42 (30.2%)
Diabetes type 2	25 (18.2%)	16 (17.0%)	10 (7.2%)
Mental Health Diagnosis	62 (45.3%)	51 (54.3%)	61 (43.9%)
Substance Use Disorder	25 (18.2%)	10 (10.6%)	14 (10.1%)

Results: Viral Load Suppression Rate in those "Retained in Care"



Results: Lost to Follow-Up

	Full MORE N=137	Medium MORE N=94	Low MORE N=139
Active “in-care”	72.3% (n=99)	44.6% (n=62)	58.3% (n=81)
Lost to Follow-Up*	9.5% (n=13)	14.4% (n=20)	20.1% (n=28)
Transfer/moved/incarcerated	8.0% (n=11)	5.0% (n=7)	14.4% (n=20)
Deceased	10.2% (n=14)	3.6% (n=5)	6.5% (n=9)
Adjusted Active (minus deceased/transfer)	87.6% (n/N=99/113)	75.6% (n/N=62/82)	73.6%(n/N=81/110)



*Lost to Follow-Up defined and no medical or phlebotomy visit in the last 12 months

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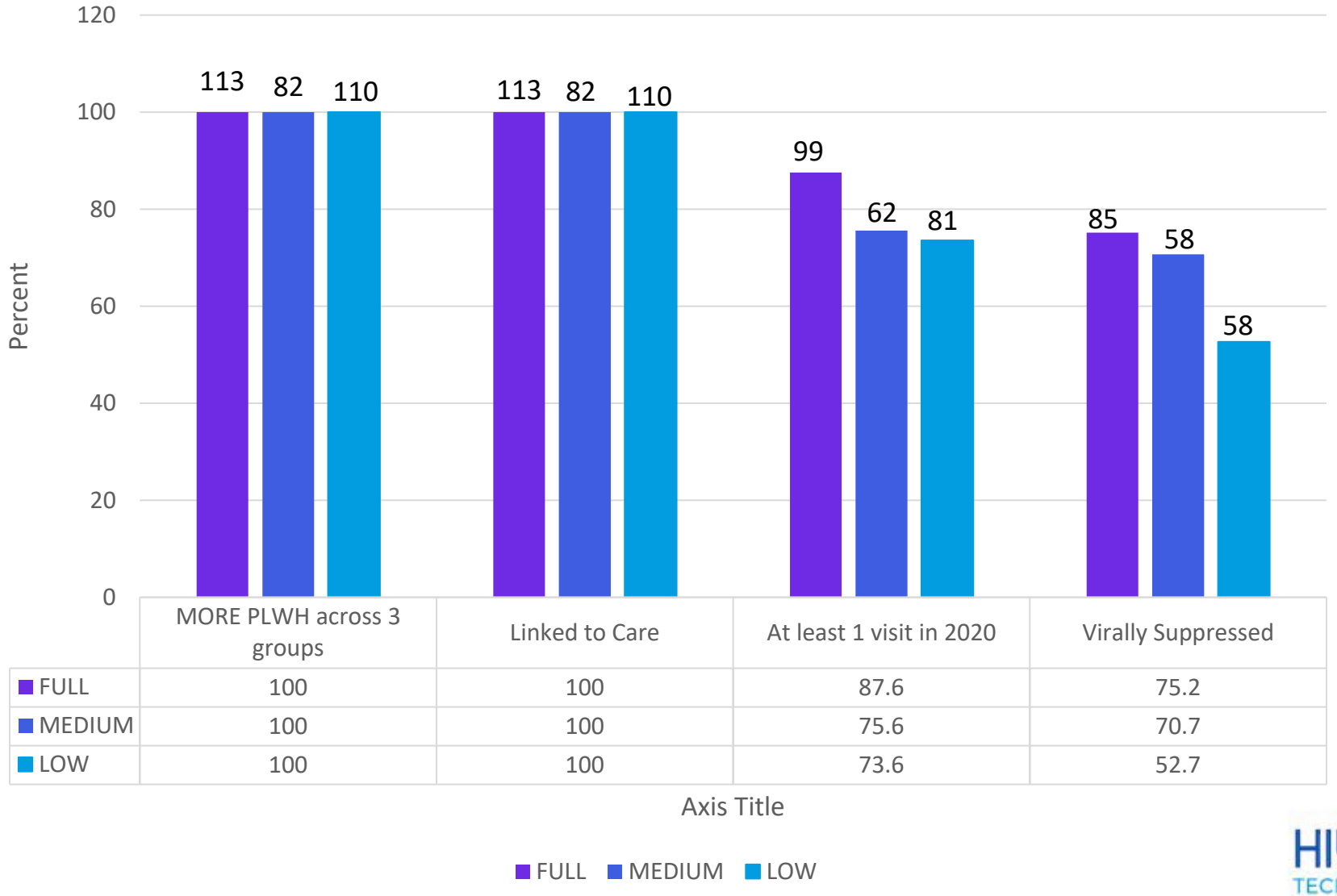
Results: MORE HIV Care Continuum 2020



	MORE PLWH across 3 groups	Linked to Care	At least 1 visit in 2020	Virally Suppressed
FULL	100	100	87.6	75.2
MEDIUM	100	100	75.6	70.7
LOW	100	100	73.6	52.7

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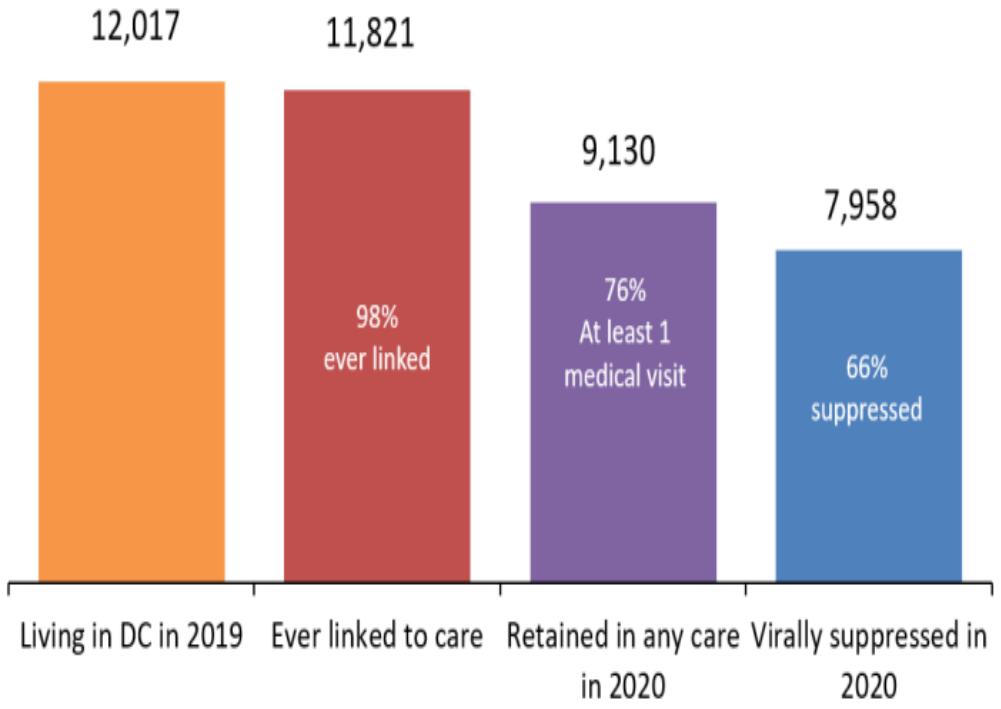
Washington, DC HIV Care Continuum 2020

Figure 6. HIV Care Continuum among People Living with HIV in DC, 2020



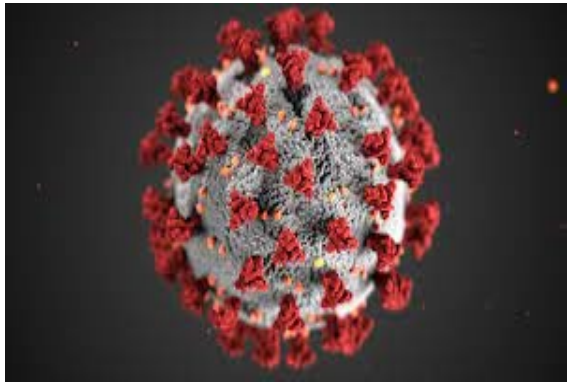
Evaluation Challenges

- Priority to mirror standard of care/observational data vs. Randomized Controlled Trial
- Rolling Enrollment: variable program “exposure time”
- Difficulty defining Retention in Care
  - HRSA measure vs
  - “at least 1 visit in last year”
- Lack of resources for ongoing comprehensive evaluation
  - Staff time
  - Biostatistician funding

Implementation Challenges

As of March 2020

- COVID-19 Pandemic



- Variable external and internal uptake and buy-in
- Staff turnover/Burnout
- Sustainability: Cost

COVID-19 Pandemic Shut Down

On March 14th, 2020 in response to Coronavirus Pandemic, WWH moved all non-COVID related visits to Telehealth. MORE home visits were also suspended during that time and FULL MORE services had to quickly shift to serve our patients

Mobile Providers (MAPP)

- Home visits switched to Telehealth visits (audio and audio/visual)
- Home phlebotomy visit switched to outside Labcorp facilities
- Weekly Care Planning

Mobile Care Navigators (MCN)

- Facilitated scheduling of telehealth appts
- Scheduled Labcorp phlebotomy appointments
- Facilitate transportation (Lyft/Uber)
- Help with prescription delivery
- Provide phone minutes
- Mailed food cards
- Adherence counselling

Post COVID-19 Shut Down MORE services

WWH re-opened to limited primary care in-person visits in July 2020 but MORE home visits were still prohibited. Limited home visits were allowed in June 2021 but remain slow.

Mobile Providers (MAPP)

- Limited Home Medical/Phleb Visits
- Increased utilization of flexible hours at clinic
- Continued telehealth use
- Weekly Care Planning

Mobile Care Navigators (MCN)

- Facilitate scheduling of visits
- Facilitate transportation (Lyft/Uber)
- Help with prescription delivery
- Provide phone minutes
- Provide food cards
- Adherence counselling

Strategies to Increase Program Buy in: External Stakeholders

Preparation phase:

- Meetings with funders, local community members, community-based organizations.

- Partnered with and compensated members of local Ryan White and HIV Prevention Steering Committees to gather recommendations for the program

Ongoing:

- Dissemination of evaluation outcomes to funders and community members

Strategies to Increase Program Buy in: Internal Stakeholders

Preparation Phase:

- Periodic meetings with WWH's CEO, Chief Health Officer and Chief Program Officer to provide context and review the proposed intervention

Ongoing:

- The MORE team holds recurring meetings with other WWH staff (e.g., medical providers, population health, nurses, care navigation staff) to provide updates to the program and elicit referrals

- Dissemination of findings to WWH staff

Engaging Non-Traditional Partners for Support: Community Based Organizations (CBOs)

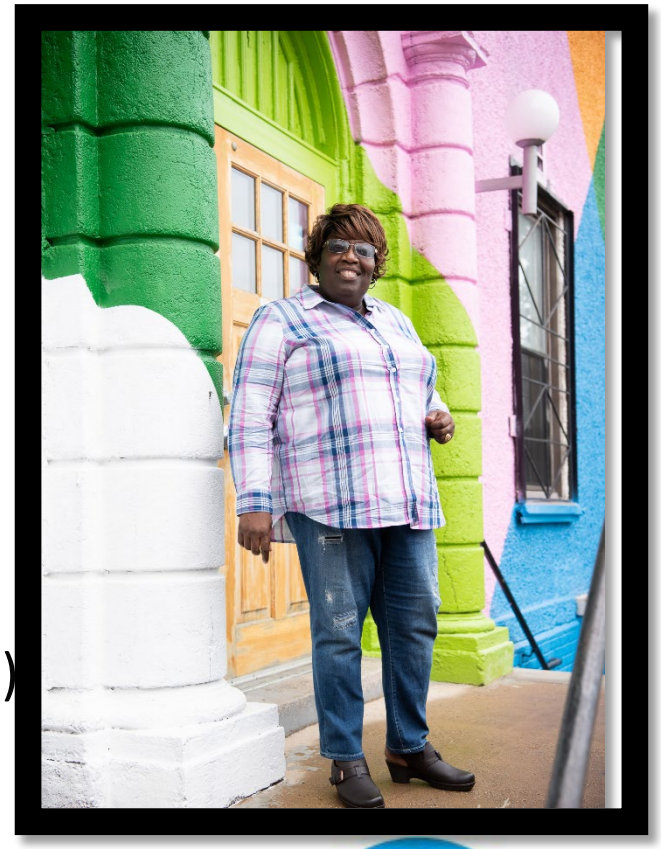
Pop up clinics at CBOs in 2016/2017

- Opportunity to see multiple patients at one place
- Foster re-engagement by being seen
- Less collaboration since pandemic

Engaging Non-Traditional Partners for Support: Peer Support

Peer Support Community Health Worker: Robin Thomas (she/her)

- Home drop-ins
- Support Calls/Adherence Counselling
- Support group for Women living with HIV
  - "The Break Room" at MRC



Peer Recovery Specialist: Vickie Sellers (she/her)

- Works with the MOUD program (not HIV specific)
- Support calls
- Runs weekly recovery support groups

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Engaging Non-Traditional Partners for Support: Pharmacy

- Both the 1525 (NW) and MRC (SE) locations have onsite pharmacies
- Each location conducts routine surveillance of fill frequency for patients using our pharmacies
- Each provide Prescription Delivery services

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Sustainability: Cost Analysis

- Cost analysis was conducted using the CIE Cost Analysis Calculator:
  - http://ciehealth.org/innovations
    - Total cost for implementing the FULL MORE intervention was estimated at roughly **$347,098** annually
      - 80.3% of all direct cost was staffing and personnel
      - 10% of direct program non-personnel costs included staff computer-related expenses and medical supplies
      - 9.8% was client-specific costs which included food cards, educational materials and transportation related costs.
    - Direct cost per client served was **$3,478** ($4,285 with overhead)

Next Steps & Future Directions

1.) Use lessons learned from evaluation to target and modify intervention to better fit service delivery in the
   - Re-approach those in the Low MORE group
   - Less focus on home visits and increase flexible hours
   - Integration and expansion of "FULL MORE" services to internal CN
     - 2-way SMS
     - uber/lyft rides
     - weekly team base care planning
   - Re-integrate and engage new non-traditional partners

2.) Complete comprehensive impact evaluation of 6-years including VS and RIC with before/after COVID-19 comparisons and to examine whether VS and RIC is sustained

3.) **Explore strategies to incorporate the administration of long-acting injected medication (LA CAB/RPV)**

4.) Suggestions?

References

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2022 NATIONAL HIV & HEPATITIS TECHNICAL ASSISTANCE MEETING

Thank You!

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