Adherence 2017

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Outcomes from Whitman-Walker Health's Mobile Outreach, Retention &Engagement (MORE) Program for HIV+ Individuals in Washington, DC

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Whitman Walker Health

1525 14th st NW

Max Robinson Center

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

Disclosures

No Disclosures

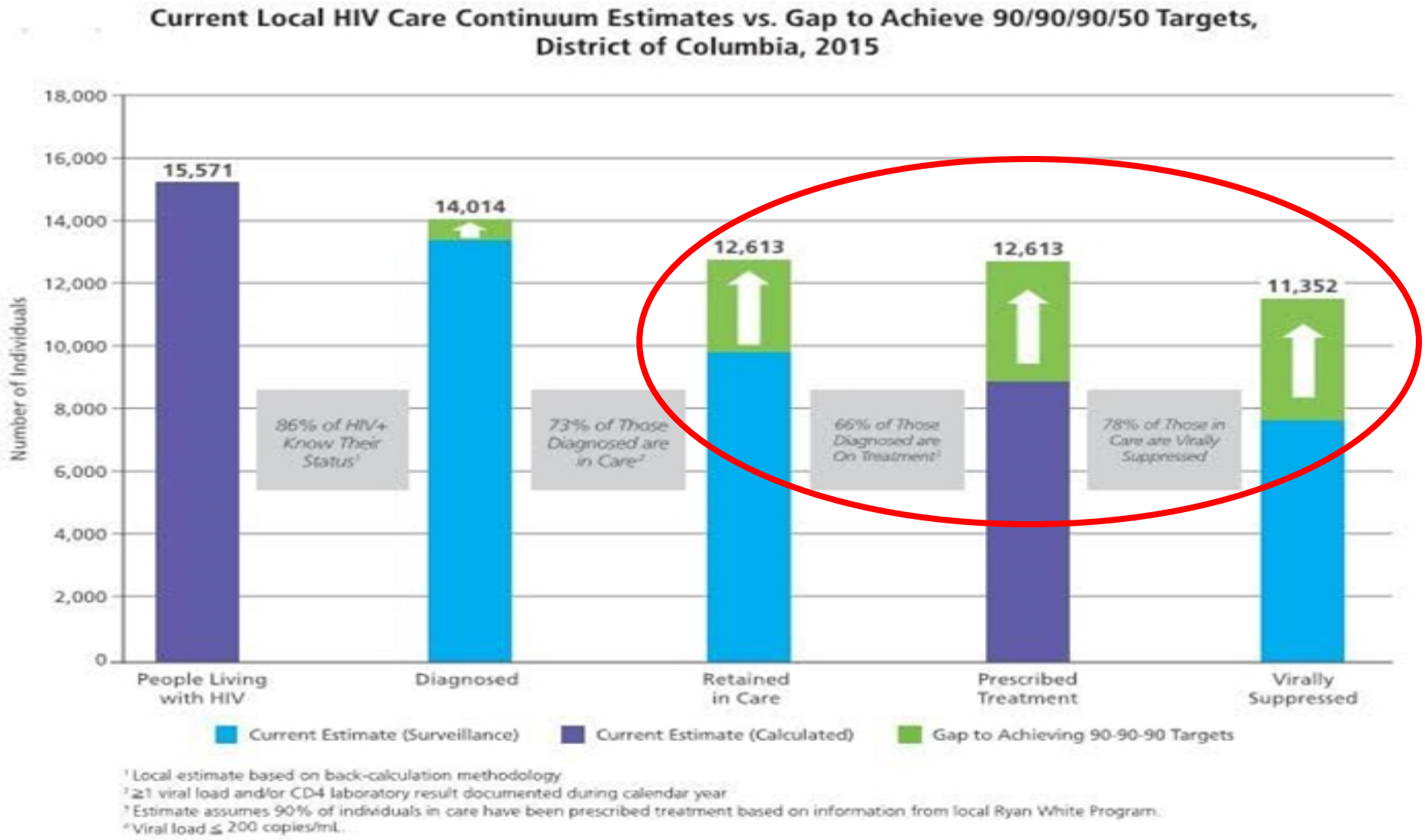
Scope of the Problem

- 15,000 (~2%) people living with HIV/AIDS in Washington, DC as of 2015

- 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

D.C. Dep't of Health, HIV/AIDS, Hepatitis, STD, & TB Admin., Annual Epidemiology & Surveillance Report: Surveillance Data Through December 2015

DC HIV Care Continuum



Reported Barriers to Care

GW Milken Institute, DC

4 most reports barriers:

- Transportation
- "Didn't feel like it"
- Forgot Appointment
- Competing priorities

Castel AD, Measuring Engagement and Retention in HIV Care in Washington, DC. Second National CFAR/APC HIV Continuum of Care. Washington, DC,

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**

Baligh et al. (2015) Barriers and facilitator to patient retention in HIV care. BMC Infectious Diseases. 15:246l

The Response

The Mobile Outreach Retention and Engagement Program (MORE)

- Public/Private Partnership
  - DC department of health
  - Washington AIDS partnership
  - Bristol Myers Squibb Foundation
  - MAC AIDS Fund

- A comprehensive intervention to offer expanded support services and medical care outside of the clinic

- Address identified barriers to care

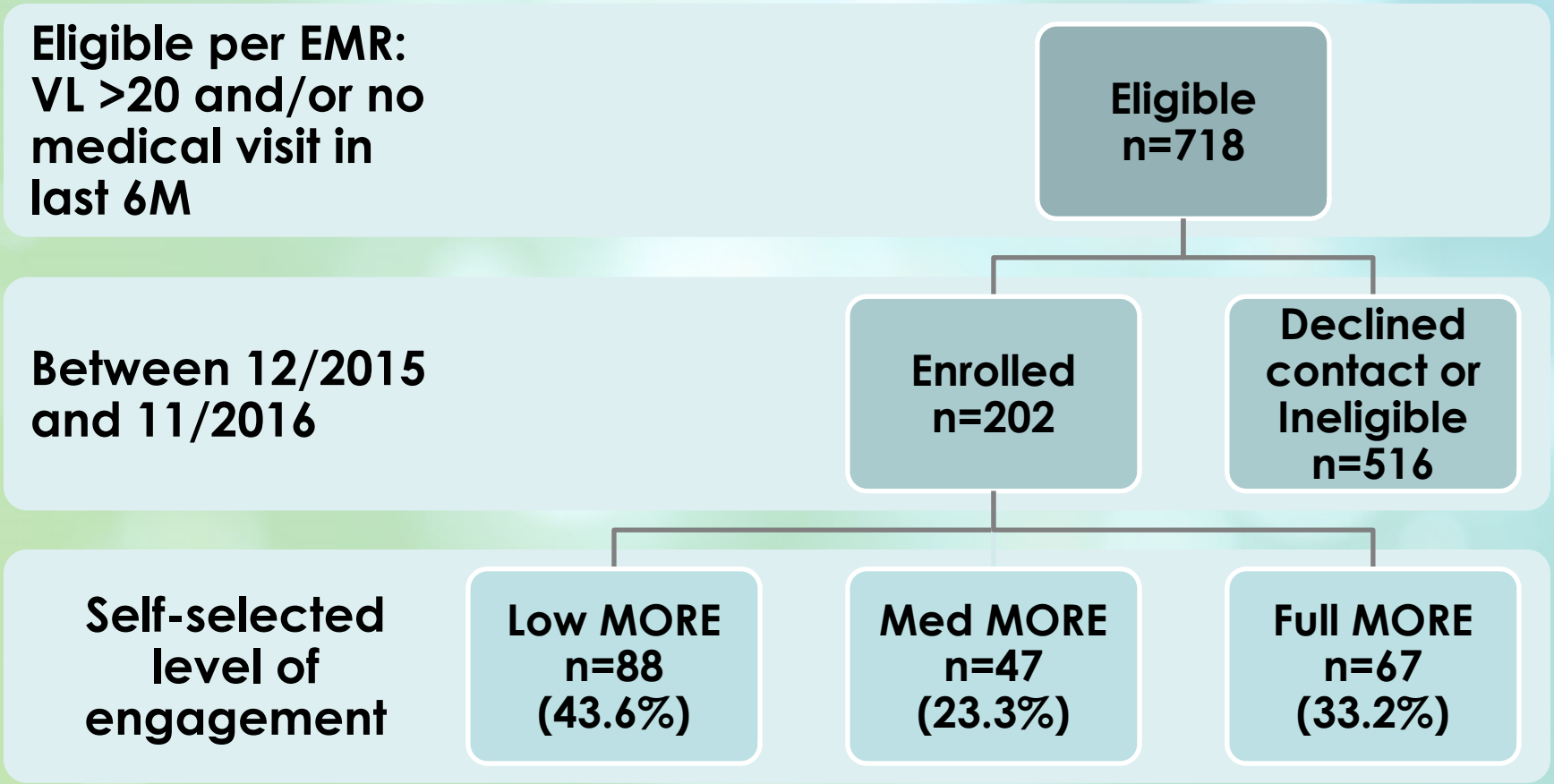
MORE Team

- Medical Providers
  - 2 Nurse Practitioners
  - 1 Physician Assistant
- Care Navigators (CN)
- Community Health Educator (CHE)
- 1 Manager

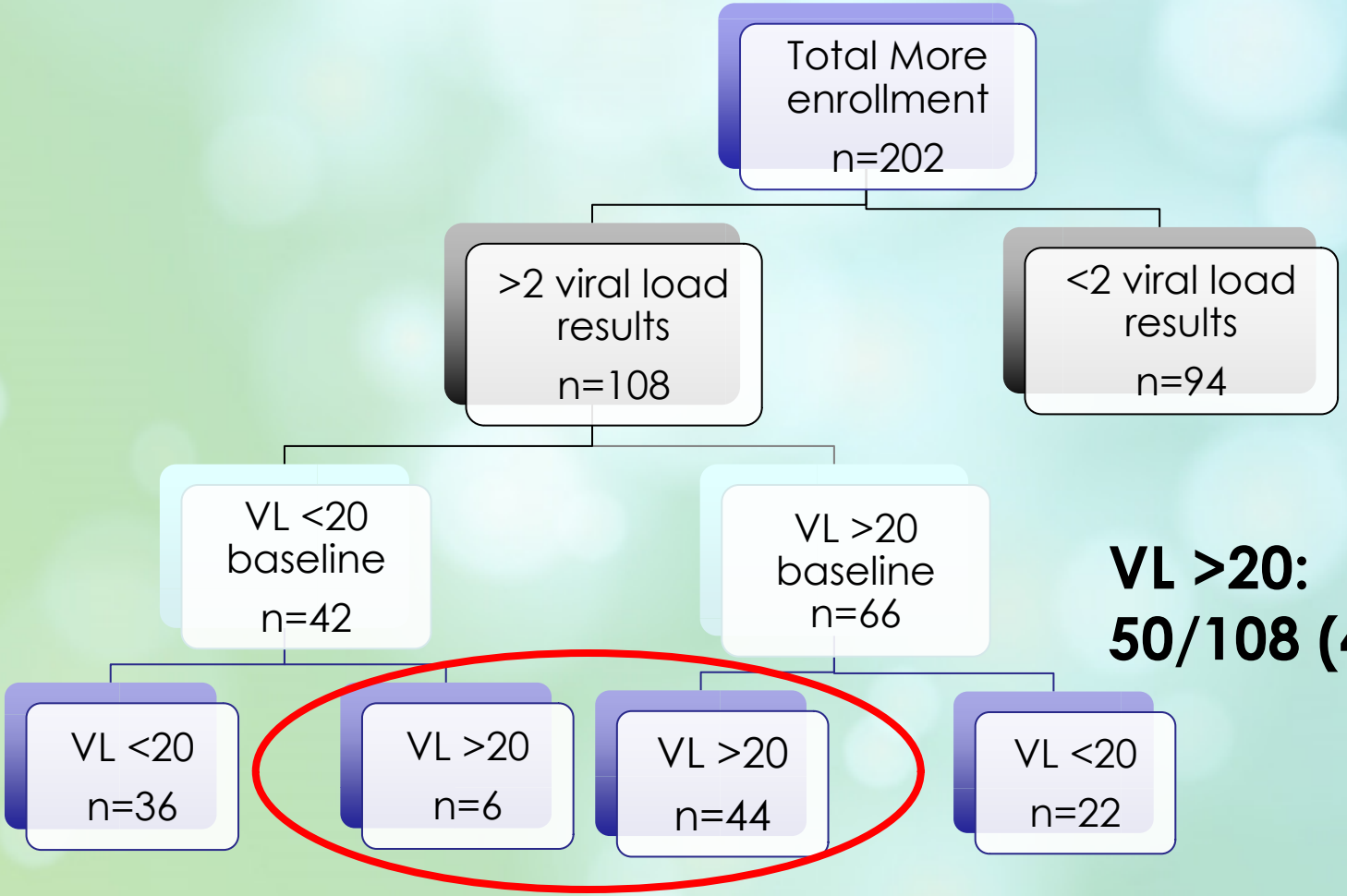
Response by Barrier

Barrier	Response
Transportation	-Medical and phlb visit in home -lyft/Uber rides and help with MTM
Forgetting	-Care navigation support/reminder calls
Stigma	-Medical and Phlb appts out of clinic setting
Feeling sick	-Medical and Phlb visits in home
Scheduling	-Home visits -Extended hours offered
Insufficient Health insurance	-Care navigation to public benefits
Competing Priorities	-Medical and Phlb home visits, extended hours
Housing	-Connection with services through CHE
Mental Health /Substance Abuse	-Transportation to appts, -Facilitation of scheduling with in-house services
Negative experience with staff/space	-Home phlb and medical visits -Increased access to support (CN/CHE) and MORE provider

Enrollment


Eligible per EMR: VL >20 and/or no medical visit in last 6M
Eligible n=718
Between 12/2015 and 11/2016
Enrolled n=202
Declined contact or Ineligible n=516
Self-selected level of engagement
Low MORE n=88 (43.6%)
Med MORE n=47 (23.3%)
Full MORE n=67 (33.2%)

After Year One



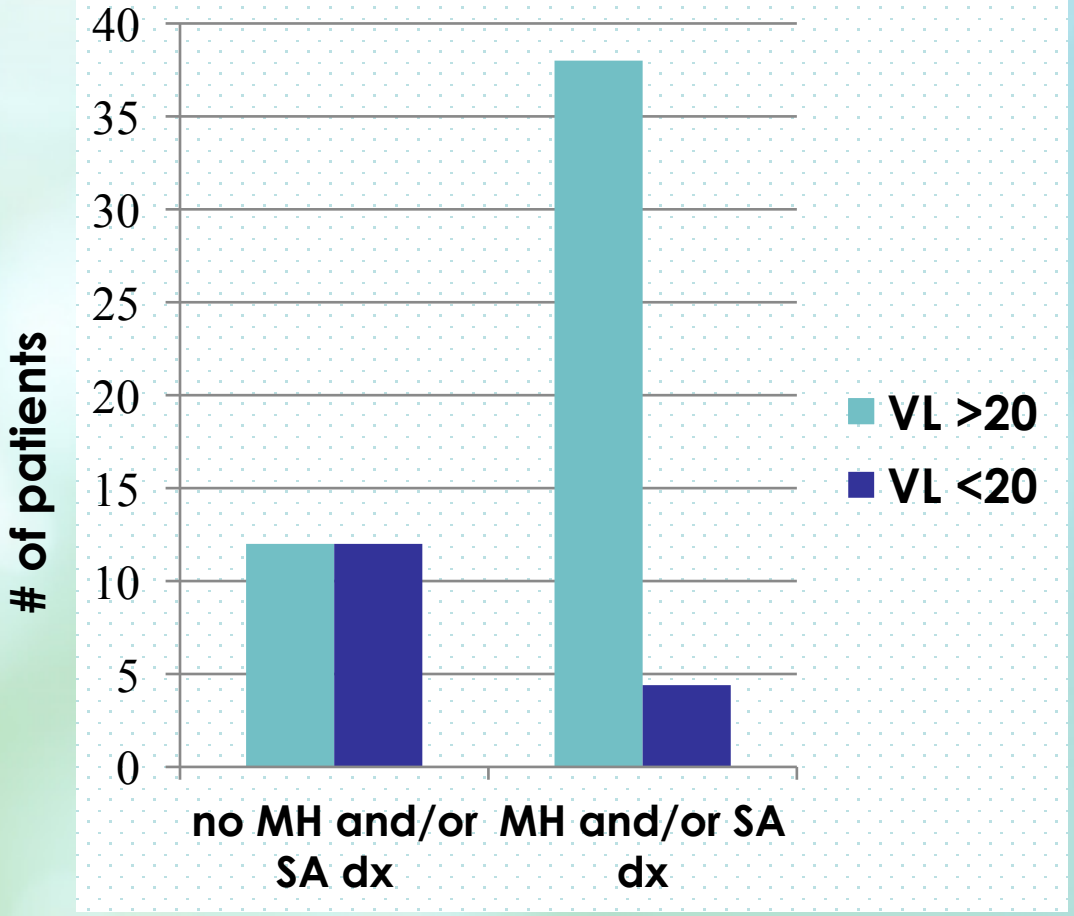
VL >20: 50/108 (46%)

Potential Contributing Factors

Factor	VL >20	VL < 20	P value
Age: 20-34 35+	14 (19.4%) 36 (50.0%)	8 (11.1%) 14 (19.4%)	0.478
Race: non-AA AA	9 (12.5%) 41 (56.9%)	5 (6.9%) 17 (23.6%)	0.641
Housing: unstable stable	22 (30.6%) 28 (38.9%)	6 (8.3%) 16 (22.2%)	0.180
Insurance: non-medicaid medicaid	26 (36.1%) 24 (33.3%)	7 (9.7%) 15 (20.8%)	0.113
Mental health (MH)/Subs abuse (SA): no yes	12 (16.7%) 38 (52.8%)	12 (16.7%) 10 (13.9%	0.011
# visits: 2-10 visits 11+ visits	27 (37.5%) 23 (31.9%)	12 (16.7%) 10 (13.9%)	0.966
Missed doses Wk: 0 doses 1+ doses	19 (44.2) 11 (25.6%)	8 (18.6%) 5 (11.6%)	0.911
Enrollment group: low medium Full	21 (29.2%) 12 (16.7%) 17 (23.6%)	8 (11.1%) 6 (8.3%) 8 (11.1%)	0.900

Results

- 38/50 (76.0%) with VL>20 had hx of Mental Health and/or Substance Abuse dx
- Relationship consistent across MORE groups



Conclusion

- Participants with **mental health and/or substance abuse diagnoses** were significantly **less likely** to **achieve viral suppression**
- Despite receiving increased support services through MORE
- Independent of the level of MORE support

Limitations

- Retrofitted for research
- Priority to mirror standard of care/observational data
- Combined Mental health and/or substance abuse diagnosis
- Rolling Enrollment
- Ramp Up in first year
- Slow uptake by providers
- **SUSTAINABILITY**

Future Directions

- Distinguish between mental health diagnoses from substance abuse
- Streamline internal referrals and scheduling for BH appointments
- Collaboration with BH "wrap-around" service agencies
- Behavioral Health Specialist on MORE team

- **Suggestions?**

90/90/90/50 by 2020

Thank you!

- Funders
  - MAC AIDS FUND
  - Bristol Myers Squibb
- DC Department of Health
- Washington AIDS Partnership
- Shattuck and Associates
- Megan Coleman, NP
- MORE Team
- Patients of the MORE program