HRSA
Health Resources & Services Administration

Evaluating the Impact of the RWHAP: From Cost Effectiveness to Clinical Care

2020 National Ryan White Conference on HIV Care and Treatment

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Vision: Healthy Communities, Healthy People

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HRSA's HIV/AIDS Bureau (HAB) Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

HRSA's Ryan White HIV/AIDS Program (RWHAP)

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV
  - ✓ More than half of people with diagnosed HIV in the United States – nearly 519,000 people – receive care through the RWHAP
- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 87.1% of RWHAP clients were virally suppressed in 2018, exceeding national average of 62.7%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018; CDC. HIV Surveillance Supplemental Report 2018;21(No. 4)

HRSA Ryan White HIV/AIDS Program

Workshop Outline

- HIV/AIDS Bureau Evaluation Portfolio
- Recently Completed Studies
  - Study #1: Cost-effectiveness of the RWHAP
  - Study #2: Clinical care models & HIV clinical outcomes
  - Study #3: RWHAP clients who do not reach and/or maintain viral suppression
- In-Progress Evaluation Studies

HIV/AIDS Bureau Evaluation Portfolio

A Data-Driven Approach to Enhancing the RWHAP

- Purpose: To demonstrate the impact of the RWHAP and to inform programmatic decision-making
- Identify gaps
  - Gather input from stakeholders (e.g., Federal partner agencies, national partner organizations, community members)
  - Analyze quantitative RWHAP client-level data
  - Analyze qualitative information from implementation science projects and other sources
- Develop and implement evaluation studies
- Inform programmatic decisions

Cost-Effectiveness of the RWHAP

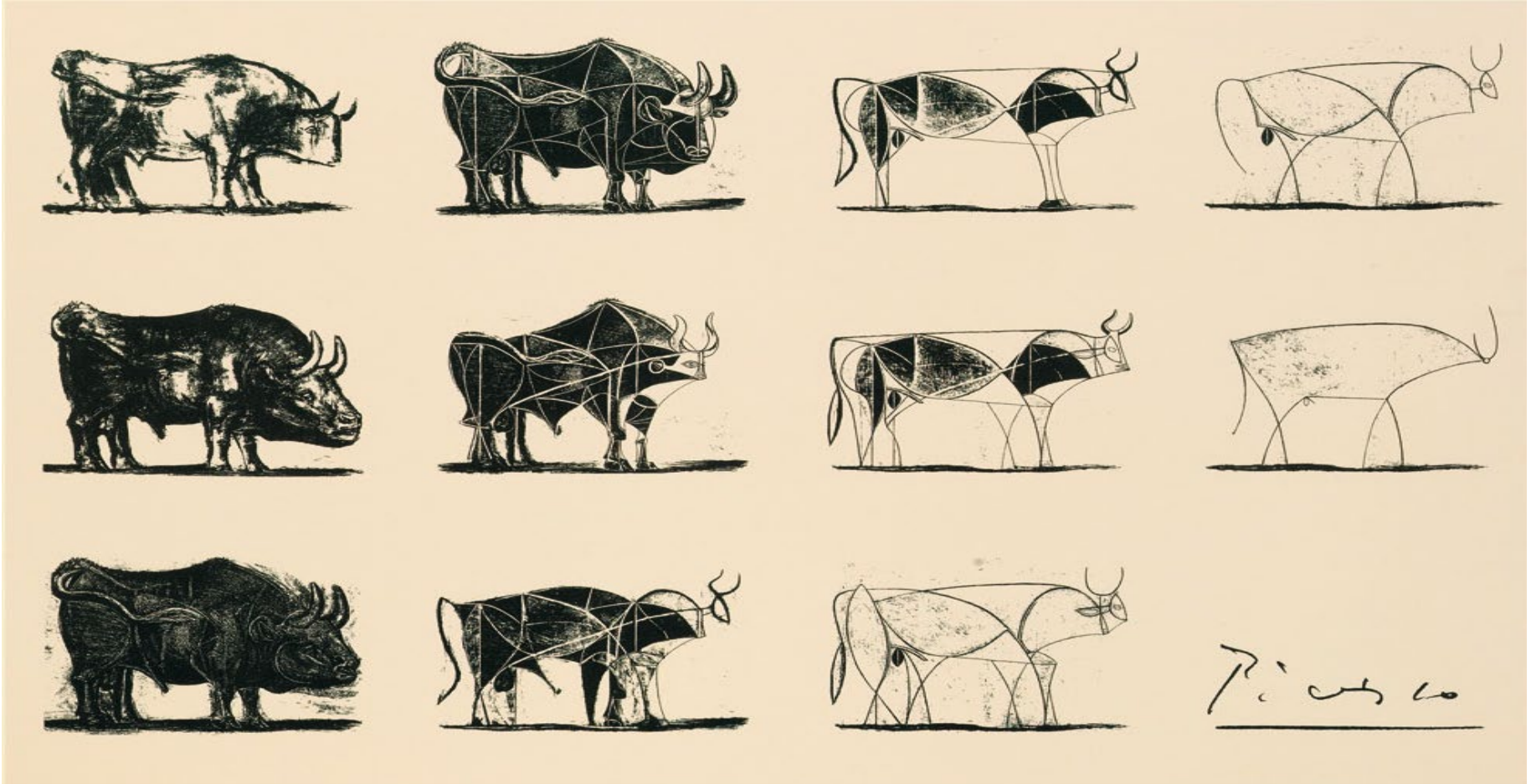
An evaluation study conducted by Mathematica and Mission Analytics Group

Study Questions

What is the cost-effectiveness of the RWHAP, compared with a scenario where RWHAP services are not available?

What is the ***projected impact of the Ending the HIV Epidemic initiative Diagnose and Treat pillars*** on the HIV epidemic and the RWHAP?

What is a mathematical model?



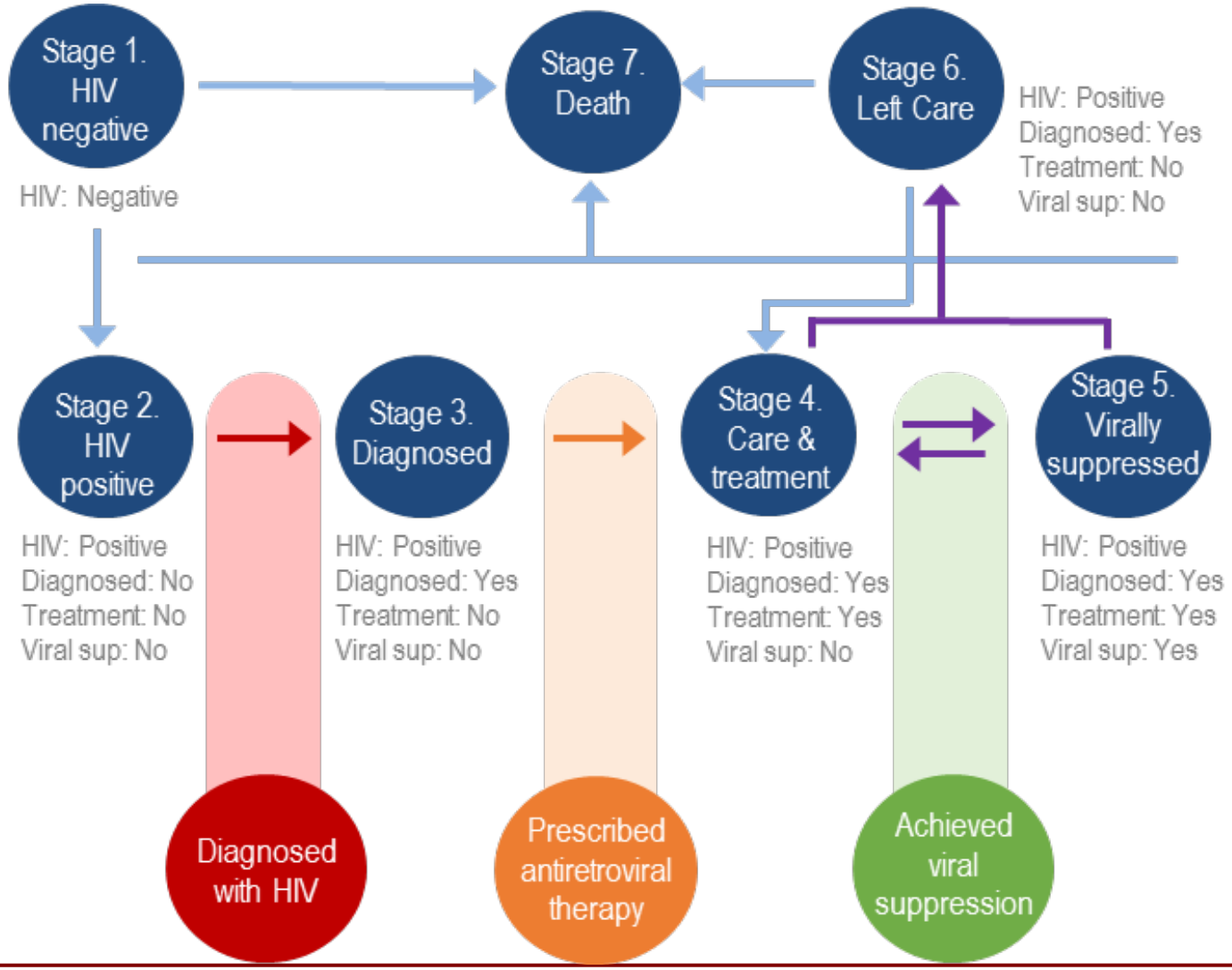
Model Overview

- Model is parameterized to represent the characteristics of the HIV epidemic and care system in the United States over 50 years
- Model inputs are based on data from:
  - RWHAP Services Report (RSR), ADAP Data Report (ADR), and allocations reports
  - HIV surveillance data
  - Published scientific literature
- RWHAP service categories included:
  - Outpatient ambulatory health services (OAHS) + ART
  - Medical case management (MCM)
  - Mental health/substance use (MH/SA)
  - Other RWHAP services (Support+)

Model Overview (continued)

- Key model outcomes:
  - Number of new HIV infectious
  - Number of life years among people with HIV
  - All-cause mortality among people with HIV
  - Total costs of HIV care and treatment
    - ✓ OAHS/ART
    - ✓ MCM
    - ✓ MH/SA
    - ✓ Support+
    - ✓ Emergency department
    - ✓ Inpatient
  - Incremental cost effectiveness ratio (ICER)

Model Structure



Cost-Effectiveness Analysis Scenario Definitions

- Receipt of needed services is the primary driver of model outcomes
- ***RWHAP scenario***: base case parameters
- ***Non-RWHAP scenario***: uninsured RWHAP clients lose access to needed services received through the RWHAP (conservative assumption)

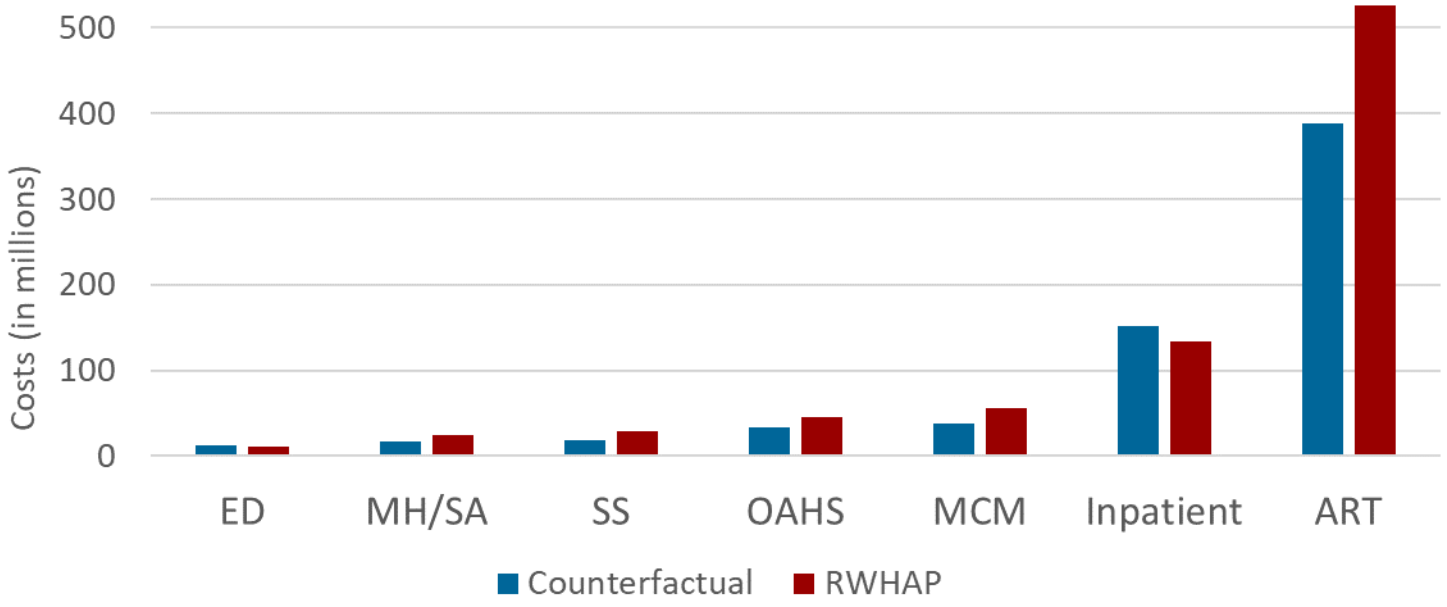
	Percentage of clients who receive a needed service (%)	
Service	**RWHAP scenario**	**Non-RWHAP scenario**
OAHS/ART	100.0	57.6
MCM	93.5	75.9
MH/SA	84.0	72.2
Support+	78.7	62.0

Impact of RWHAP on Health Outcomes

Outcome	RWHAP scenario	Non-RWHAP scenario	Difference
Percentage of people with HIV who were ever:			
In care and treatment (%)	88.3	63.8	+24.5
Lost to care and treatment (%)	3.4	14.7	-11.3
Virally suppressed (%)	82.6	57.4	+25.2
Health outcomes			
Number of new HIV infections	844,550	1,034,747	-190,197
Number of deaths among people with HIV	600,865	868,752	-267,887

RWHAP Costs and Cost-Effectiveness

Outcome	RWHAP scenario	Non-RWHAP scenario	Difference
Total costs (in millions)	$825,963	$660,815	$165,148
Cost per QALY	$2,147	$1,769	$378
ICER	$29,573	n/a	n/a

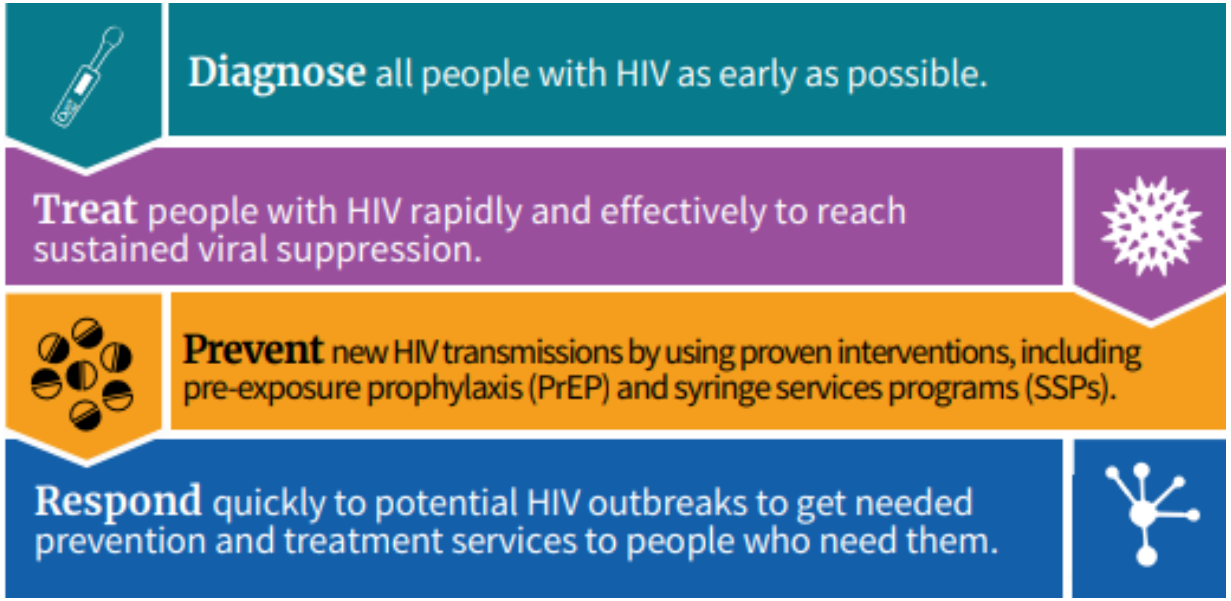


Comparison of RWHAP to Other HIV Care and Prevention Interventions

Intervention/Program	ICER
Genotypic resistance testing at treatment failure (Weinstein 2001)	$17,900
Genotypic resistance testing of treatment-naïve patients (Sax 2005)	$20,200
Three-drug ART regimen (Freedberg 2001)	$23,000
RWHAP	**$29,573**
Inpatient HIV testing (Walensky 2005)	$47,100
Routine outpatient HIV testing every five years (Paltiel 2005)	$61,000
Providing PrEP to 20 percent of general MSM population (Juusola 2012)	$185,000

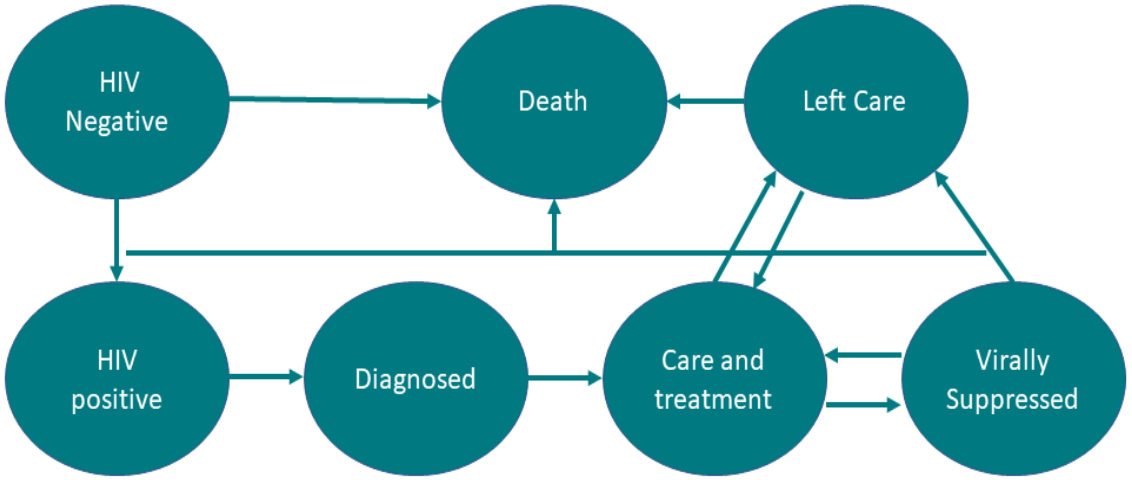
RWHAP and Ending the HIV Epidemic Initiative (EHE)

- The RWHAP will play a central role in the Ending the HIV Epidemic (EHE) initiative
- Adapted cost-effectiveness mathematical model
  - Focus on Diagnose and Treat Pillars
  - 10-year projections
  - Overall impact and impact on RWHAP clients

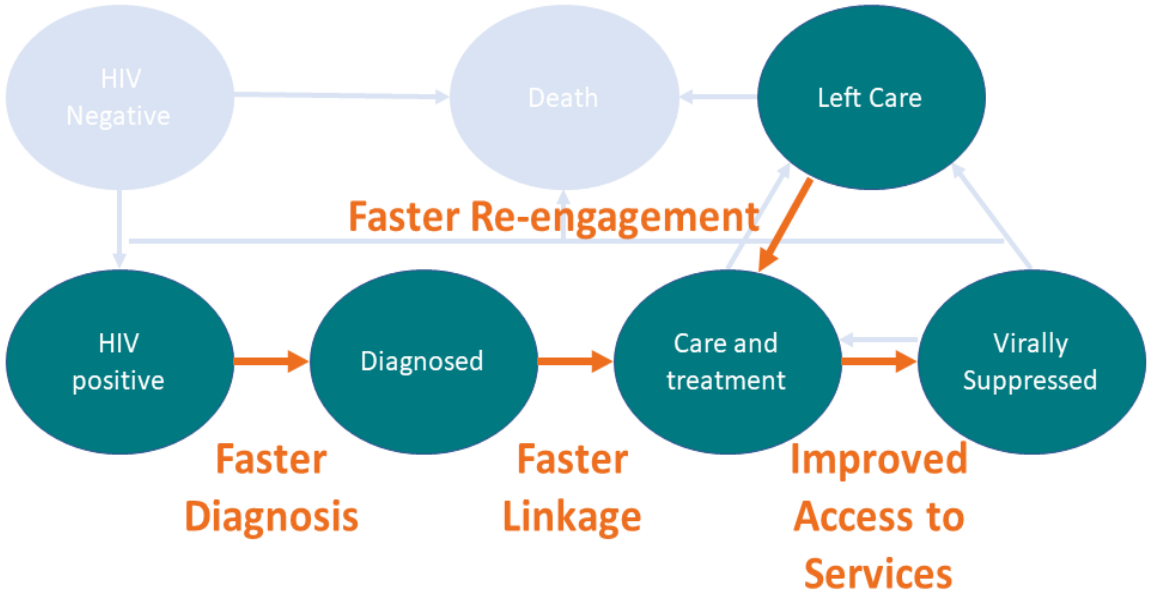


EHE Analysis: Scenario Definitions

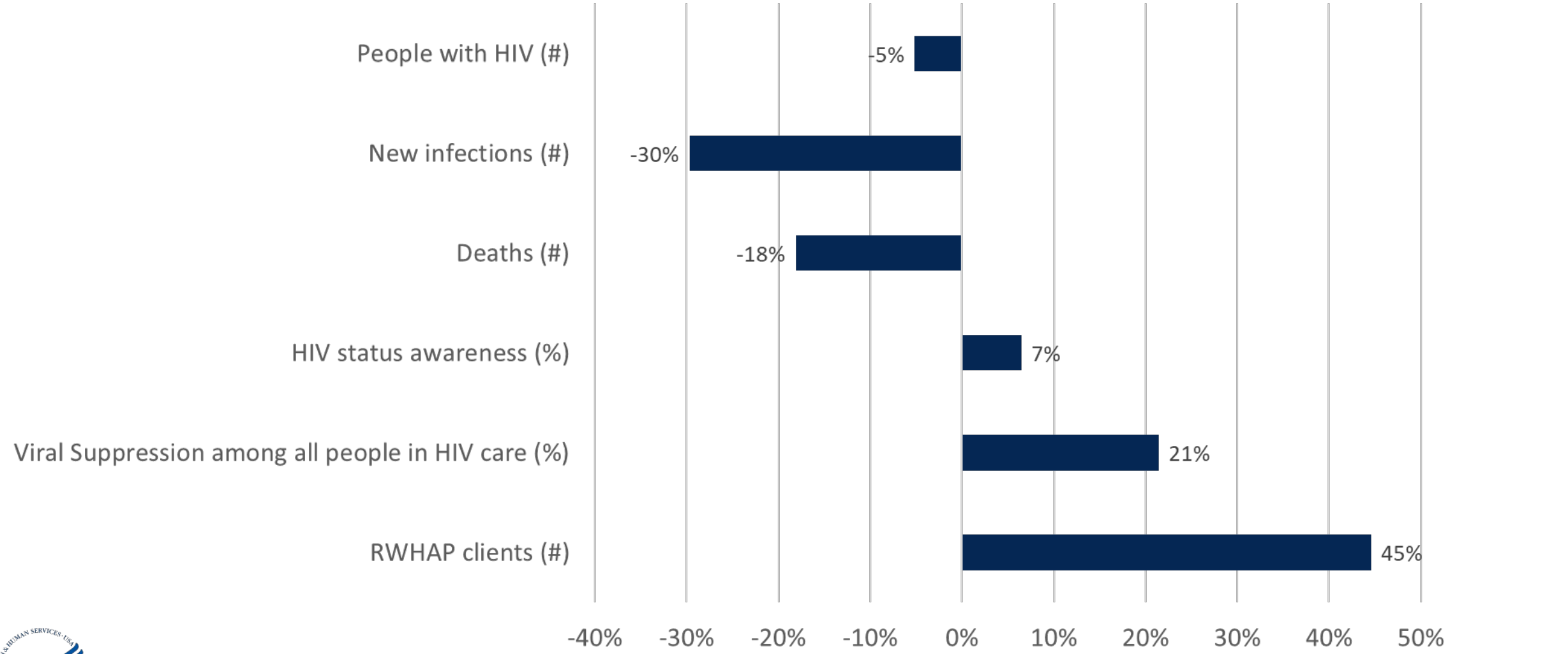
Seven stages in the model



Changes from the EHE initiative

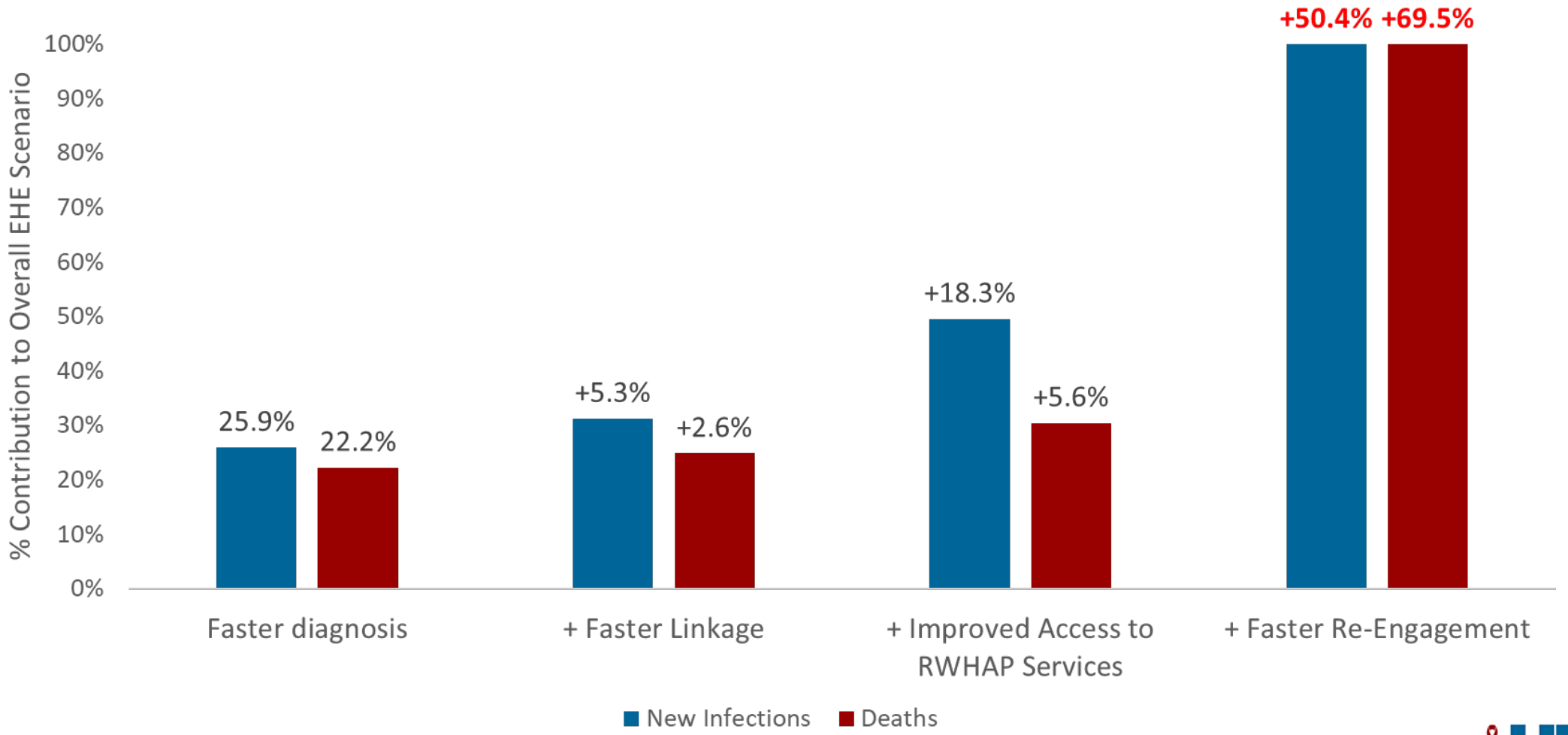


Projected Difference Between EHE Initiative Scenario and Current RWHAP Scenario in Year 10



HRSA Ryan White HIV/AIDS Program

Faster Re-Engagement in Care is Largest Driver of New Infections and Deaths



HRSA Ryan White HIV/AIDS Program

Conclusions

- Compared to a scenario in which RWHAP services are not available, the current RWHAP ***is cost-effective***.
- This model estimates that the RWHAP contributes to:
  - An increase in
    - ✓The proportion of people with HIV in care and treatment
    - ✓The proportion of people with HIV who are virally suppressed
  - A decrease in
    - ✓The proportion of people with HIV lost to care and treatment
    - ✓New HIV infections
    - ✓Deaths among people with HIV

Conclusions

- With EHE implementation, this model projects that the RWHAP can expect to serve a significantly larger client population, which is contingent on the strength of organizational infrastructures, workforce capacity, and resources.
- The RWHAP plays a critical role achieving the 10-year goals of the EHE initiative, particularly through the re-engagement of people with HIV who had fallen out of HIV care.
- The RWHAP alone is not sufficient to achieve these goals; partnerships with other Health and Human Services agencies, local governments, and on-the-ground medical and support service providers will be essential to achieving the goals of the EHE initiative.

Clinical care models & HIV clinical outcomes

An evaluation study conducted by Abt Associates

Models of Care Overview

- Study Purpose:
  - To discover which clinic care models lead to better outcomes for RWHAP clients, and why.

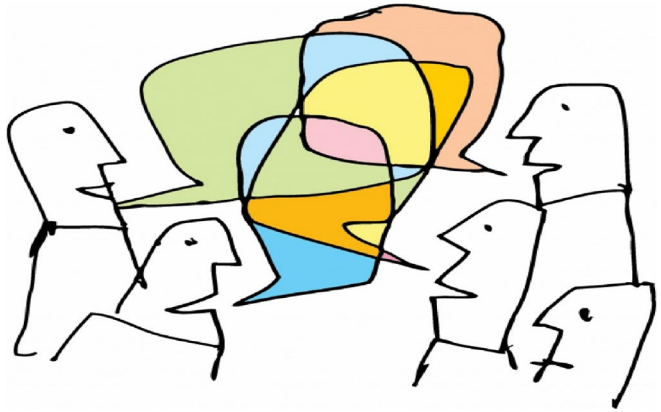
MODELS OF CARE (MoC)	
Primary	Primary care provider is lead provider for HIV care, includes general medical care; refers out for additional infectious disease (ID) and other specialist services.
Specialty	HIV or ID provider is the lead provider for HIV care, includes general medical care; refers out other specialist services.
Integrated	Involves both the primary and specialty care provider collaborating in the overall care of the patient.

Key Research Questions

Topic Area	Research Question
Defining Model of Care	1. What are the models of care used by RWHAP clinical care providers? 2. How do staff roles vary within models of care? 3. How do models of care used in the treatment of other chronic diseases differ from the models of care used in the treatment of HIV?
Patient Experience	1. To what extent do patients seek out specific models of care? 2. How are issues of stigma and cultural competency addressed in different models of care?
Clinical Outcomes	1. Which models of care have better HIV clinical outcomes, including retention and viral suppression? 2. How well is non HIV specific care provided among different models of care - such as routine vaccination, routine colon cancer screening, smoking cessation, etc.?

Data Collection Activities

- Qualitative Data
  - Provider Interviews**
  - Client Focus Groups**



- Quantitative Data
  - Medical Records Abstraction**
  - Provider Web Survey
  - RSR Data

**completed in-person

Study Sample Overview

- Study sample was drawn from the provider web survey
  - 50 sites targeted for recruitment, 45 successfully recruited (achieved 90% of recruitment goal)
- MoC was initially classified through responses provided in the provider web survey

Original MoC Classifications	Distribution of Sites	
Integrated	23	51%
Specialty	15	33%
Primary	7	16%
Total	**45**	**100%**

Initial Construction of MoC Measure

- Developed from MoC, Suppression, and Outcomes (*qualitative*) provider interview questions assessing MoC
- Open-ended responses originally coded into five categories based on response options provided in the interview guide and thematic analysis

Category	Definition
Exclusively Primary Care	Primary care clinic that has not integrated HIV care
Exclusively HIV Specialty Care	Specialist clinic that has not integrated primary care
Primary Care-Led Co-Managed	Primary care clinic that has integrated HIV care
Specialist-Led Co-Managed	Specialist clinic that has integrated primary care
Integrated*	Respondents unable to choose either primary led-co-managed or specialist-led co-managed.

*"Integrated" was not provided as a possible response option to providers in interviews. It was created based on analysis of open-ended qualitative responses. It is possible more clinics would have selected this option if they were given the choice.

Final Construction of MoC Measure

Five categories collapsed, to create a final three-category measure

Five-Category Measure	Distribution of Sites		Three-Category Measure	Distribution of Sites	
Exclusively HIV Specialty Care	10	14%	Exclusively HIV Specialty Care	10	14%
Specialty-led Co-managed Care	32	44%	Integrated Co-managed Care	59	82%
Integrated Care	17	24%			
Primary Care-led Co-managed Care	10	14%			
Exclusively Primary Care	3	4%	Exclusively Primary Care	3	4%

Analytic Methods - Quantitative

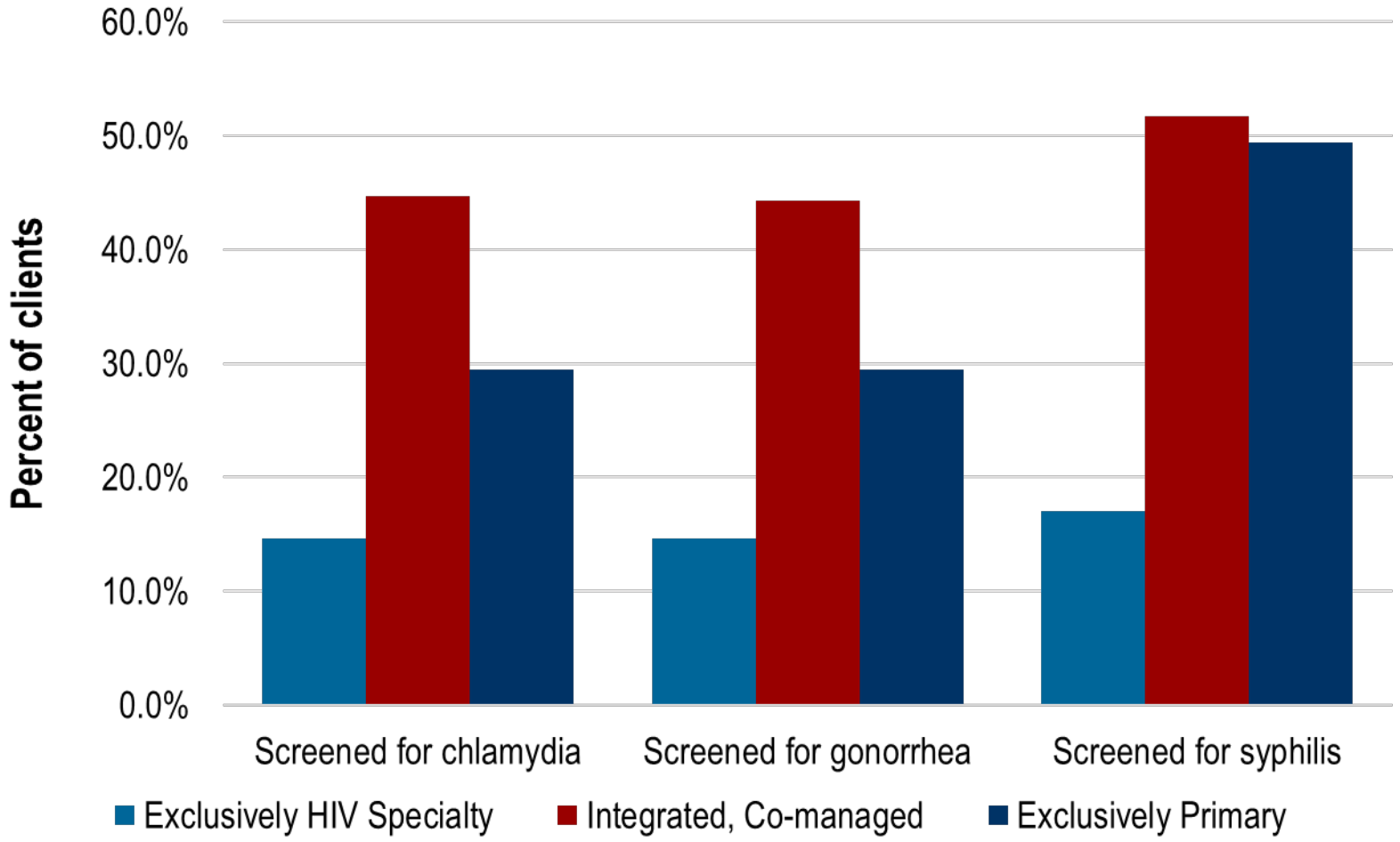
- Pooled data from MoC, Viral Suppression, and Outcomes studies
- Utilized both provider-level and client-level data
- Techniques included: bivariate descriptive analyses, logistic and multinomial logistic regression analyses and adjusting standard errors to account for clustering of clients within providers
- Domain-based analyses focused on research questions

Analytic Methods - Qualitative

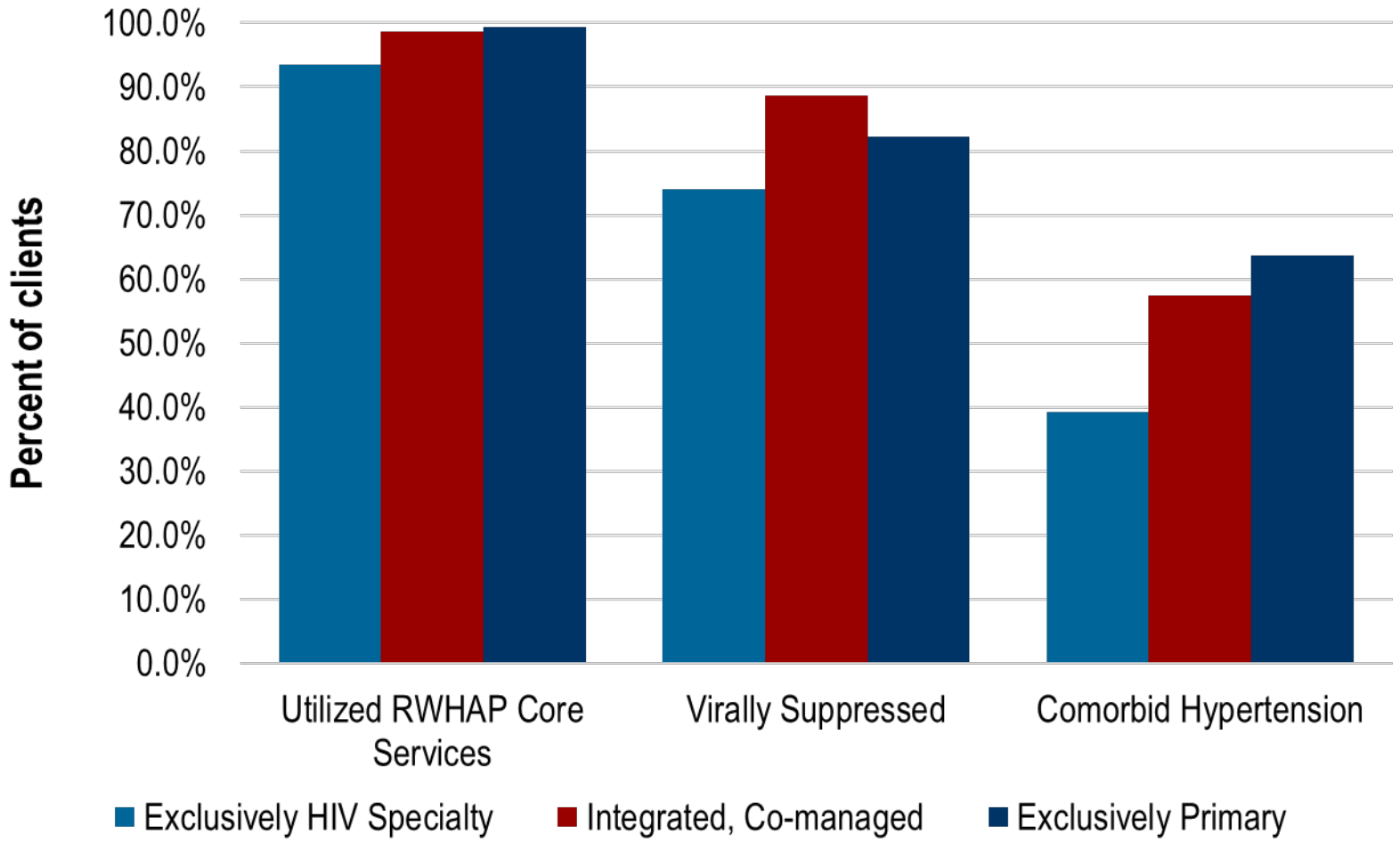
- Conducted thematic analysis to pinpoint key themes emerging across data sources
  - Developed a priori thematic codebook based on RQs and background knowledge
  - Trained three independent coders, conducted reconciliation process to establish strong interrater reliability

- Conducted all analyses using NVivo 11 and developed templates to auto-code interviews by question

STI Screenings by MoC



Client Clinical Characteristics by MoC



Key Findings – Care Delivery (1)

Staff Role and Model of Care – Findings from Provider Interviews

- Clinics had a “team-based approach” regardless of MoC
- Physicians, case managers, and nurses were the most common staff roles across all MoC
- Team-based model more successful in meeting patient needs as compared to other models
- Case managers and linkage to care roles viewed as particularly integral

Key Findings – Care Delivery (2)

Barriers to External Care Coordination as Reported in Provider Interviews at Integrated, Co-managed Recipient Sites

- Inability to track client follow-up/through with external providers (often due to lack of shared health record system and/or lack of DUA)
- Lack of appointment availability/client acceptance by external providers
- Difficulty arranging and ensuring transport for clients to external sites

Key Findings – Care Delivery (3)

Screenings and Preventative Care

- Majority of providers reported conducting screenings for mental health and substance use
- Integrated care models were more likely to screen for STIs
- Many providers indicated preventive care services may not be covered for Ryan White clients who do not have other insurance assistance, resulting in barriers to services

- Providers strived to conduct screenings on at least an annual basis for most issues related to comorbidities (e.g., Hepatitis, chronic disease, mental health, substance abuse)
  - Specialty-only providers typically indicated clients were encouraged to complete routine screenings through their PCP
  - Other providers indicated many of their screenings took place during intake prior to moving forward with care coordination
  - Screening for STIs typically occurred based on risk factors (every visit to annually)

Key Findings – Care Delivery (4)

Management of Other Chronic Diseases as Reported by Providers at Integrated, Co-managed Recipient Sites

- Providers indicated communication between all team-members on the client's panel (across HIV and non-HIV services) is necessary for smooth delivery of care
- In some clinics, chronic disease more likely to be managed by a nurse practitioner, physician assistant, or internist; while HIV care provided by a specialist physician

Key Findings – Client Experience (1)

Client Choice and Care Seeking Behavior

- Clients and providers reported the following factors increased a client's likelihood of staying at a clinic:
  - Services available in one place, a "one-stop shop"
  - Location of services (either closer or further away)
  - Availability of appointments
  - Ability to walk-in
  - Not feeling rushed during appointments
  - Smooth referral process and coordination with other providers
  - Strong relationship with provider and receiving quality care
- Some clients reported not having a choice in providers or clinics due to:
  - Limited providers/clinics in a given geographical area
  - Health care coverage restrictions on providers or facilities

Key Findings – Client Experience (2)

Perceived Impact of MoC on Stigma

- The clinic's presentation as a primary care clinic and "not just" an HIV clinic served to reduce stigma among individuals seeking services
- Integrated waiting rooms make people with HIV seeking services less identifiable to others seeking care in the same clinic, also reducing stigma

Perceived Impact of MoC on Cultural Competency

- Providers across all MoC suggested *staffing resources* were critically important to cultural competency, specifically including:
  - Staff with requisite skills and training (e.g., language fluency, trauma training); and
  - Representatives of the community served (e.g., people with HIV, racial/ethnic minorities, LGBTQ individuals)

Lessons Learned

Study Design

- Analysis plan relied on clearly defined care models, though sites actually reported more integration of services.
- Rigid and prescriptive classification limits exploration of other types of care delivery models that do not fit into the three categories.
  - Addressed here through qualitative data

Sampling, Recruitment, and Data Collection

- Multiple studies leveraged the same sample; project timeline in future initiatives should account for delays if multiple studies are using the same sample for recruitment.
- Sites required time for local IRB approval.
- Ad hoc trainings for new contract staff.
- Provider interviews conducted in group settings allowed providers to come in and out of room as schedules permitted.

Key Takeaways

- While we originally believed we could group providers into five models of care, providers noted it was sometimes difficult distinguish "leaders" of care at their semi-integrated sites.
  - A consolidated three-tiered measure (Primary, Specialty, Integrated) was constructed to better reflect providers' self-reported categorization of their service model type.
- Clients face barriers to care that are ameliorated by aspects of the care model, but clients often lack a choice in where to access care.

RWHAP clients who do not reach and/or maintain viral suppression

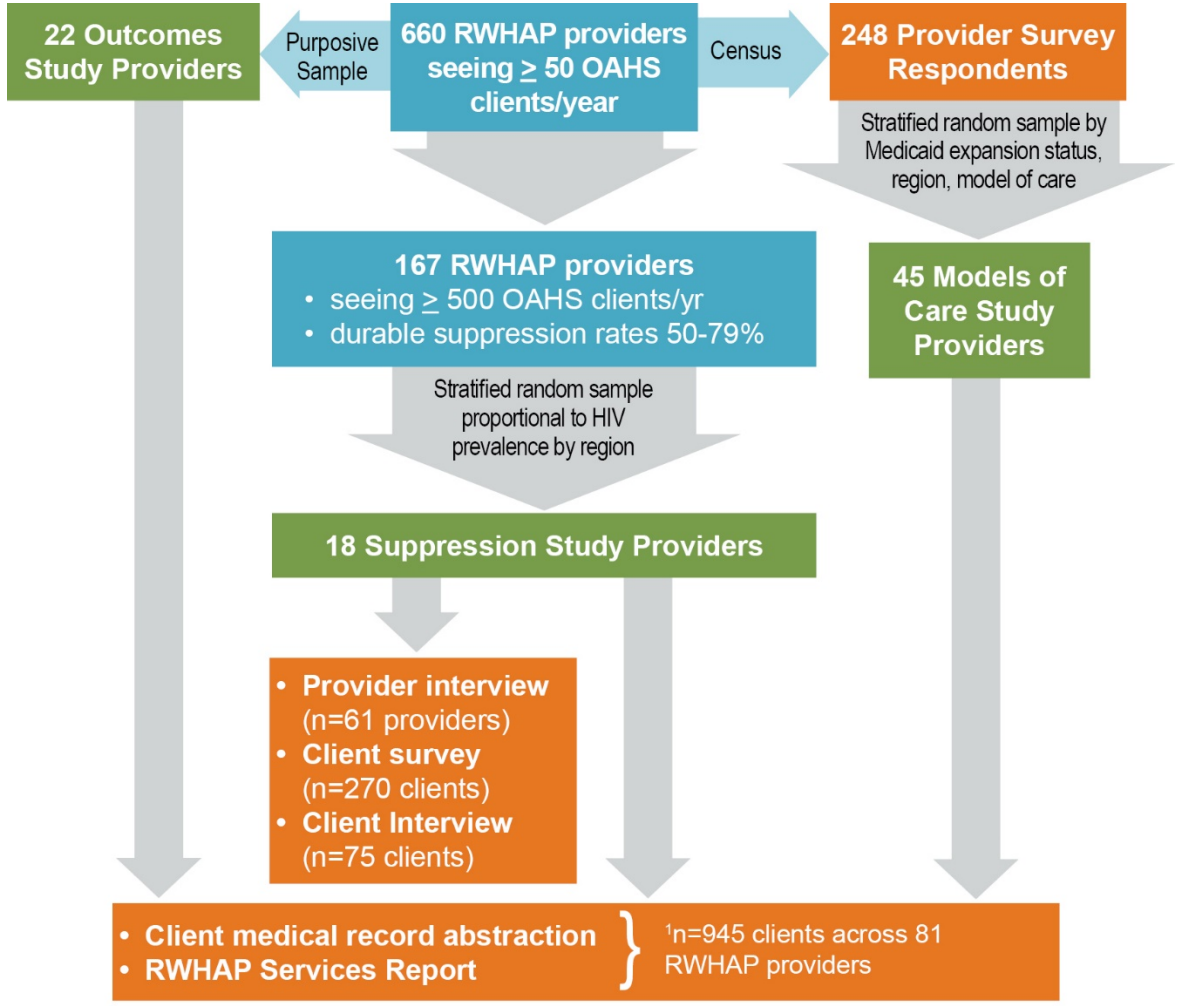
An evaluation study conducted by Abt Associates

Study Purpose

What are the ***characteristics of RWHAP clients*** who do not reach and/or maintain viral suppression?

What ***circumstances create barriers*** to successful management of RWHAP clients' HIV?

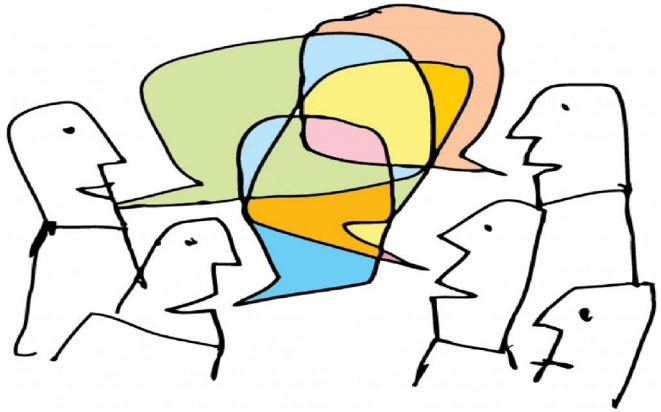
Sampling and Recruitment: Provider Organizations and Clients



[1]Excludes 2 RWHAP providers with no recorded OAHS visits in 2017 and 2 RWHAP providers with missing data on key model covariates for all sampled clients.

Data Collection Activities

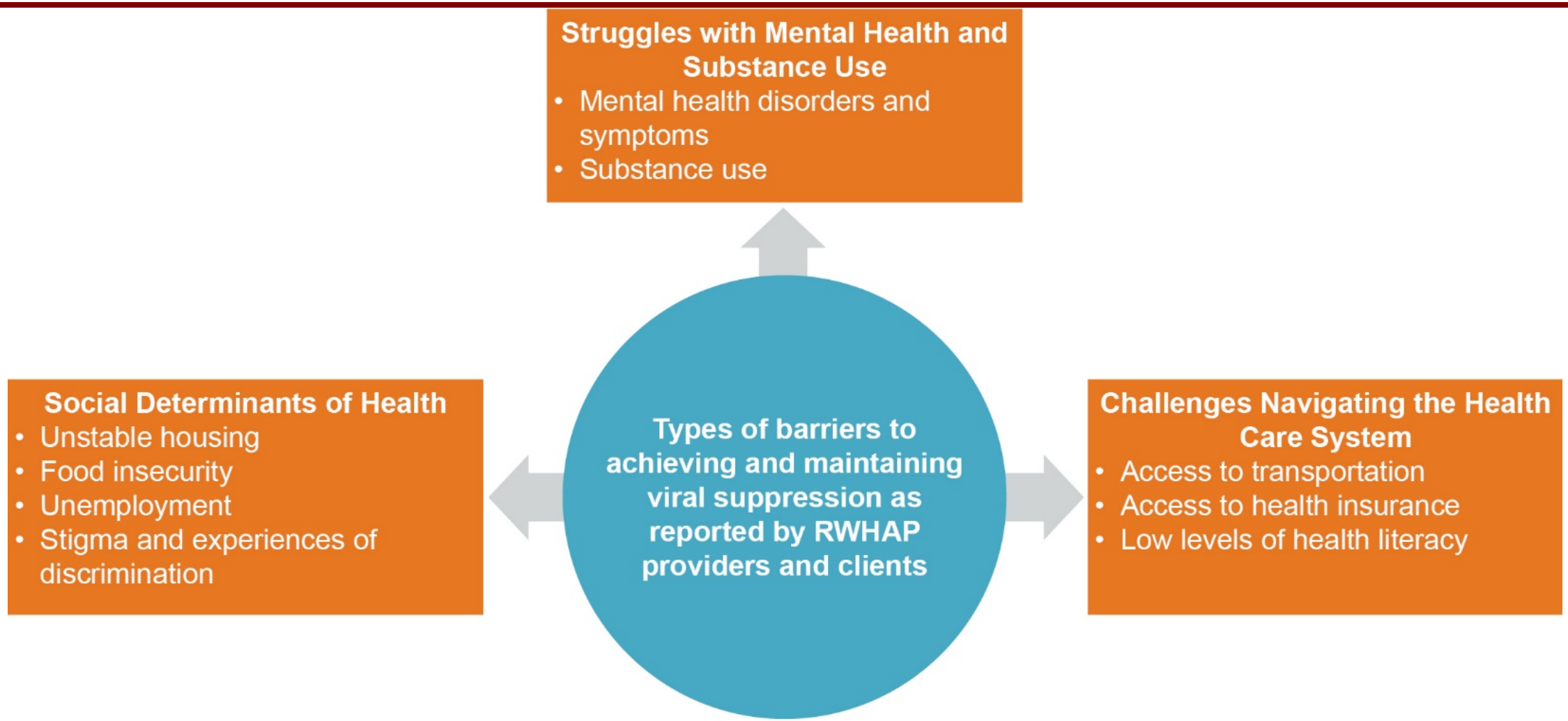
- Qualitative Data
  - Provider Interviews**
  - Client Surveys**
  - Client Interviews**



- Quantitative Data
  - Medical Records Abstraction**
  - Provider Web Survey
  - RSR Data

**completed in-person

Barriers to Reaching and Maintaining Viral Suppression



Overarching Theme

There are 3 main groups of clients that aren't able to maintain viral suppression:

- some clients have comorbidities like substance use and mental health issues and those priorities prevent them from taking their HIV medication
- […] social determinants like unstable housing, or lack of personal safety become more important than medication, and
- logistical issues of getting their needs met, like lapses in insurance coverage, lack of transportation, and really not understanding the system for how to get their medication.

– Provider

Barrier: Mental Health & Substance Use

- Mental illness or substance use disorder interfered with clients' ability to regularly attend appointments, take their medication, and reach or maintain viral suppression

"Sometimes I get depressed and I don't want to go to my appointments."
—RWHAP client

"Alcohol was the most important thing in my life. It came before everything. It would make me not care about getting the services."
—RWHAP client

"Some clients have other co-morbidities like substance use and mental health issues and those are the priorities which prevent them from taking their HIV medication."
—RWHAP provider

Facilitator: Access to Behavioral Health Services

"To have a counselor—someone to talk to. The mental health plays a big part in the situation. Get a few things off your chest and help you feel better and make you want to do the right thing. It's good to be around positivity."

—RWHAP client

- 15% of provider survey respondents indicated access to mental health services as the system-level factor that most positively impacts client decisions to accept ART after a previous refusal
- However, current capacity and infrastructure are barriers

Barrier: Unstable Housing

- Clients described being unable to follow through with their HIV treatment plan due to the competing demands and stressors associated with being homeless
- Clients and providers alike also described experiences of clients losing health care coverage due to housing instability when coverage re-enrollment or service verification is lost in the mail

"Housing was an issue. I've been homeless and lived out of my car. A couple of times I lived far away and took a lot of effort to get to my care. … My homelessness was a challenge to getting these services. It was the last thing on my mind when I was homeless."

—RWHAP client

Housing is still one of the main factors why clients are not coming in to get into care. I would say it's number one for why clients are not coming into care. If they don't have anywhere to lay their heads, they're not worried about getting care for their health. Even people without HIV have a main focus on housing. I can advocate and say please take your medicine, but I understand where they are coming from."

—RWHAP provider

Barrier: Unemployment

- Clients and providers often described unemployment as a precipitating event triggering unstable housing, impacting access to services, and resulting in food insecurity

"Not being employed is impacting [my] ability [to stay in care]. … [I'm] about to lose [my] car."
—RWHAP client

"Food is one of the biggest challenges for clients to adhere to treatment because clients are nervous to start medications due to low food."
—RWHAP provider

Facilitator: Housing Services & Partnerships

- Housing services can help clients experiencing homelessness find stable housing
- Providers discussed partnering with local agencies that offer housing support

"Housing is also one of the greatest challenges in the city. The site works with local agencies that offer housing support. This year the site brought in case managers to schedule housing assistance in house at various locations."

—RWHAP provider

Barrier: Access to Transportation

- One of the most commonly barriers to engagement and retention in care cited by providers and clients
- In addition to missed medical appointments, some clients also cited inadequate access to transportation, and distance to the specialty pharmacy as barriers

"Not getting transportation gets in the way of getting the care I need. I don't get physical care at all … the transportation issue is not having money all the time to get the transportation I need … so it's not so much the bus ride. It's the money for the bus."

—RWHAP client

Facilitator: Transportation Services

- Transportation strategies, including funding buses or vans to pick up clients and transport them to appointments, offering gas cards and fare for public transportation, providing vouchers for ride share services, and mail order prescription services

"The pharmacist calls a week in advance to tell me that I am going to get my medication. I get my medication by mail, which is better than coming to get the medication because it saves me gas and cab fare."

—RWHAP Client

"The clinic staff will go pick people up. More recently, the clinic has started using [rideshare healthcare appointment transportation], which is a division of [rideshare services]. It has been a godsend."

—RWHAP provider

Barriers: Stigma and Discrimination

- Although providers and clients suggested HIV-related stigma has diminished in recent years, both groups felt that concerns about privacy and fear about being identified as a person with HIV still prevent some clients from seeking treatment

"In the past, I had an ophthalmologist. I guess he did not read about my HIV status so when he saw that I did, dropped [me] immediately. I had a pharmacist who refused to see [me] on religious grounds. Another pharmacist declared out loud, 'I didn't know you had HIV.' More recently I was at [redacted] and a doctor kept refusing to operate on my hernia."

—RWHAP client

"[I am] worried about [my] roommates finding the medications around the house and finding out what they are, and sometimes [I] wouldn't be able to take them because [my] family or roommates would be around."

—RWHAP client

Facilitator: Reducing Stigma

- Many clients expressed a strong desire confidentiality in their clinic setting and when picking up medications, or receiving medications through the mail to avoid disclosure of their HIV status

"They mail [my medication] to me so I don't have to be embarrassed about picking up a bunch of pills.... It's not like in big red letters what it is and who it's for. … And they always ask how many days of medications you have left. If you have less than two days' they will send it right away. It's in a timely fashion, according to how you need it."

—RWHAP client

"It doesn't matter that we have this nice fancy clinic, it's still that HIV diagnosis that still carries the stigma. We get client feedback so that we can be aware so that we are not creating a stigma. We got feedback from our clients which caused us to reconfigure the way we do the signing in the lobby. People were uncomfortable because there are people waiting behind them and they don't want to say why they are there. Now everyone gets a piece of paper to sign in and that made it so this client started to come back into care."

—RWHAP provider

Barrier: Complex Health Care Systems & Health Literacy

- Clients and providers noted difficulties navigating the health care system, including enrollment for support services and health care coverage, which providers attributed to low health literacy
- Low health literacy can also impact a client's understanding of their diagnosis and treatment protocol

"Learning who to call, learning the support system. Learning what they offer, and provider or case manager contacting the support services or finding a number that you can call. People need to talk about this and expand upon that."

—RWHAP client

"Health literacy is a challenge. The reading level average in the state is 8th grade and some clients have a reading literacy level less than that. Knowing what CD4 count is and understanding adherence can sometimes take a year or longer for the client to grasp."

—RWHAP provider

Facilitator: Effective Case Management

- Case managers are critical to helping clients navigate the complicated healthcare system, keeping them linked to support services, and providing emotional support

"Meeting with case managers [helps] because it makes me understand my situation. They explain your condition and what is going on with me. They tell me what I should do and what I should not do. It shows me that they care."

—RWHAP client

"Provide me with someone to talk to on a regular basis that's not going to point me in the direction of fruitless busy work. Someone that is going to be there to support me, listen, allow me to bounce things off of. Like my case manager, who lets me talk things out and let things work out through verbalizing it. Give me the type of support that people are in the trenches with me."

—RWHAP client

Facilitators: Social Support, Support Groups, and Peer/Community Navigators

- Support groups and peer/community navigators were identified as important sources of emotional support for clients navigating their HIV diagnosis and care

"The clinic should involve individuals who are HIV-positive and who are experienced and living with it as part of care team and can share their life story about how they are able to address issues."

—RWHAP client

"Support like family, having someone who is aware of their diagnosis which can be such a relief to have at least one person to talk to outside of the clinic especially for patients who are only able to come to the clinic about once every three months."

—RWHAP provider

Summary of Facilitators

- Interviews with clients and providers identified a number of facilitators to reaching viral suppression, including
  - mental health services,
  - effective case management,
  - services that help clients meet their daily needs (housing and transportation)
  - support groups, and
  - greater anonymity and confidentiality when seeking services.

Conclusions

- RWHAP providers and clients identified three main types of barriers:
  - co-morbid mental health disorders and/or substance use disorder;
  - social factors that limit a client's ability to be retained in care; and
  - logistical challenges in navigating the healthcare system
- RWHAP service categories and recipient-led innovative approaches work to mitigate these barriers and improve clinical outcomes
- As we work to end the HIV epidemic, current and future RWHAP initiatives will develop, adapt, and replicate evidence-informed interventions to continue to successfully address these barriers

Next Steps & In Progress Evaluation Studies

Next Steps and In-Progress Work

- Next Steps
  - Apply study findings and conclusions to improve the work of the RWHAP
  - Publish the results of these studies in peer-reviewed journals
- In-Progress Studies and Projects
  - Assessing Care and Health Outcomes Among RWHAP Clients Who Do Not Receive RWHAP Funded Outpatient Ambulatory Health Services
  - Assessing Rapid Eligibility and Six-Month Recertification of Eligibility for RWHAP Services
  - Chart Abstraction of RWHAP Recipient Data
  - RWHAP Recipient Compilation of Best Practice Intervention Strategies

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