Innovations in HIV: Applying Past Lessons to Accelerate Uptake of Treatment

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Adherence 2022 • November 7-9 • Washington, DC

UNAIDS Targets

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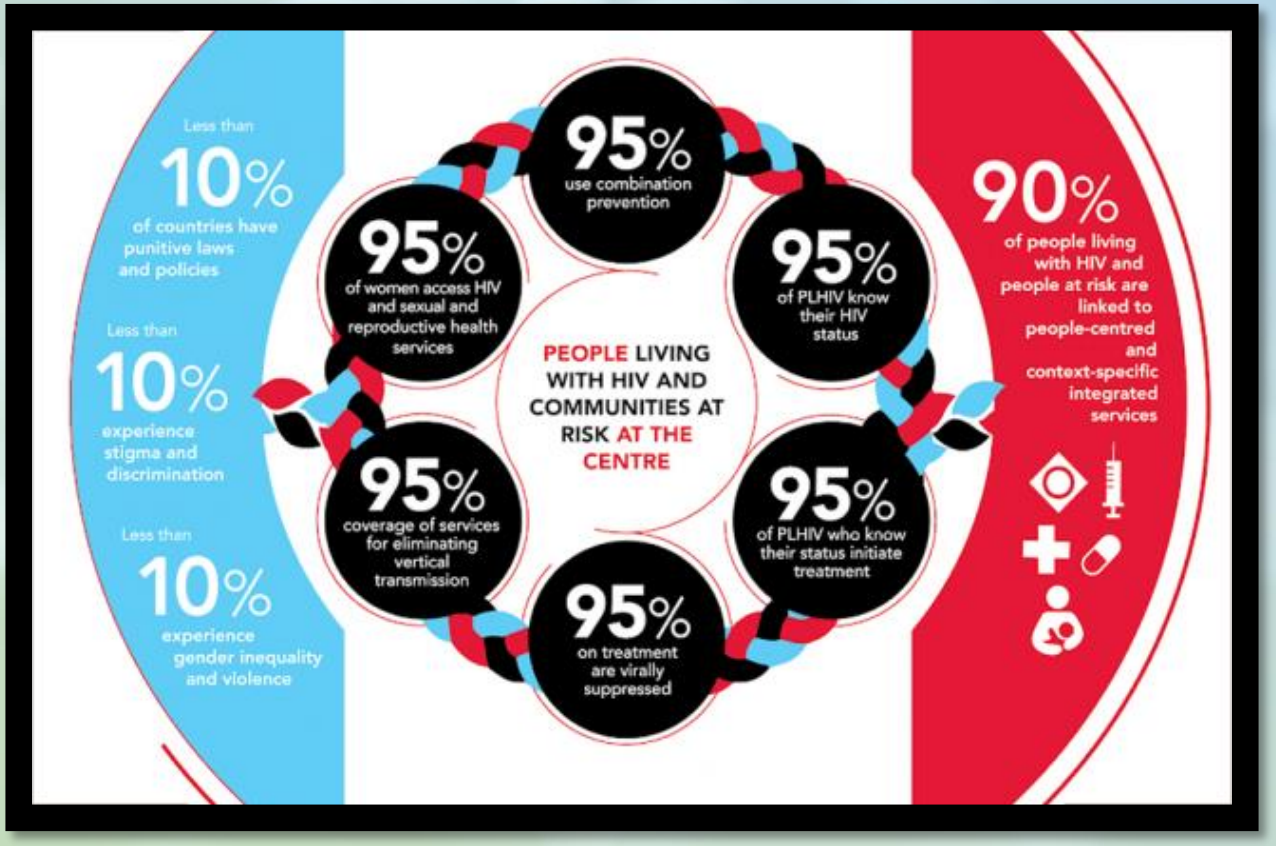

Unaids.org. (2021, July 21). 2025 AIDS targets: The next generation of goals for the global aids response. UNAIDS. Retrieved November 1, 2022, from https://www.unaids.org/en/resources/presscentre/featurestories/2021/july/20210721_2025-aids-targets

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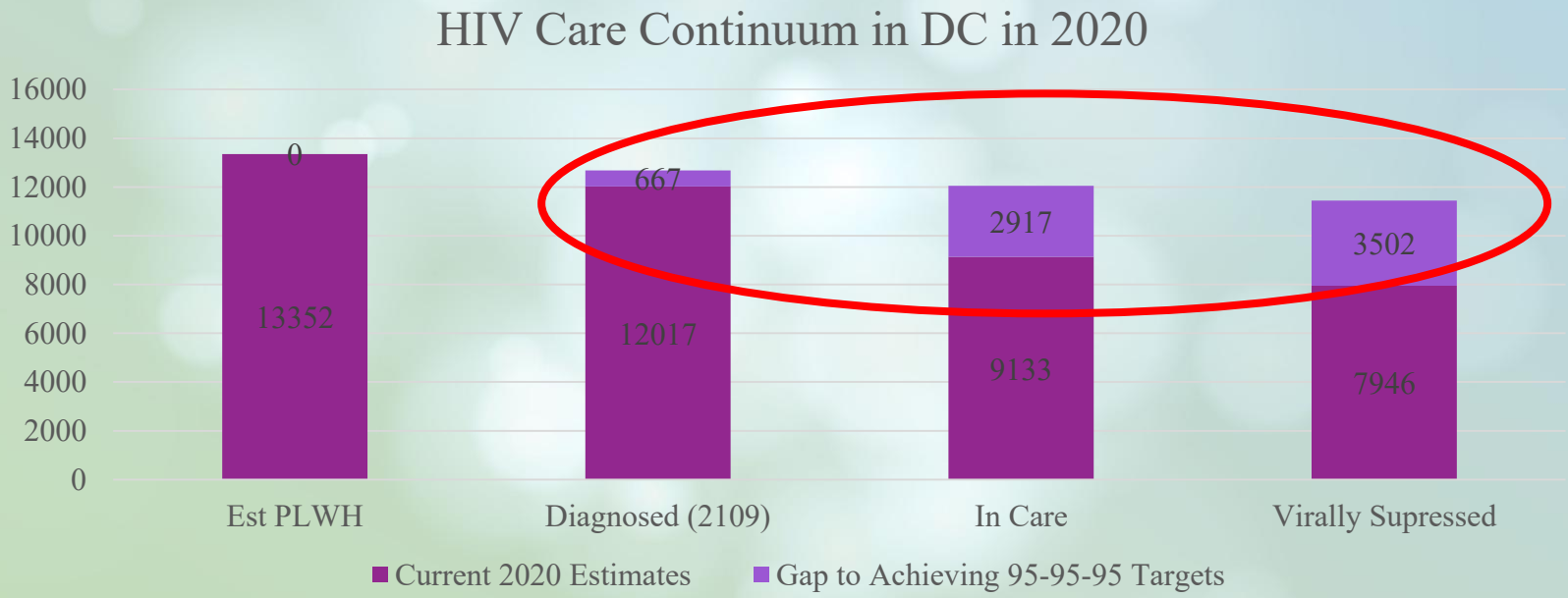
What does this look like in Washington D.C.?



Government of the District of Columbia DC Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA). (2021). 2021 Annual Epidemiology & Surveillance Report. Retrieved November 1, 2022, from https://dchealth.dc.gov/node/1580346

Whitman-Walker Health

Barriers to Care

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- Social Determinants of Health: conditions in the environments where people are born, live, learn, work, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
  - Economic Stability
  - Education
  - Health Care Access and Quality
  - Neighborhood
  - Social and Community Context
- Stigma
- Fragmented Health Care System

Social Determinants of Health. Social Determinants of Health - Healthy People 2030. (n.d.). Retrieved November 2, 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health

SDoH and Care Outcomes Among People Living With HIV (PLWH) in the U.S.

- Data from the 2015–2019 Medical Monitoring Project: Annual Survey of 15,964 PLWH

Table 4. Unadjusted Prevalence Ratios Comparing Care Outcomes by the Oregon Social Determinants of HIV Health Index Among People With HIV in the United States, Medical Monitoring Project, 2015–2019

	Model 1 Missed Appointment			Model 2 Excellent Adherence			Model 3 Durable Viral Suppression		
	% (95% CI)	PR (95% CI)	*P* Value	% (95% CI)	PR (95% CI)	*P* Value	% (95% CI)	PR (95% CI)	*P* Value
OSHI score									
0 indicators	9.8 (8.2–11.3)	Ref		71.1 (68.9–73.4)	Ref		71.8 (69.2–74.4)	Ref	
1 indicator	15.8 (14.0–17.5)	1.62 (1.35–1.93)	<.001	63.3 (61.0–65.6)	0.89 (0.85–0.93)	<.001	69.8 (67.5–72.1)	0.97 (0.93–1.02)	.202
2 indicators	21.7 (19.8–23.7)	2.23 (1.86–2.67)	<.001	58.9 (56.5–61.2)	0.83 (0.79–0.87)	<.001	67.4 (64.6–70.1)	0.94 (0.89–0.99)	.028
3 indicators	28.5 (25.9–31.0)	2.92 (2.50–3.41)	<.001	56.8 (54.2–59.4)	0.80 (0.76–0.84)	<.001	63.1 (60.3–65.9)	0.88 (0.84–0.92)	<.001
≥4 indicators	39.0 (37.2–40.8)	4.00 (3.37–4.74)	<.001	49.4 (47.5–51.4)	0.69 (0.66–0.73)	<.001	55.1 (53.0–57.2)	0.77 (0.73–0.81)	<.001

Abbreviations: OSHI, Oregon Social Determinants of HIV Health Index; PR, prevalence ratio.

Menza, TW et al., Social Determinants of Health and Care Outcomes Among People With HIV in the United States, Open Forum Infectious Diseases, Volume 8, Issue 7, July 2021, ofab330, https://doi.org/10.1093/ofid/ofab330

UniquelyU

NIH Funded award to WWI evaluating factors that contribute to viral suppression and support U=U

- 250 SMM-LHIV for 2 years post diagnosis
- Repeated collection of dried blood spots, other measures of adherence, risk factors, structural barriers, and resilience factors will be used to understand the impact of factors on VS
- To date unemployment, recent incarceration history, and identifying with multiple racial/ethnic categories negatively impact ART uptake

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WWH Response: MORE

Mobile Outreach Retention and Engagement

A comprehensive intervention to offer expanded support services and medical care outside of the clinic in response to identified barriers to care. 718 Patients were eligible. 370 enrolled. Patients choose their level of engagement.

LOW (n=137)	MEDIUM (n=94)	HIGH (n=139)
Low MORE participants receive: SOC • Medical visits at the health center • Phlebotomy at the health center during standard hours • Insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards which can be accessed by individual	Medium MORE participants receive: • The care navigator will track visits, give reminder calls, aid is scheduling, perform adherence counselling and offer connection to additional support services	Full MORE participants receive: a **MORE** team • **Mobile medical visits** • Medical visits at the health center with **flexible hours** • **Mobile phlebotomy** services • **Food Cards** and connection to services • **Phone minutes** • **Weekly team care planning**

Outcomes of MORE after 5 years

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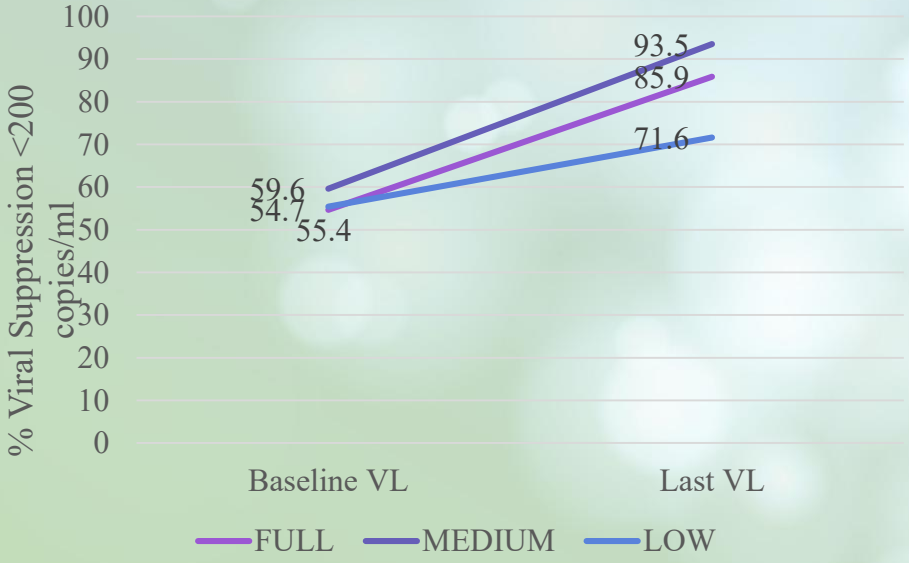
Rates of Viral Suppression



Rates of Retention

	Full MORE N=137	Medium MORE N=94	Low MORE N=139
Active "in-care"	72.3% (n=99)	44.6% (n=62)	58.3% (n=81)
Lost to Follow-Up*	9.5% (n=13)	14.4% (n=20)	20.1% (n=28)
Transfer/moved/in carcerated	8.0% (n=11)	5.0% (n=7)	14.4% (n=20)
Deceased	10.2% (n=14)	3.6% (n=5)	6.5% (n=9)
Adjusted Active (minus deceased/transfer)	87.6% (n/N=99/113)	75.6% (n/N=62/82)	73.6%(n/N=81/110)

Sustainability: Cost Analysis

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Cost analysis was conducted using the CIE Cost Analysis Calculator: http://ciehealth.org/innovations

- Total cost for implementing MORE was **$347,098** annually
  - 80.3% of all direct cost was staffing and personnel
  - 10% of direct program non-personnel costs included staff computer-related expenses and medical supplies
  - 9.8% was client-specific (food cards, educational materials and transportation related costs).
- Overall cost per client served was **$4,285**

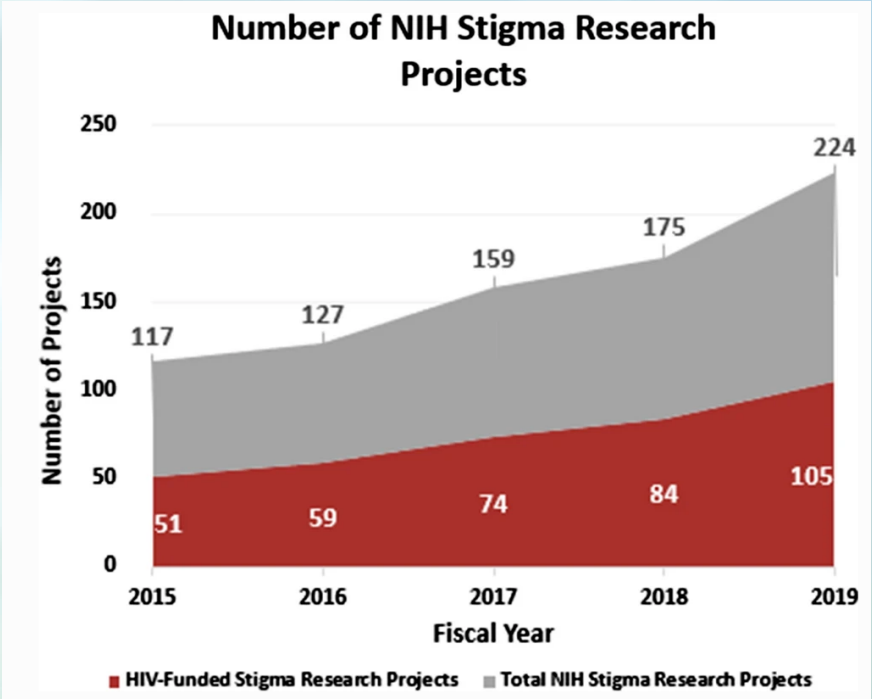
Estimated 2021 cost $13,300 per hospital stay day[1], ER visit was $1,082 in 2019[2]

1. Dahlen, G. (2022, October 21). Inpatient - average cost, typical prices, ballpark. Consumer Health Ratings. Retrieved November 2, 2022, from https://consumerhealthratings.com/healthcare_category/inpatient-average-cost-typical-prices-ballpark/.
2. Dahlen, G. (2022, October 13). Emergency room - typical average cost of hospital ed visit. Consumer Health Ratings. Retrieved November 2, 2022, from https://consumerhealthratings.com/healthcare_category/emergency-room-typical-average-cost-of-hospital-ed-visit/

Stigma: Critical Barrier to HIV interventions

Health-related stigma frameworks address:

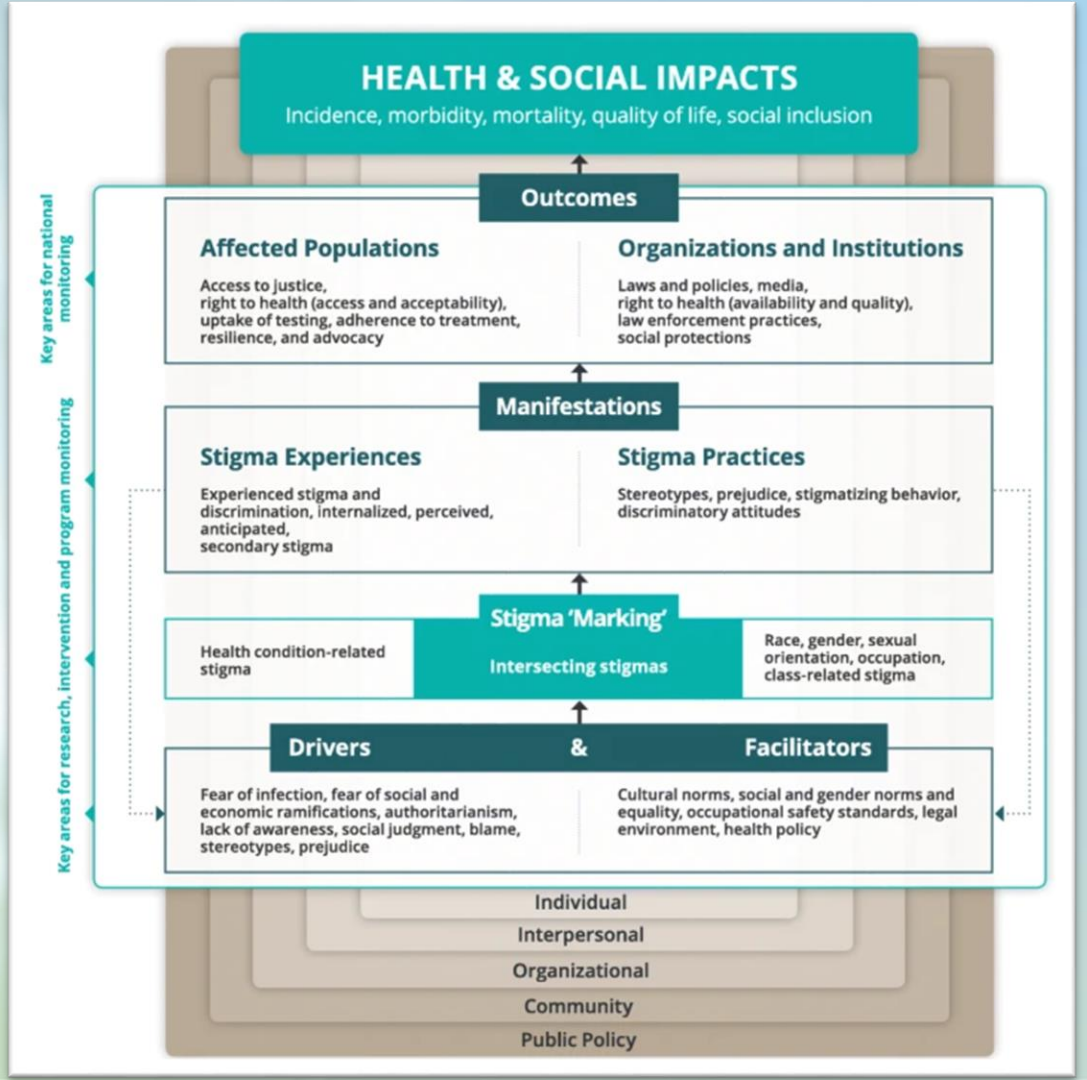
- Individual psychological pathways
- Social pathways (cultural and gender norms)
- Structural pathways (laws and health policy)



Greenwood, G. L., et al. (2021, April 22). HIV-related stigma research as a priority at the National Institutes of Health - AIDS and behavior. SpringerLink. Retrieved November 2, 2022, from https://link.springer.com/article/10.1007/s10461-021-03260-6

The Health Stigma & Discrimination Framework

- Intersectional Model
- Moves away from focusing on the individual
- Doesn't distinguish between the stigmatized and the stigmatizer
  - Focuses on drivers and facilitators
- Broader social, cultural, political, and economic forces are centered
- Allows for a structure to research stigma across diseases



Stangl, A. L. (2019, February 15). The health stigma and discrimination framework: A global, crosscutting framework to inform research, Intervention Development, and policy on health-related stigmas - BMC medicine. BioMed Central. Retrieved November 2, 2022, from https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1271-3#Sec1

UPLIFT

NIH funded study to George Washington University Blinken School of Public Health and Whitman-Walker Institute

Study to establish a 5,500 person longitudinal epidemiologic cohort to test socio-structural models of risk and identify new opportunities for structural and community-level intervention.

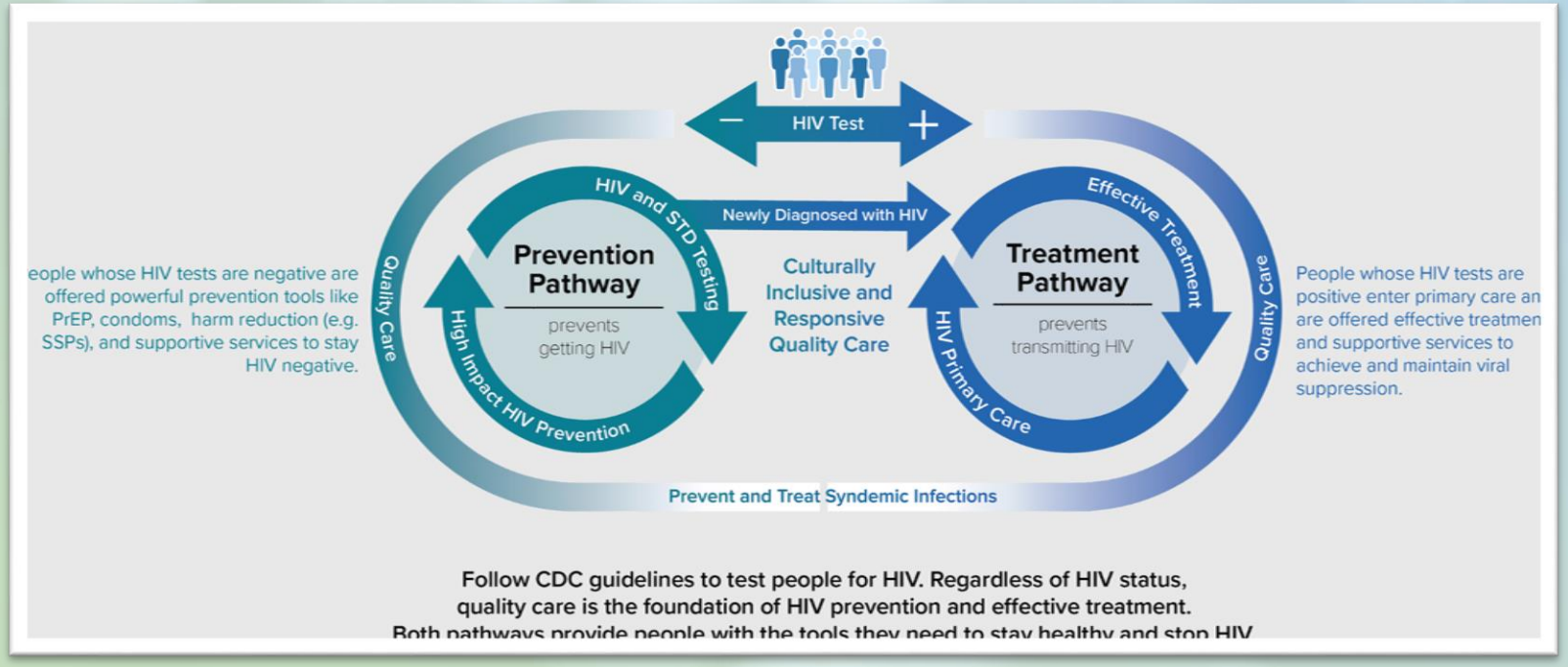
Aim: To create novel metrics to quantify state-level policy and social climate indicators that create intersectional oppression for BLM SGMSM, specifically structural racism, anti-LGBTQ stigma, and restrictive HIV-related healthcare.

DC CFAR: Integrated Services Pilot

The goals of the study are

1. Characterize clinical trajectories at the intersection of gender-affirming services (GAS) and HIV prevention services (PrEP)
2. Identify effective strategies for integration of GAS and PrEP through interviews to inform a program for subsequent implementation and evaluation

Integrated Care: Status Neutral Approach



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DC Ends HIV

Incorporates Status Neutral Care

High V Model

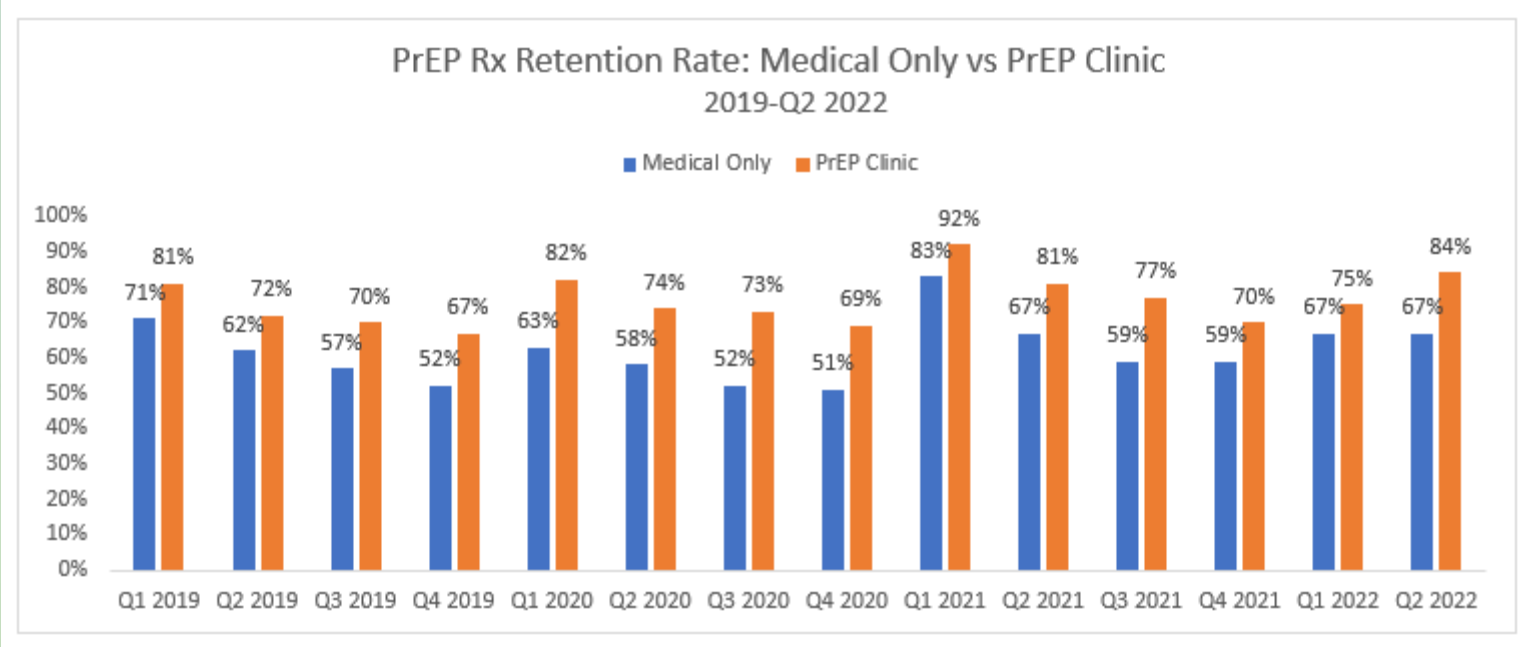
- Find
- Teach
- Test
- Link
- Keep

The big picture. DC has reached the next phase in our plan to end the HIV epidemic. (n.d.). Retrieved November 4, 2022, from https://www.dcendshiv.org/our-plan/the-big-picture

Care at WWH

- Longstanding Stand Alone Programs
  - Red Carpet Program – Same Day Access
  - Fast Forward: Immediate ART Initiation Program
  - PrEP Clinic – Care Navigation and Public Benefits Coordinator – Streamlined Care

Quarterly PrEP Rx Retention



Status Neutral Care at WWH

- Providing access to same day care and treatment for all those as risk for HIV
  - Integrating separate programs into a singular approach
- Focusing on whole person health
  - Language focuses on health rather than disease

Next Generation of ARVs

- Long Acting Injectables (LAI)
  - Expand choice
  - Create opportunity to improve medication adherence
  - May help reduce stigma
  - Promote equity
- Implementation hurdles
  - Staffing support to attain medication, administer injections, and support enrolled patients

Takeaway lessons? We See You.

Effective treatment entails a whole person approach to care that provides supports to overcome SDoH, stigma, and inequities. New exciting treatments will need to be implemented within the broader context of health care programs which support patients in order to reach the 95-95-95 goals.