2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

ADAP As Core Public Health:
Innovative Strategies Utilized by the MA Infectious Disease Drug Assistance Program (IDDAP) to Reduce Health Disparities and Improve Health Outcomes

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Disclosures

Presenters have no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Outline innovative uses of Ryan White/ADAP funds to improve enrollment and retention in medical care, treatment, and ADAP.
2. Describe partnerships with HIV surveillance to utilize ADAP funding to improve linkage and retention in care, and viral suppression
3. Identify strategies for reducing health disparities among people living with HIV (PLWH) and other vulnerable populations using the ADAP infrastructure.

Obtaining CME/CE Credit

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

http://ryanwhite.cds.pesgce.com

Integration of Care & Prevention

- The 2016 *Massachusetts Integrated HIV/AIDS Prevention and Care Plan* relies heavily on the IDDAP program to improve health outcomes among PLWH including:
  - Improving care continuum outcomes to 90/90/90
  - Eliminate progression to AIDS among PLWH
  - Link 90% of HIV/HCV co-infected individuals to HCV treatment
- MA completed a re-procurement of its HIV prevention and care services in 2017 under a single, fully integrated procurement: *HIV/HCV/STI/TB Prevention, Linkage, and Retention in Care and Treatment*
  - Funds HIV/HCV/STI/TB prevention, screening, and linkage to care
  - Medical case management and intensive linkage services (ARCH)
  - Specialty care and supportive services for PLWH
  - Procurement prioritizes services to populations disproportionately impacted by HIV (MSM, PWID, non-US born individuals, transgender-identified individuals)

Context

- Generous Medicaid program (including 2001 expansion of 1115 waiver to include PLWHAs up to 200% FPL)
- State healthcare reform enacted in 2006
- State AIDS line allows for flexibility in allocating resources across infectious diseases
- No waitlists for ADAP & “open formulary” since 2001
- State Office of HIV/AIDS (OHA) adoption of “treatment as prevention” concept early on

Context Cont.

- State has subcontracted the administration of the ADAP to a CBO for more than 20 years
- In 2015 state re-procured drug assistance program and requested responses that addressed potential expansion to include other infectious diseases
- Funded program re-named Infectious Disease Drug Assistance Program (IDDAP) and includes the HIV Drug Assistance Program (HDAP), the PrEP Drug Assistance Program (PrEPDAP), & the TB Drug Assistance Program (TB DAP)

PrEPDAP

- Began in July 2017
- Based on HDAP Model
- Income eligibility up to 500% FPL
- Has served 223 clients at an average cost $412.96/client/fill
- Depending on applicant's insurance, covers either full cost of drug or out of pocket costs (co-pays, deductibles, coinsurance) associated with prescription

TB DAP

- Began in April 2016
- Previously all drugs for TB clinics were being purchased by state and distributed to clinics & pharmacies
  - No 3rd party billing
  - High cost
  - Waste?
- No income eligibility limit for program
- Depending on insurance status of individual, full cost or out pocket costs for drugs are covered
- Challenging to roll out

Use of HRSA Flexibility Policy

- **Policy Notice 07- 03:** The Use of Ryan White HIV/AIDS Program, Part B, AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services
- 1st application for utilization of flexibility policy was in 2001
- Massachusetts funded activities under flexibility policy:
  - **Outreach** in the form of targeted PSA
  - **Monitoring** (viral resistance assays)

Use of Flexibility Policy Cont.

- **Adherence**
  - Community –based model
  - Insurance navigation (BRIDGE)
  - Engagement & Re-engagement through Peer/Nurse model based on funded SPNS project
  - Active Retention in Care for Health (ARCH) for high acuity individuals
  - Engagement & re-engagement in ADAP through data to care model

MA HDAP Health Outcomes

- 5,913 active clients in HDAP (as of 07/01/18)
  - of which 5,392 had at least 2 VL tests on or before 7/01/2018;
  - and had at least 1 VL test between 01/01/2017 and 07/01/2018.
- Of those 5,392 clients:
  - 95.2% were virally suppressed according to HHS guidelines (N=5,131)
  - 4.8% had HIV RNA above 200
- Variations among age groups:
  - 90.6% among HDAP clients aged 29 or younger
  - 92.9% among HDAP clients between ages 30-49
  - 96.5% among HDAP clients over age 49
- Among HDAP clients aged 29 or younger not virally suppressed (HIV RNA greater than 200 at last measurement):
  - 80% identified as a racial or ethnic minority (Black/AA, Hispanic/Latino)
  - 75% identified as male, of which 40% identified as MSM.

Improving Retention & Engagement

Benefits Resource Infectious Disease Guidance and Engagement Team

- Initially funded with HRSA ADAP Flexibility Funds- now funded with ADAP Earmark
- Staff include one Program Manager, and three (3) full-time staff

Goals include:

- To assist Massachusetts residents with HIV in accessing available health coverage programs, with an overall goal of preventing gaps in coverage and reliance on more expensive systems of care;
- To assist case managers at health care sites in helping their patients negotiate and access comprehensive health insurance coverage and programs, with an overall goal of increasing providers' knowledge and familiarity with available coverage options;
- To reduce the turnaround time of HDAP new and recertification applications from submission to final approval and notification, through the diversion of insurance-related requests for assistance to specialized staff.

BRIDGE Team: Menu of Services

Field-based HDAP and Benefits Enrollment Services

- Staff work with subrecipients to conduct needs assessment, including identification of technical assistance needs and discussion of agency and client data.
- Provide outreach to clients who are unenrolled in HDAP/insurance
- On-site in-person one-on-one insurance enrollment sessions/appointments
- Staff may regularly out-post at subrecipients; frequency and duration depend on subrecipient needs

Training and Technical Assistance Services

- Data sharing, including HDAP enrollment “line-list”/data-to-care
- Staff training and TA
- Consumer/client training and TA

BRIDGE Team: MAI Outreach Services

- During FFY18, MAI resources were awarded to the HDAP BRIDGE Team to increase HDAP enrollment among Black/African-American and Hispanic/Latino individuals.
- Services are prioritized at agencies within cities/towns among the top ten by HIV incidence
- Outreach activities include engagements with peers, training at peer support groups, outreach at community events (e.g. health fairs, awareness days), and outreach to individual case managers as needed.
- Clients are tracked by the agency and case manager; outcomes are monitored to ensure clients are remaining enrolled, accessing treatment, and achieving viral suppression.
- BRIDGE will prompt case manager follow-up if clients do not maintain enrollment in HDAP.

Accomplishments & Outcomes- SFY18

- BRIDGE provided technical assistance to 329 providers from 38 agencies during 32 in-person sessions and 2 webinars.
- BRIDGE provided outreach at 15 events serving 2,580 people.
- The BRIDGE team, in collaboration with ADAP staff, helped more than 250 clients who either lost their insurance or lacked comprehensive coverage to enroll or re-enroll in health insurance during open enrollment.
- BRIDGE provided screening and eligibility determination support to over 1500 HDAP applications during SFY18.

Case Study- Improving Care Retention

- BRIDGE staff provided training and technical assistance to a large urban medical provider that was having long-term issues with keeping their clients active in HDAP
- Technical assistance included:
  - Two (2) needs assessment and planning meetings with agency staff, including the HIV program director, data manager, case management supervisor, and benefits coordinator
  - Providing monthly data runs on all of the provider's HDAP clients, both active and inactive in HDAP, who had been active in HDAP at some point since the beginning of the past fiscal year.

Case Study- Improving Care Retention

- Technical assistance also included one-on-one and group trainings
  - During the last fiscal year, the BRIDGE team increased the number of small trainings focused on key tips for screening HDAP applications and instituted 1-1 training for new provider staff
  - Over 4 years, our BRIDGE team provided over 16 trainings focused on HDAP application screening and navigating health insurance to the provider agency's staff, as well as 5 one-on-one trainings for new staff who were screening HDAP applications.
- The provider site launched a large-scale outreach effort with their inactive HDAP clients after getting data from the BRIDGE team that showed that fewer than half of their clients who had been active in HDAP since the start of the last fiscal year were currently active in HDAP;

Within 5 months, from 3/15/18 to 8/15/18, the agency was able to increase the number of active HDAP enrollees by 188 clients (from 357 to 545), or by 53%.

Medical Co-Pay Pilot

- Reduce financial barriers to care for low income HIV+ individuals who may delay or skip medical appointments due to costs
- Improve engagement and retention in care for these individuals
- Coverage of out-of-pocket co-payments, deductibles, and co-insurance for select outpatient medical procedures/services
- The pilot aims to (1) identify the types of medical visits and/or costs that pose major barriers to accessing care and treatment, and (2) minimize barriers that prevent patients from seeking critical medical care and/or adhering to medical treatments.

HIV/HCV Co-Infection

- Awarded supplemental funds in CY2018 to support expansion of BRIDGE Team to support increased access to HCV treatment among individuals co-infected with HIV/HCV
- Focusing on two key strategies during the HRSA supplemental project period:
  - Increased provider awareness of the scope of coverage provided by ADAPs for HIV/HCV co-infected individuals, including enhanced provider messaging and targeted outreach to providers/case managers that serve populations disproportionately impacted by co-infection (e.g. PWID);
  - Follow-up with case managers that submit applications to ADAP indicating the client is infected with HCV – with no known treatment status- to assess barriers to treatment, provide education to client/case manager, and support linkage to HCV treatment

Improving Viral Suppression

- As earlier referenced, 90% of HDAP clients ages 29 and below are virally suppressed.
  - Among those who aren't achieving viral suppression, the majority are young men of color.
- As part of MDPH's QM efforts, the HDAP program is developing an intervention to address these persistent rates of viral non-suppression among this demographic group. Activities include:
  - Review of client level data, in collaboration with HRSA-funded HIV Surveillance and Field Epidemiologists to determine the extent to which these clients are out of care and/or not virally suppressed.
  - Development of a clinician led intervention supported by HDAP and MDPH staff, including adherence support and linkage to care services delivered by peers, case managers, and other community health workers (CHWs).

Partnership with HIV Surveillance

Use of ADAP funds to support HIV surveillance epidemiologists, to generate analyses related to linkage to and retention in care, access and adherence to antiretroviral therapy, and individual health among HDAP enrollees:

- Analysis of rates of linkage to care (within 30 days of diagnosis) among newly diagnosed HDAP enrollees, including assessment of challenges related to timely linkage and identification of potential barriers to accessing care.
- Analysis of retention and engagement in care among HDAP enrollees, including identification of patterns related to transitioning out of HDAP as well as falling out of care.
- Use of HDAP data linked to the HASP surveillance registry to examine patterns of viral suppression over time among cohorts of HDAP enrollees.

Partnership with HIV Surveillance(cont.)

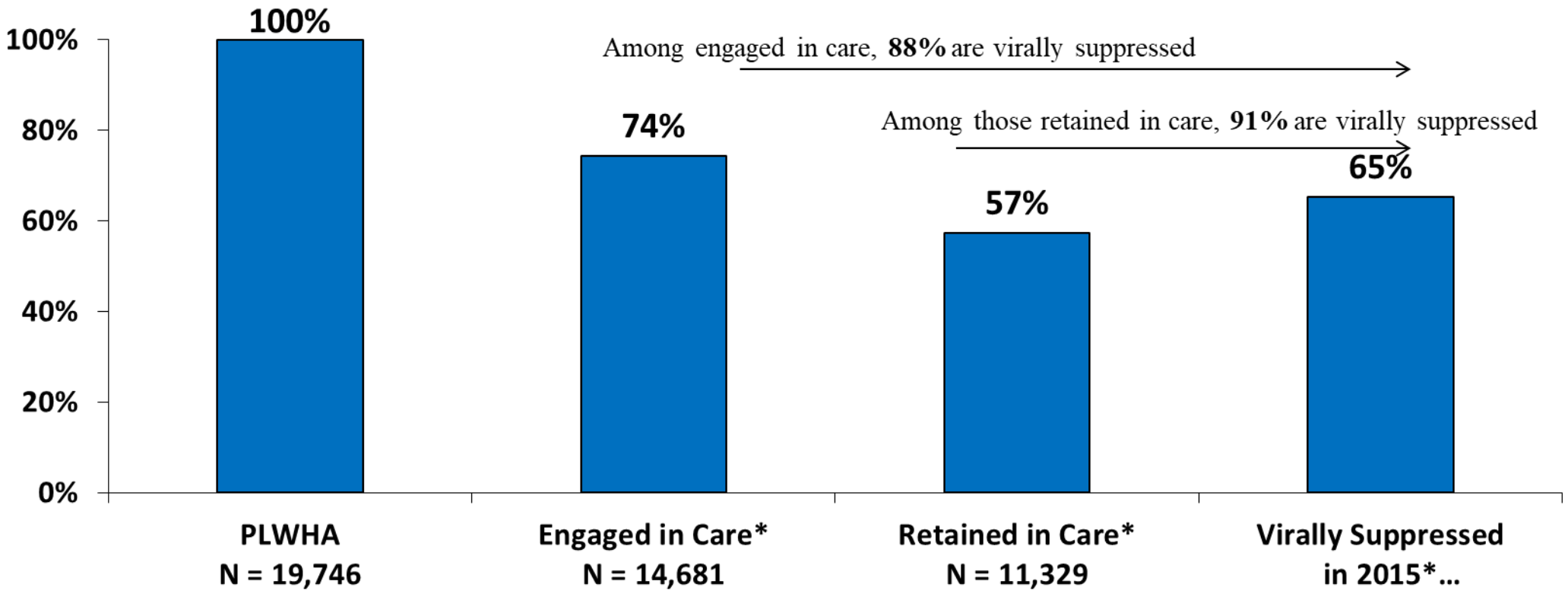
Additional qualitative analyses include:

- Conducting focus group discussions or in-depth interviews with specific sub-populations of HDAP enrollees (e.g.: enrollees who were not linked to care; intermittent enrollees; enrollees who are not virally suppressed; enrollees who report specific sociodemographic characteristics).
- Such efforts would allow a thorough examination of the real-world barriers to and facilitators of accessing and utilizing comprehensive care through HDAP and contribute to a more complete understanding of why disparities may exist among HDAP enrollees.

Treatment as Prevention

- During period of significant state budget cuts between in 2002 & 2012, ADAP was held harmless
- ADAP has continued to expand and maintain an open formulary despite rising costs
- Declining HIV prevalence (between 2000 and 2014, annual new HIV infections diagnosed in Massachusetts decreased by 47%).

Massachusetts Care Continuum



* Lab received by MDPH

[1] Includes individuals diagnosed through 2015 and living in MA as of 01/01/17, based on last known address, regardless of state of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 01/01/18