VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

The Adaptability of Anti-retroviral Treatment and Access of Services (ARTAS) for Reengagement into HIV Care

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Disclosures:

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Learning Objectives:

1. Apply the tenets of the ARTAS intervention and tailor the model to meet the needs of diverse populations to fill program gaps.

2. Leverage program income, prevention funds, or Part B case management funds to implement ARTAS.

3. Define the tools needed to drill-down the data to identify and re-engage clients and determine the efficacy of this model.

HIV Care Continuum. Engaged or retained in care. Achieved viral load suppression.

UPMC Pinnacle REACCH Program

- Part of UPMC Pinnacle, the leading hospital and healthcare system in Central Pennsylvania
- Located in uptown Harrisburg
- Founded in 2000 to provide HIV care to pregnant women
- Provides comprehensive care and treatment to 700 PLWH including specialty HIV and primary care, and on-site case management, counseling, dental services, and medication-assisted treatment (MAT).

UPMC Pinnacle. Polyclinic Campus. Harrisburg, PA.

CDC High Impact Prevention: ARTAS

Anti-retroviral Treatment and Access to Services (ARTAS)

- Evidence-based for people newly diagnosed with HIV
- Motivational interviewing style
- Strengths-based, client-centered
- Five sessions over a 90 day period
- Assess barriers to care & link to community resources
- Community, home, or program-setting

The Adaptability of ARTAS

REACCH Program MSWs utilize ARTAS with clients who meet at least one of the following criteria:

- Lost-to-care (medical visit >180 days)
- Have a detectable viral load (VL >200 copies/mL)
- Re-entry into the community after incarceration
- Newly diagnosed

Case Study – Can you relate?

Your client is a 50 year old African American MSM who has been out of HIV medical care for over 2 years. He moved out of your program's service area, relocated and never engaged in care, and then returned back to your service area. He pops up on your program's radar during a hospitalization unrelated to HIV (accident/injury). Your agency's social worker reaches out to him by phone post-discharge from this hospitalization and he has multiple barriers to care including insurance, declining health with multiple comorbidities, oral health needs due to his injury, substance abuse, and unstable mental health.

Viral Load Suppression

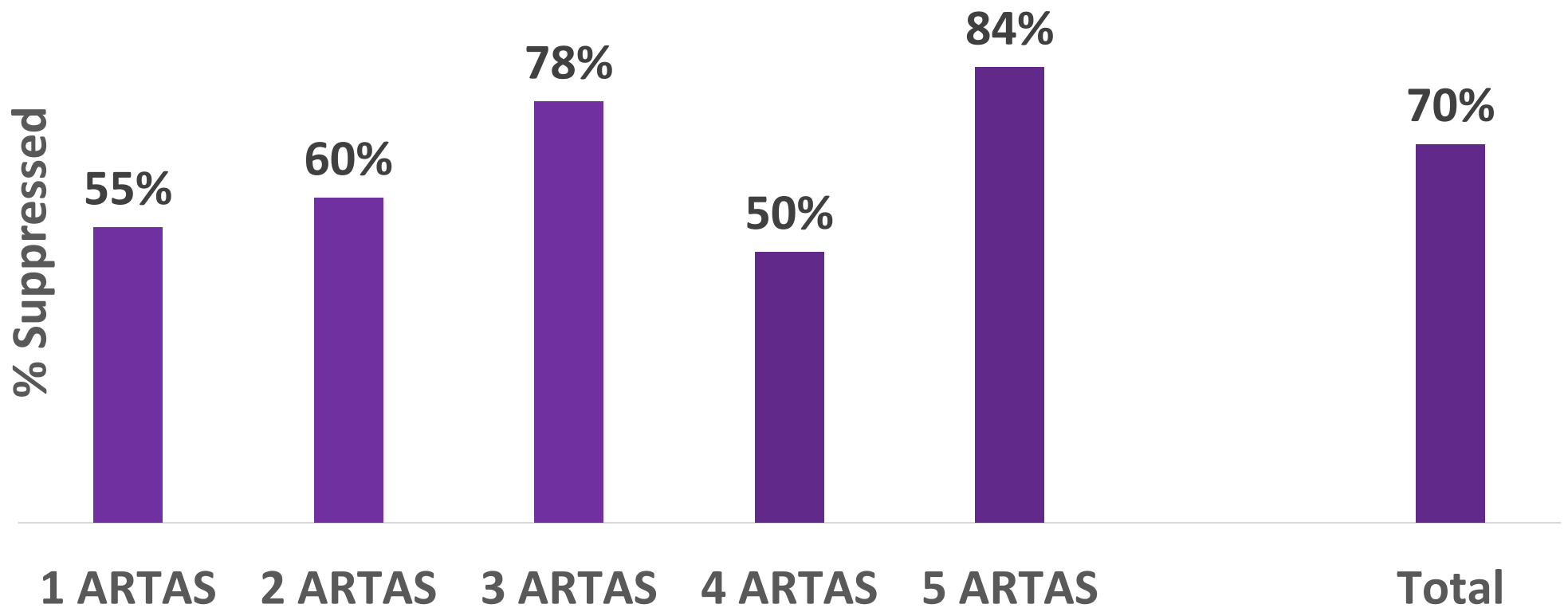
Core 01 Measure - Viral Load Suppression

"Percentage of clients with HIV infection whose last viral load in the measurement year is less than 200 copies."

113 patients were enrolled because they had an unsuppressed viral load

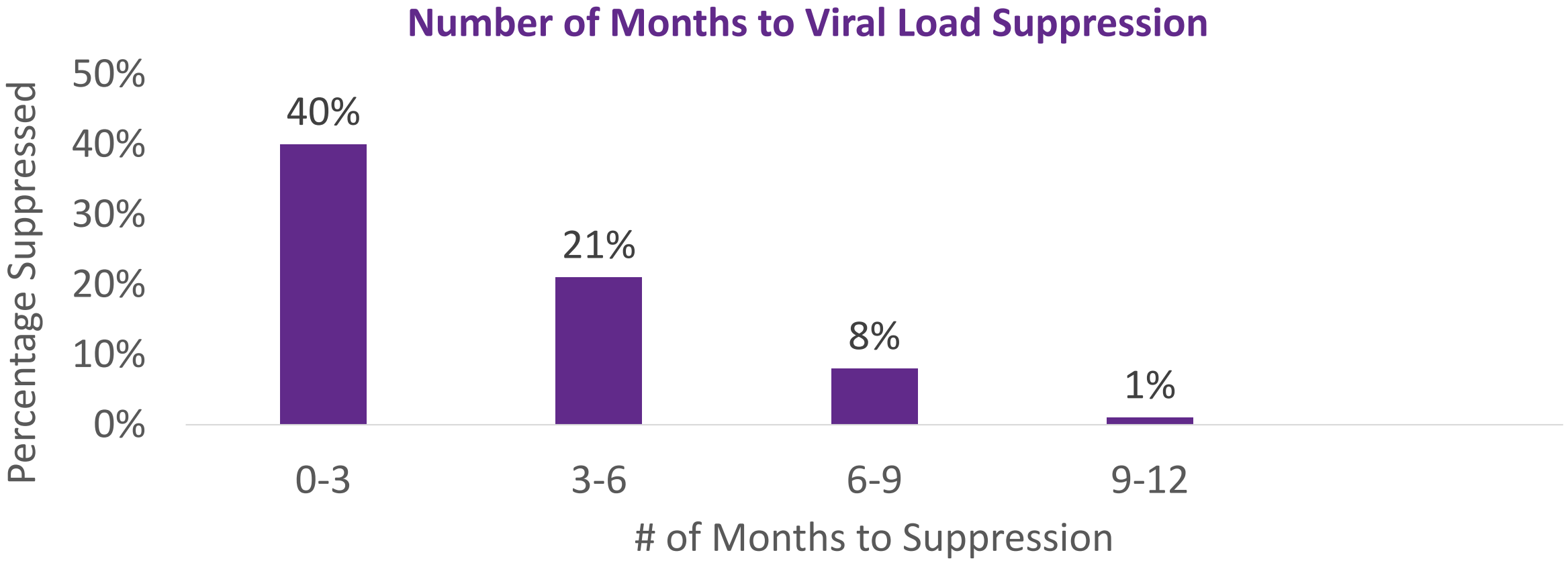
79 (70%) of clients who received at least 1 ARTAS session achieved viral load suppression within 1 year

Viral Load Suppression



Viral Load <200 copies/mL as measured by the viral load lab result closest to the 12th month from enrollment
N: 134; 1 ARTAS: 24; 2 ARTAS: 22; 3 ARTAS 21; 4 ARTAS: 17; 5 ARTAS: 50

Viral Load Suppression



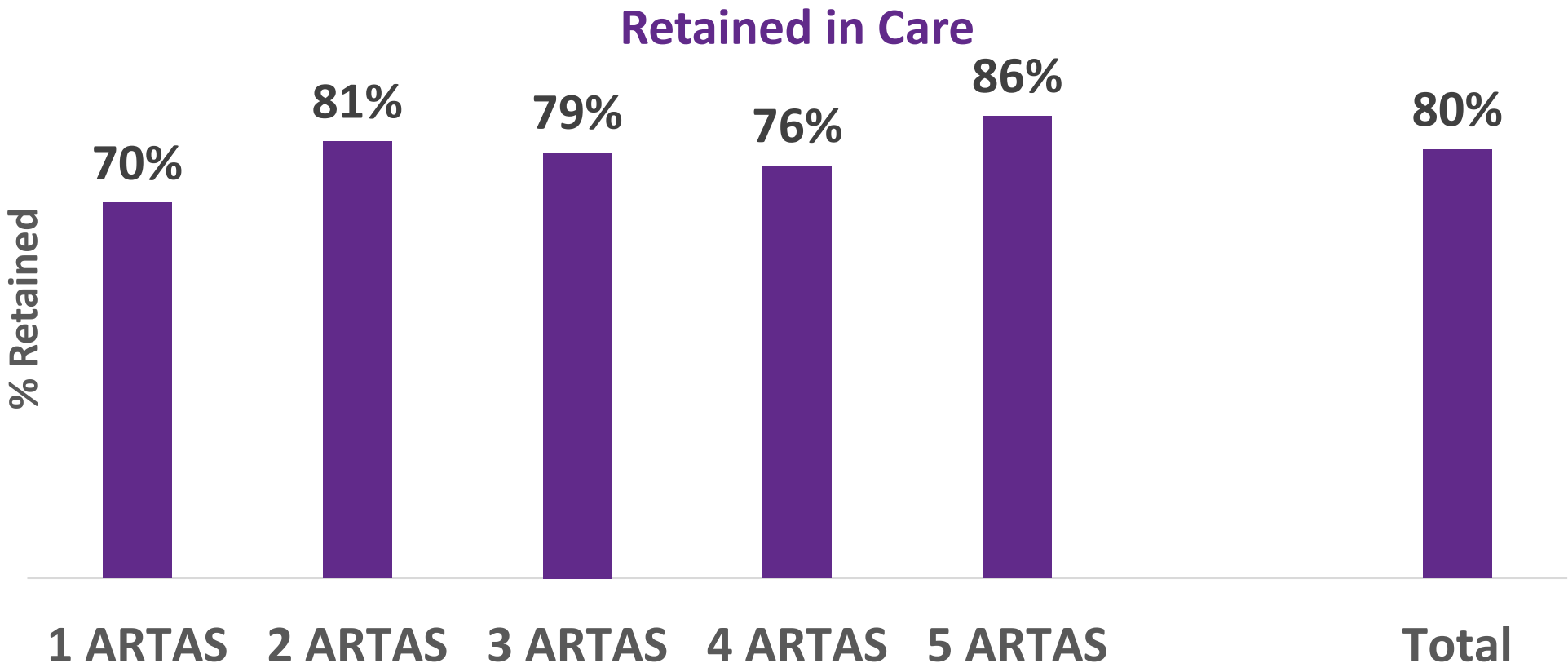
N: 134; 1 ARTAS: 24; 2 ARTAS: 22; 3 ARTAS 21; 4 ARTAS: 17; 5 ARTAS: 50

Retention

Measure – Patient still attending medical visits 1 to 1½ years after enrollment in ARTAS (at least 1 OAHS between 12 and 18 months)

- 122 clients were enrolled because they did not have a medical visit in >180 days
- 97 (80%) of clients who attended at least 1 ARTAS session became retained in care

Retention



Retention defined as 1 medical visit between 12 and 18 months from enrolling in ARTAS

N: 122; 1 ARTAS: 23; 2 ARTAS: 21; 3 ARTAS: 19; 4 ARTAS: 17; 5 ARTAS: 42

Medical Visit Frequency

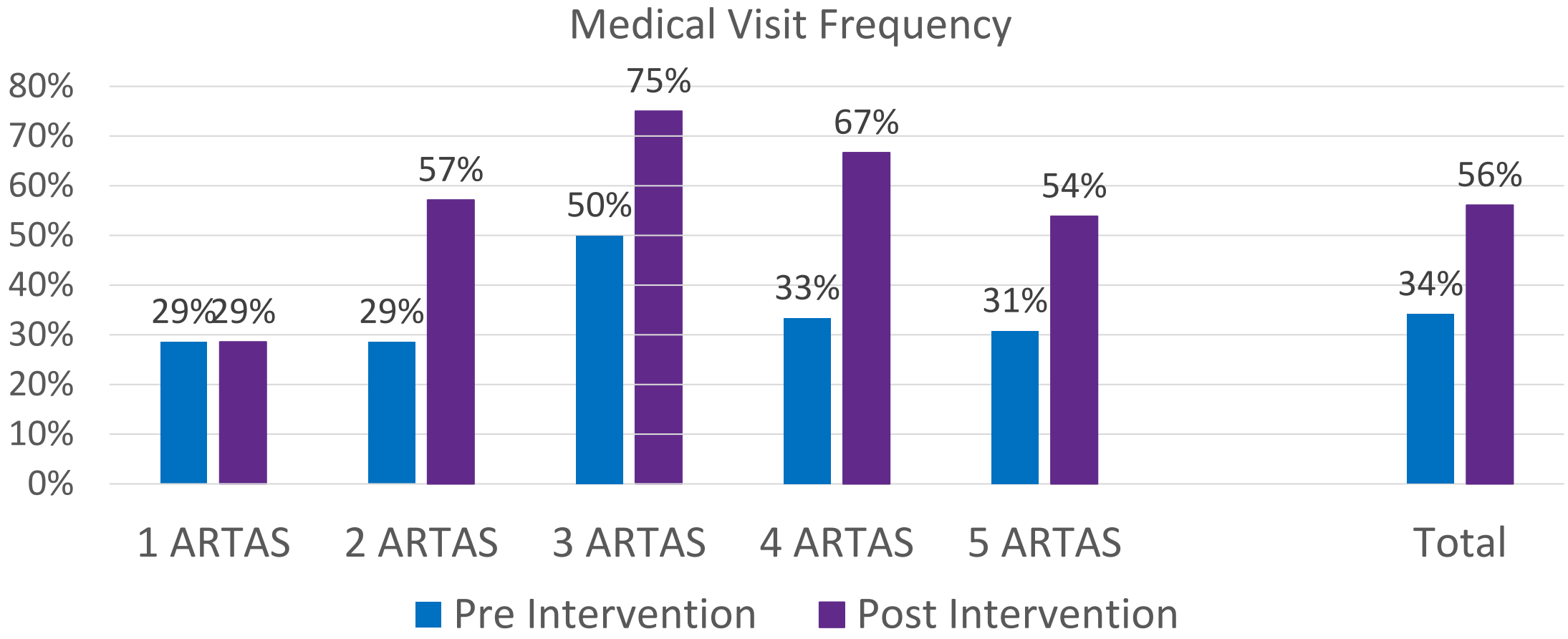
Core 03 Measure: HAB Medical Visit Frequency

"Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits"

- 41 clients who were in care at REACCH for at least two years pre-enrollment and two years post-enrollment

- Medical Visit Frequency rate improved from 34% (14) pre-intervention to 56% (23) post-intervention for clients who had at least 1 ARTAS session

Medical Visit Frequency

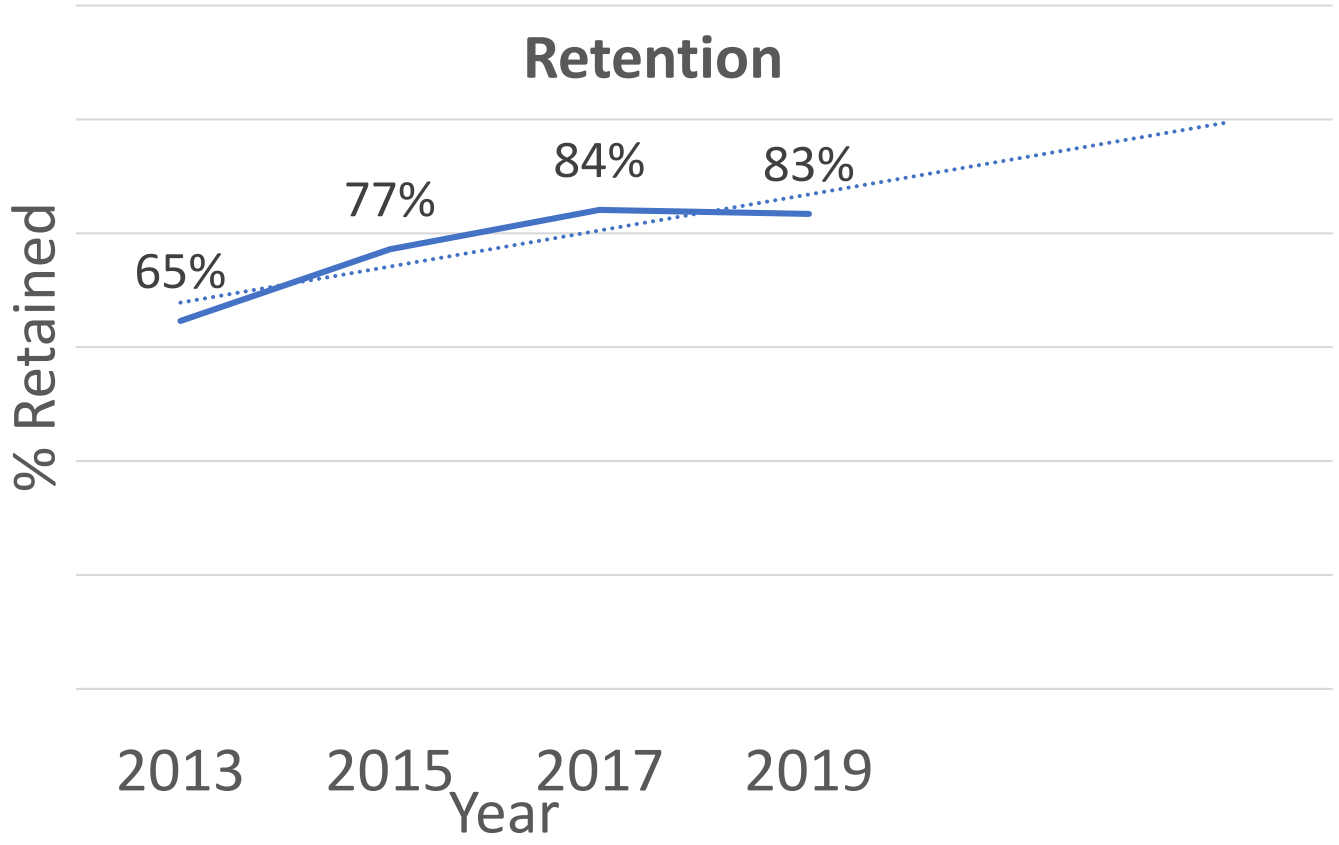


N: Total: 41; 1 ARTAS: 7; 2 ARTAS: 7; 3 ARTAS: 8; 4 ARTAS:6; 5 ARTAS: 13

Impact on Overall Program Outcomes

Medical Visit Frequency (Core 03)

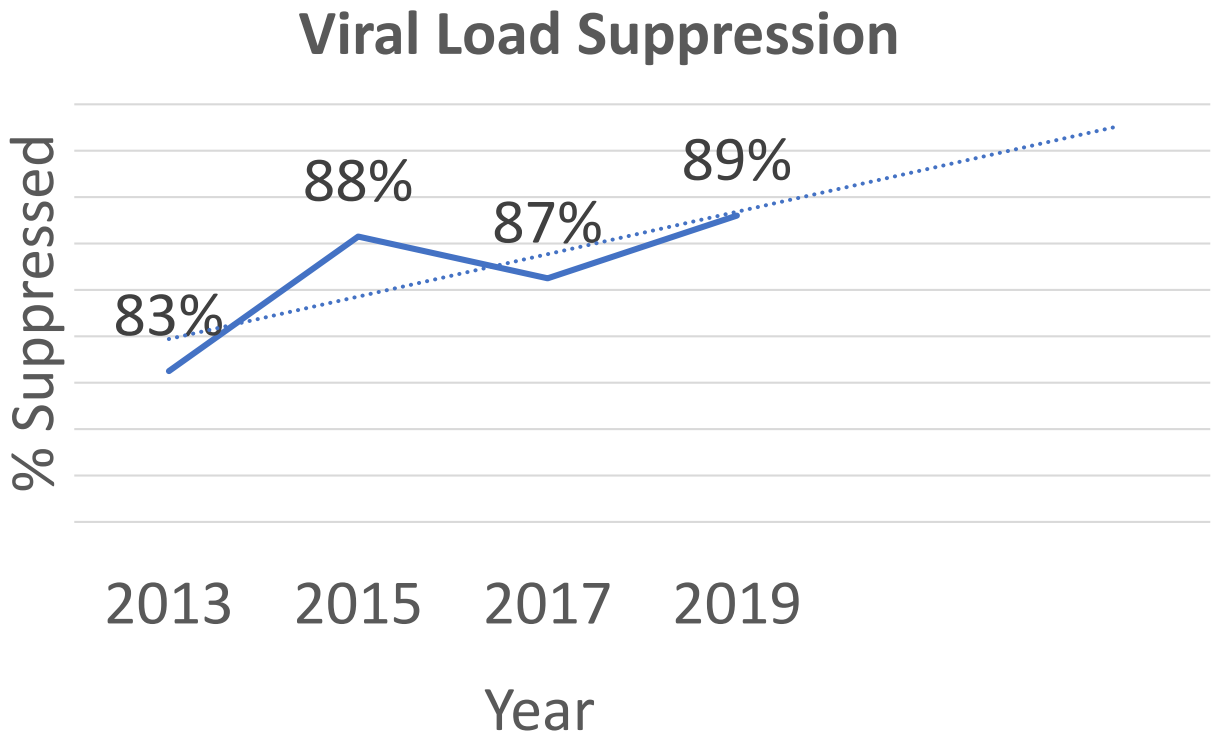
2013: 64.6% (268/415)
2015: 77.2% (312/404)
2017: 84.1% (391/465)
2019: 83.4% (460/550)



Impact on Overall Program Outcomes

Viral Load Suppression (Core 01)

- 2013: 82.5% (402/464)
- 2015: 88.3% (428/485)
- 2017: 86.5% (486/562)
- 2019: 89.8% (605/674)



Tips for Implementation

- **REACCH's first year of implementation**
  - Utilized the agency readiness check-list
  - Focused on training of model
    - Requested in-person CDC ARTAS training
    - Full manual available on CDC website
  - Incorporation of social work assessment into new patient intake process
  - Staffing
    - One staff served approximately 60 clients in first year
      - One staff - approximately .75 FTE
      - Sessions last 45-60 min each, with 15-30 min in follow-up
      - Funded through Ryan White Part C Capacity Development grant
      - Approx. $3K in incentive expenses for clients
  - Primarily provided sessions in the community

Case Study: Tips for Implementation

How can you prioritize when a client has many barriers to care?

Your client is a 50 year old African American MSM who has been out of HIV medical care for over 2 years. He moved out of your program's service area, relocated and never engaged in care, and then returned back to your service area. He pops up on your program's radar during a hospitalization unrelated to HIV (accident/injury). Your agency's social worker reaches out to him by phone post-discharge from this hospitalization and he has multiple barriers to care including insurance, declining health with multiple comorbidities, oral health needs due to his injury, substance abuse, and unstable mental health. How would you prioritize and address his many needs?

Case Study: Tips for Implementation

What is the difference between case management & ARTAS?

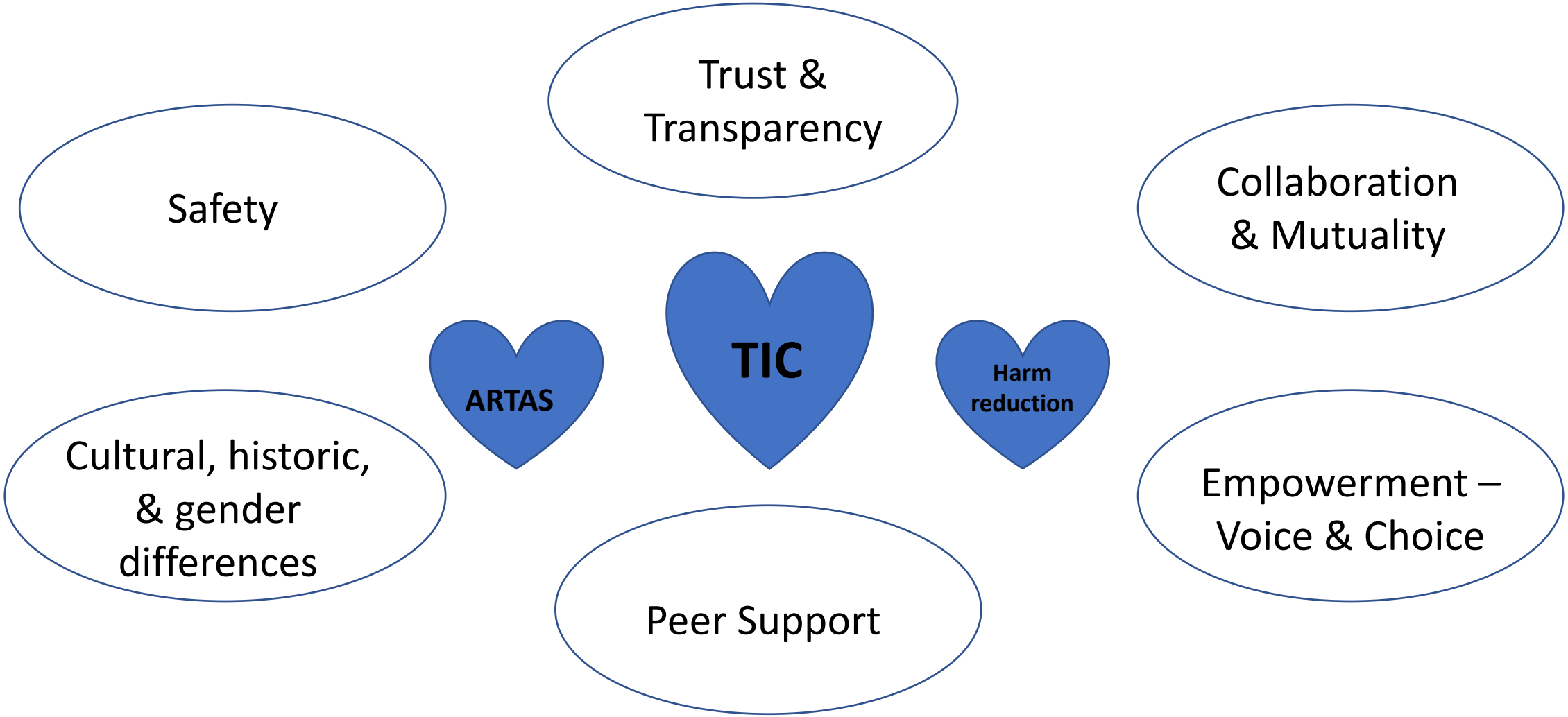
Your client is a 40 year old African American woman who has been out of HIV medical care for at least 5 years. At time of re-engagement into care, the client's CD4 count is less than 35, and she and her boyfriend are homeless. She used to be connected to another HIV service provider and does not feel comfortable going there any longer. Client reports that her biggest barriers to care have been her experience of homelessness, a lack of transportation, and her mental health. She reports experiencing periods of time when she did not care whether or not she lives or dies. With the support of her boyfriend, she has recently determined to seek out HIV medical care again.

Case Study: Tips for Implementation

How do the principles of harm reduction apply to the implementation of ARTAS?

Your client is a newly diagnosed 35 year old white MSM who injects drugs. He was diagnosed in the hospital and comes into your office days later, still in complete shock. He shares with you that he is very scared and anxious about his diagnosis, that he has been injecting methamphetamines for over 10 years, and that he just isn't sure that he can commit to taking a medication daily. He expresses a desire to cut back on his meth use in order to try ART, however wants to take HIV treatment initiation slowly.

Trauma-Informed Care



Tips for Implementation

How do the principles of trauma-informed care apply to the implementation of ARTAS?

REACCH. Patient education room.

REACCH. Rocking chairs in hallway.

Drill-down Data

- **Drill down data to identify gaps in care**
  - Viral Load Suppression
  - Medical Visit Frequency
  - Gap Measure
- **Health Disparities**
  - Identify disparities within the program
  - Program's client demographics vs. service area incidence rate
- **Strong collaboration between Case Management and Quality Management teams**
- **Tools**
  - Electronic Medical Record, CAREWare
  - Health Disparities Calculator

Setting Eligibility Criteria

- Utilize drill down data to identify priority populations
- Pilot intervention with a subgroup
- Example priority populations:
  - Newly diagnosed
  - Lost to care
  - Unsuppressed viral load > 1 year
  - New patients, not newly diagnosed, establishing care
  - Re-entry into the community from prison system
  - Immunocompromised: low CD4 count and high viral load
  - Returning referrals

Measure Efficacy

- **HRSA/HAB performance measures**
  - Viral load suppression
  - Medical visit frequency

- **Internal Measures**
  - Retention
  - Healthcare disparities

A Review: Tips for Implementation

- **A**gency and staff readiness – skill-set of staff is key!
- **R**emain strengths-based and use incentives
- **T**rust building and collaboration between QM & MSW
- **A**dherence and motivational interviewing
- **S**upport harm-reduction and client-centered approaches

Leverage Funding

- **Funding opportunities to explore for your program:**
  - Part C Capacity Development grants
    - REACCH began this initiative using this funding source
  - Ryan White Part B
    - For staff time & incentives/gift cards
  - 340(B) Program income
    - REACCH uses this for incentives/gift cards
    - REACCH provided $10.00 gift cards per session – may receive up to 5 total
    - Approximately $3k spent in incentives
  - Minority AIDS Initiative funding
  - CDC ARTAS specific funding

Helpful Resources

- CDC ARTAS Manual:
  - https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc
  - Case scenarios available through CDC
  - Session prompts – Page 128-129 in manual
    - Consider if using these forms are necessary, or if you can document directly in EMR
- Agency readiness checklist – CDC & REACCH additions
- Client pre-assessment for collecting baseline knowledge

Q&A Session

Obtaining CME/CE Credit

- If you would like to receive continuing education credit for this activity, please visit:

- **http://ryanwhite.cds.pesgce.com**

References

- ARTAS Evidence-based for linkage to HIV care and retention in HIV care. https://pubmed.ncbi.nlm.nih.gov/18285714/
- Harm reduction coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/
- Trauma informed care implementation resource center. https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/
- Target HIV, Center for Quailty Improvement and Innovation. https://targethiv.org/cqii

Additional Questions?

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