COMMUNITY-BASED APPROACHES TO LINKAGE, ENGAGEMENT, AND RETENTION IN HIV CARE

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Statement of Conflicts of Interest

- June Gipson has no actual or potential conflict of interest in relation to this presentation

Open Arms Healthcare Center

- **Open Arms Healthcare Center (Open Arms)** is an innovative, holistic primary healthcare clinic that offers preventive, clinical, and mental health services to underserved, underinsured, and underrepresented populations in Mississippi, with emphasis on the **L**esbian, **G**ay, **B**i-sexual, **T**ransgender, and **I**ntersex (**LGBTI**) communities.

Open Arms Healthcare Center-Hattiesburg

Open Arms Healthcare Center-Mobile

Open Arms Healthcare Center Pharmacy

Open Arms Healthcare Center-Hattiesburg

Open Arms Healthcare Center-Jackson

Open Arms Healthcare Center-Gulfport

Goals

- Provide affordable healthcare to the LGBTI and other underserved, underinsured and underrepresented communities in Mississippi.
- Develop models of health care, disease prevention and health education, promotion and outreach programs that meaningfully improve the health of Mississippi's most vulnerable populations.
- Provide the highest level of patient care by integrating best practices and assimilating the most current and relevant healthcare services.
- Be nationally recognized as a healthcare center that utilizes the most innovative healthcare services now and in the future.

Services

- Women’s Health
- Primary Healthcare
- Sexual and Reproductive Health
- Men’s Health
- Transgender Health
- Behavioral Health
- Preventive Screening
- Clinical and Behavioral Research
- Transportation
- Emergency Food Assistance
- Pharmacy
- Wellness Services

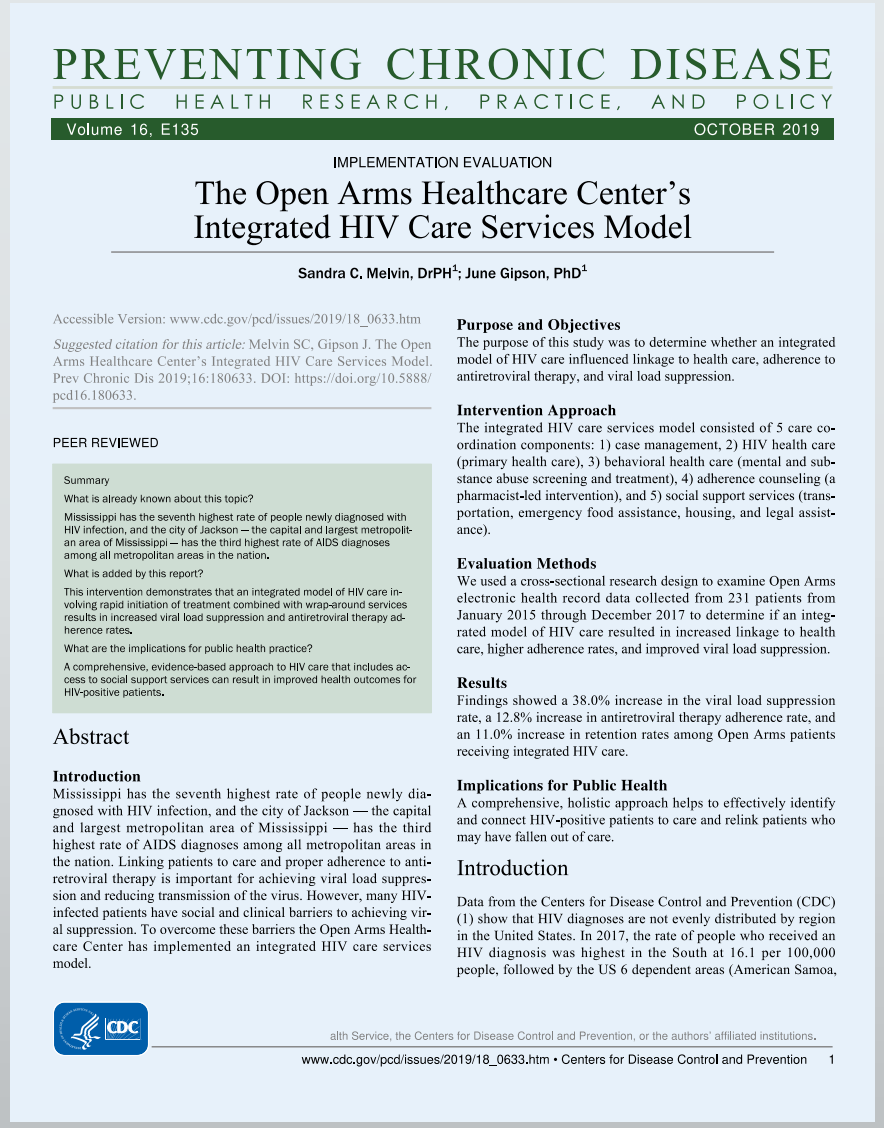
HIV Patient Demographics

- Open Arms has provided HIV prevention, care, and treatment services since its inception in 2013. Currently, Open Arms has over 4,500 patients of which 130 are HIV positive. Thirty percent of the patients are over the age of 50. Open Arms has an 85% HIV linkage rate (81% national and 71% state), 60% HIV retention rate (50% national and 40% state), 77% HIV receipt of care rate (66% national and 73% state), and an 86% viral suppression rate (57% national and 54% state).
- The rate of infection among men who sex with men (MSM), is six times that of heterosexual females, with MSM at 84.8%, heterosexual females at 14.1% Female, and 1.4% for Transgender individuals. Of the HIV patients served at Open Arms, 66.2% are uninsured, and 30% are at or below the 200% poverty level. Although, Open Arms serves patients across the state of Mississippi, most of our patients geographically live in the Jackson Metropolitan area.

HIV Services

- Ryan White (Part B) - is designed to improve the quality, availability, and utilization of HIV health care and support services.
- Support Groups- are designed to provide support to a group of people with common experiences or concerns who provide each other with encouragement, comfort, and advice. Open Arms offers the following support groups for HIV positive men and women.
- Mississippi Positive Network- is designed to educate and enable advocates from across Mississippi around HIV policy and its intersections.
- LifeStyle Program (HIV Aging)- extend the Integrated HIV Care Service Program five care coordination components to include wellness components that disproportionally impact the health outcomes for 50 and older HIV positive individuals including: (1) Nutrition, (2) Physical Activity, and (3) Social Engagement activities.
- Housing-Open Arms provide direct HOWPA services and partners with other HIV housing entities for temporary housing and permanent housing solutions for HIV positive patients

INTEGRATED HIV CARE SERVICES MODEL



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IMPLEMENTATION EVALUATION

The Open Arms Healthcare Center's Integrated HIV Care Services Model

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PEER REVIEWED

Summary

What is already known about this topic?

Mississippi has the seventh highest rate of people newly diagnosed with HIV infection, and the city of Jackson — the capital and largest metropolitan area of Mississippi — has the third highest rate of AIDS diagnoses among all metropolitan areas in the nation.

What is added by this report?

This intervention demonstrates that an integrated model of HIV care involving rapid initiation of treatment combined with wrap-around services results in increased viral load suppression and antiretroviral therapy adherence rates.

What are the implications for public health practice?

A comprehensive, evidence-based approach to HIV care that includes access to social support services can result in improved health outcomes for HIV-positive patients.

Abstract

Introduction
Mississippi has the seventh highest rate of people newly diagnosed with HIV infection, and the city of Jackson — the capital and largest metropolitan area of Mississippi — has the third highest rate of AIDS diagnoses among all metropolitan areas in the nation. Linking patients to care and proper adherence to antiretroviral therapy is important for achieving viral load suppression and reducing transmission of the virus. However, many HIV-infected patients have social and clinical barriers to achieving viral suppression. To overcome these barriers the Open Arms Healthcare Center has implemented an integrated HIV care services model.

Purpose and Objectives
The purpose of this study was to determine whether an integrated model of HIV care influenced linkage to health care, adherence to antiretroviral therapy, and viral load suppression.

Intervention Approach
The integrated HIV care services model consisted of 5 care coordination components: 1) case management, 2) HIV health care (primary health care), 3) behavioral health care (mental and substance abuse screening and treatment), 4) adherence counseling (a pharmacist-led intervention), and 5) social support services (transportation, emergency food assistance, housing, and legal assistance).

Evaluation Methods
We used a cross-sectional research design to examine Open Arms electronic health record data collected from 231 patients from January 2015 through December 2017 to determine if an integrated model of HIV care resulted in increased linkage to health care, higher adherence rates, and improved viral load suppression.

Results
Findings showed a 38.0% increase in the viral load suppression rate, a 12.8% increase in antiretroviral therapy adherence rate, and an 11.0% increase in retention rates among Open Arms patients receiving integrated HIV care.

Implications for Public Health
A comprehensive, holistic approach helps to effectively identify and connect HIV-positive patients to care and relink patients who may have fallen out of care.

Introduction

Data from the Centers for Disease Control and Prevention (CDC) (1) show that HIV diagnoses are not evenly distributed by region in the United States. In 2017, the rate of people who received an HIV diagnosis was highest in the South at 16.1 per 100,000 people, followed by the US 6 dependent areas (American Samoa,

alth Service, the Centers for Disease Control and Prevention, or the authors' affiliated institutions.

www.cdc.gov/pcd/issues/2019/18_0633.htm • Centers for Disease Control and Prevention 1

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Open Arms Healthcare Center's Integrated HIV Services Model

Open Arms Healthcare Center's Integrated HIV Care Services Model (IHCS Model)

- The IHCS Model is an integrated HIV care service program that addresses the healthcare, behavioral health, and psychosocial needs of HIV positive patients. IHCS consist of six care coordination components that are designed to work bi-directionally to achieve: (1) retention in HIV care, (2) antiretroviral therapy adherence, and (3) viral suppression among HIV positive individuals.
- Services include:

  (1) case management,

  (2) HIV, primary, and specialty healthcare

  (3) behavioral healthcare (integrated mental and substance abuse screenings)

  (4) adherence counseling

  (5) social support services (transportation, emergency food assistance, housing, and legal)

  (6) wellness (physical activity, nutrition, and social engagement).

Integrated HIV Care Services Model

(1) <u>Case Management and Patient Navigation</u>

If a patient is previously positive or test preliminary positive for HIV onsite (Open Arms Main Site) or offsite (mobile clinic or satellite locations) they are immediately linked to a case manager either face-to-face or via telehealth.

(2) Within 48 hours, the case manager will assess the client's medical and psychosocial needs in the overall context in which HIV risk behaviors occur including: demographic information; health history; STD and sexual health history; substance and alcohol use; mental health; adherence to HIV related treatment (re-engagement into care); social and environmental support; intentions and motivations; and barriers to safer healthier behaviors. The completed assessment is designed to give the case manager a comprehensive picture of the client's healthcare and social support needs.

(3) Upon completion of the assessment, the case manager coordinates care between medical appointments with the patient navigator, physician/provider, mental health counselor, and LifeStyle Wellness Coordinator. The case managers also assess eligibility for: (1) AIDS Drug Assistance Programs (ADAP), (2) indigent care financial assistance, (3) Medicaid/Medicare applications, (4) commercial insurance, and (5) sliding fee scale. In addition, the patient navigator assists the patient with initiating social support and wellness services, and provides appointment reminders and coordinates transportation, medication pick-up, and emergency food assistance.

Integrated HIV Care Services Model

(2) <u>HIV Care</u>

Open Arms's standard protocol for HIV care is rapid initiation of ART, a full battery of labs, and an initial and follow-up visits with the infectious disease and behavioral health clinicians.

- ART-In emergency circumstances, a standard 2-week (14 day) supply of medications is given to the patient pending approval to the MSDH Ryan White Program.
- Urochemistry- includes a complete blood count (CBC), comprehensive metabolic profile (CMP); lipid profile, urinalysis, viral load and Genosure Prime; CD4, hepatitis profile (including A, B, and C), QuantiFERON-TB, G6PD, HLA-B5701, toxoplasmosis, and STDs (syphilis, chlamydia, and gonorrhea).
- HIV care visits- facilitated through the Partnership for Health (PfH) intervention. Patients receive a full examination, which includes a comprehensive screening. PfH is an evidence-based, brief clinic-based, individual-level, provider-administered intervention that emphasizes the importance of the patient-provider relationship to promote patients' healthful behavior (CDC, 2013).
- Geriatric Screening-The geriatric assessment is a multidimensional, multidisciplinary meaningful use assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances. Evaluation of specific elements of physical health that include nutrition, vision, hearing, fecal and urinary continence, and balance. The geriatric assessment aids in the diagnosis of medical conditions; development of treatment and follow-up plans; coordination of management of care; and evaluation of long-term care needs and optimal placement.
- After there is a determination of CD4/viral load within the first three (3) months of diagnosis and the patient has attended the first two (2) medical appointments, the patient is considered linked to care.

Integrated HIV Care Services Model

(3) <u>Behavioral Health</u>

The Mental health therapist completes an initial intake, which assesses for trauma, drug and alcohol, previous mental health history and diagnoses, current and past medication history, risk factors, barriers to care, assesses for suicidal/homicidal ideation and medical issues. The intake process also screens for anxiety using the GAD-7 scale, and depression using the PHQ-9 tool. Individuals requiring a higher level of care are referred external resources (Hind Behavioral Health Services). An Individual Care Plan (ICP) is created after the 3rd session with the patient. Follow-up visits are based on severity of signs and symptoms and the impacts on daily functions.

Integrated HIV Care Services Model

(4) <u>Adherence Counseling</u>

Open Arms has an integrated Adherence Pharmacy/Provider Program that treats patients living with HIV (HIV medications) or at-risk for HIV infection (PrEP), who struggle with medication adherence. The Adherence Pharmacist main activities include:

- reviewing labs with physicians and clients;
- making drug recommendations to the physicians;
- counseling clients on medication side effects and drug-drug interactions;
- checking pricing of drugs at the patient's preferred pharmacy before new prescriptions are written to ensure that cost is not a barrier to adherence;
- contacting clients two weeks after a new prescription to discuss any side effects they may have experienced;

Integrated HIV Care Services Model

(5) <u>Social Support services:</u>

Open Arms provides internal and external referral services. Onsite services include: HIV support groups, pharmacy, transportation, and emergency food assistance. External service sites include: WIN Job Center (employment opportunities); Mississippi Center for Justice (legal); University of Mississippi Medical Center (severe psychiatric needs), and Grace House (Housing for People living with HIV/AIDS).

Integrated HIV Care Services Model

- **Re-engagement to HIV Medical Care**
  The patient navigator re-engages HIV positive patients who haven't picked up medications in 30 days, and/or who have missed appointments. The patient navigator requests a report from contract pharmacies, of patients who have not picked up his/her medication in the last 30 days. The patient navigator contacts the patient and refers the patient to the social worker who will address any barriers to care. When a patient misses one appointment, a follow-up call is made by the patient navigator to re-schedule the appointment.
- If a patient misses two or more consecutive appointments, they are referred to the case manager or social worker for follow-up and to discuss barriers and social determinants of health including a barrier assessment to determine the cause of noncompliance. Re-engaged clients are re-assessed to determine CD4/viral load and linked to care. The patient navigator continues to monitor appointments and continues communication with the patient, as needed.

WELLBEING, SOCIAL ENGAGEMENT, AND SUPPORT SERVICES

Goal

- To improve health outcomes and quality of life among 50-year-old individuals, living with HIV/AIDS, who reside in MS.

LifeStyle Intake Process

- LifeStyle Interest Application
- LifeStyle Intake
- LifeStyle Geriatric Health Screening
- LifeStyle Participation Contract
  - Devices/Apps
    - IPAD
    - Netflix
    - Zoom
    - Games
    - Vital Machine
  - Participation Hours
  - Program Exit

Integrated HIV Care Services Model

The LifeStyle Program (50 and older) is a series of online and face-to-face social interaction activities designed to enhance your well-being, as well as, to support you as we adjust to social distancing guidelines. The LifeStyle Program's online social interaction activities include:

(1) group movie and dinner,

(2) nutrition counseling and access to nutritional foods,

(3) daily supportive communication,

(4) online and in-person training and skill development,

(5) medication delivery service,

(6) low to no-cost online primary healthcare and mental health services, and more.

(7) wellness Activities-(Massages, Facials, Medical Sauna Treatments)

(8) cooking demonstration

(9) social events (book club, fair, USCHA)

Pre/Post Assessment

The participants received an intake and follow-up questionnaire to gauge their self-reported levels of:

- physical activity
- diet
- stress
- depression
- healthcare
- social engagement and support

Pre/Post Assessment Jan 2020-Sept 2024

- **Physical Activity**:
- Participants generally experienced an increase in physical activity over time, with significant improvements noted year over year.
- In 2024, 70.6% of participants reported being more physically active.
- **Diet and Nutrition**:
- The percentage of participants eating a healthier diet increased each year. In 2024, 76.5% reported improvements in their diet.

Pre/Post Assessment Jan 2020-Sept 2024

- **Mental Health (Depression, Stress, and Happiness)**:

- **Stress**: Stress levels showed mixed trends. Although participants reported less stress in 2024 (82.4%), earlier years, like 2020, saw an increase in high stress levels likely due to external factors such as the COVID-19 pandemic.
- **Depression**: Depression levels remained low among participants, and in 2024, 58.8% reported having low depression. There were no reports of high depression in recent years, highlighting the program's success in addressing mental health needs.
- **Happiness**: Reports of happiness increased, with 88.2% of participants in 2024 feeling happier. This suggests that the program fosters a positive emotional environment, likely through community building and support services.

Pre/Post Assessment Jan 2020-Sept 2024

- **Social Engagement and Emotional Support**:
- Social engagement and emotional support showed positive growth throughout the program. Participants reported increased social engagement, reaching 76.5% in 2024.
- **Healthcare Services**:
- Participants generally reported receiving effective healthcare services throughout the program. By 2024, 82.4% stated they had received better healthcare services, which points to improved healthcare access or advocacy through the program.

Qualitative Preliminary Results-Sept 2024

Participants were asked open-ended questions regarding satisfaction with individual and overall program services. The common themes were reduced isolation, extended family, and appreciation for the program services:

- “The Project group members have literally become my “Extended Family “, and it has been a god-send especially after dealing with the pandemic, ice storm and other critical life events”
- “Lifestyle has blessed me with new friends that are like family to me, especially Kim. She really looks out for us. Furthermore, everyone in Lifestyle has been a dependable source of strength in some low times of my life”
- “I can truly say I've enjoyed every moment spent. This is the best program I've ever joined or been a part of”
- “In every respect, Lifestyle has been beneficial to me in that I’ve forged great new friendships with people I now hold dear as family”

THANK YOU!!!