SECTION 4: MAI PLAN NARRATIVE

- DESCRIPTION OF PLAN:

Funds are prioritized for Outpatient/Ambulatory Health Services and have been awarded to the Grady Infectious Disease Program (IDP) which manages the most advanced cases of HIV disease in the EMA and which serves the majority of youth in the EMA.

In calendar year (CY) 2016, 70% of all IDP clients had an AIDS diagnosis. The breadth of IDP services along with the depth of clinical expertise engendered through the Grady/Emory partnership uniquely position the IDP to provide state-of-the art care for a client population with the highest acuity in the EMA.

IDP's 2015 optimization efforts helped streamline clinic processes so more patients could be seen and new patients could have their initial provider visit sooner. While IDP's medical and support services are tailored to help patients reach viral suppression many patients are in a cycle of dropping in and out of care (also known as churn[1]). An analysis of approximately 1,000 new and re-enrolling patients in FY 16 proved this to be the case with many new patients as well as those that re-enrolled that year already having fallen out of care as of the analysis period. Table 1 shows patients from IDPs Main Clinic that re-enrolled in FY 16 (n=311) and compares virally suppressed patients with patients that did not achieve viral suppression. An in-depth review of the electronic medical records was done in order to compare several potential factors that could have played a role in the outcomes for these patients.

Table 1: FY16 Re-enrolling patients – IDP Main Clinic

	Suppressed		**Not Suppressed**	
Factor	**# Patients**	%	**# Patients**	**%**
Unstable Housing	85	49%	63	46%
1st Prov Appt Not Kept	35	20%	32	23%
12 Yrs or Less Education	131	76%	98	71%
4 or more Missed Prov Appts	27	16%	32	23%
MSM	112	65%	97	70%
Total Patients	**173**	55.6%	**138**	44.4%

Twenty-three percent of non-virally suppressed patients missed four or more medical appointments in the 12 month period, compared to 16% of suppressed patients. Based on the outcomes and detailed chart review of the FY 16 new and re-enrolling patients across IDP clinics it is clear we have an opportunity to improve retention in care for this cohort of patients.

The FY 17 MAI funds will be utilized to implement a modified Enhanced Personal Contact intervention with the goal of improving patient retention which in turn will improve viral

[1] Gill MJ, Krentz HB. Unappreciated epidemiology: the churn effect in a regional HIV care programme. Int J STD AIDS. 2009;20:540–544.

suppression rates. We plan to base our intervention on the evidence based intervention, Enhanced Personal Contact[2]. The intervention is based on a randomized trial conducted by Gardner, et al and published in Clinical Infectious Diseases in 2014. Gardner and colleagues implemented a multisite randomized controlled trial in six US cities, three of which were in the southern US. Participants were randomized into one of three arms: enhanced contact (EC); enhanced contact plus skills (EC+skills); or standard of care (SOC) only. Enhanced contact included a trained interventionist establishing a personal relationship with the patient during an initial face-to-face meeting and subsequently remaining in contact with the patient throughout the duration of the study. At each primary care visit, the interventionist met face-to-face with the patient to provide positive reinforcement for keeping appointments and answered questions the patient may have had. Interim phone contact occurred between scheduled primary care appointments along with personal reminder calls at 7 days and 2 days before each scheduled appointment. Patients were contacted by phone within 24 hours after a missed visit. The EC+skills arm of the intervention used a strengths-based approach to help patients identify problems and address them through one-on-one training on personal organization, problem solving and communication. During the EC+skills sessions referrals were made to case managers to address unmet needs. The EC arm resulted in improved visit constancy (measure of retention) compared to the standard of care arm while the EC+skills aspect of the intervention did not add any additional benefit.

IDP will implement an Enhanced Personal Contact PLUS (EPC PLUS) intervention based on the principles of the above evidenced based intervention to improve retention in care (see Attachment A).

Data from a study done at IDP show that a predictor of poor retention is a phone number change in the previous 12 months, therefore we recognize the limitations of solely relying on phone contact for retention in care intervention[3]. Furthermore, missed visits are associated with increased mortality and missed visits are an immediate actionable event[4]. Therefore we propose an increased intensity intervention for those who miss a visit. In addition to the personal contact elements of EPC described above, EPC PLUS will add the following components:

1) Tailored patient contact between visits and after missed visits to the mode of contact the individual most prefers (see below).
2) Expanded collection and utilization of contact information for patients such as email and social media,[5]

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[2] Lytt Gardner, e. (2014). Enhanced Personal Contact with HIV Patients Improves Retention in Primary Care: A Randomized Trial in 6 US Cities. *Clinical Infectious Diseases*, 725-734

[3] Colasanti, J., Stahl, N., Farber, E., del Rio, C., & Armstrong, W. An Exploratory Study to Assess Individual and Structural Level Barriers Associated with Poor Retention and Re-engagement in Care Among Persons Living with HIV/AIDS. *Journal of Acquired Immune Deficiency Syndromes* 1 February 2017 - Volume 74 - Issue - p S113–S120

[4] Mugavero MJ, Lin HY, Willig JH, Westfall AO, Ulett KB, Routman JS, et al. Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clin Infect Dis* 2009,48:248-256

[5] Metsch LR, Feaster DJ, Gooden L, Matheson T, Stitzer M, Das M, et al. Effect of Patient Navigation With or Without Financial Incentives on Viral Suppression Among Hospitalized Patients With HIV Infection and Substance Use: A Randomized Clinical Trial. *JAMA* 2016,316:156-170

3) A comprehensive assessment of factors that resulted in a missed appointment or missed prescription pick-up in order to develop a tailored a plan for the patient that maximizes IDP's services such as medical transportation, mental health and substance use services, clinical pharmacists and that of partner agencies such as Open Hand.
4) Patients will also be encouraged to enroll in MyChart, the patient portal for IDP's electronic medical record system, Epic. MyChart provides a streamlined way for patients to send messages to their medical provider, check their latest lab results, appointments and receive messages from their care team.

Furthermore, patients who cannot be reached for six months or longer will be placed on an out-of-care list. The out-of-care list will be sent to the Georgia Department of Public Health (GDPH) to be matched with HIV surveillance data in order to identify patients who are out of care as opposed to those who transferred care. This aspect of the intervention is based on the evidence informed approach studied in the *Clinic-based Surveillance-Informed Patient Retracting* intervention. This intervention has demonstrated improvement in retention, higher rates of re-linkage to care and more rapid re-linkage to care compared to historical cohorts who did not receive this intervention[6].

Table 2: Baseline and Goal Outcome Measures for IDP Patients Receiving Enhanced Personal Contact PLUS (EPC PLUS)

Outcome	Baseline (all IDP patients)[7]	Baseline MAI Patients[8]	Goal (EPC PLUS patients)
Viral Load Suppression	74.9% (4189/5593)	52.57% (573/1090)	65%
Prescription of Antiretroviral Therapy (ART)	72.88% (3982/5464)	84.31% (919/1090)	80%
Gap in HIV Medical Visits[9]	13.92% (679/4879)	17.52% (174/996)	15%

Table 3 provides a breakdown of the MAI clients to be served using current CAREWare data. As shown in Table 3, 999 MAI patients will be provided Outpatient Ambulatory Health Services (OAHS).

The HRSA HIV/AIDS Bureau indicators to be tracked include:

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[6] Bove, J.M., Golden, M.R., Dhanireddy, S., Harrington, R.D., & Dombrowski, J.C. (2015). Outcomes of a clinic-based surveillance-informed intervention to relink patients to HIV care. *JAIDS*, 70, 262-268

[7] From Grady IDP Part A Implementation Plan FY17 1st Quarter

[8] From Grady IDP FY16 MAI Annual Report, May 2017

[9] Percentage of clients with HIV infection who did not have a medical visit in the last six months of the measurement year.

#1 **Outcome:** Increase in the percentage of clients with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Indicator: Percent and number of clients who have achieved a viral load less than 200 copies/mL.

Target: 65% of clients served will have achieved a viral load less than 200 copies/mL during the measurement year.

#2 **Outcome:** Increase in the percentage of patients with HIV prescribed antiretroviral therapy during the measurement year.

Indicator: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy[10] for the treatment of HIV infection during the measurement year.

Target: 80% of patients will have been prescribed antiretroviral therapy during the measurement year.

#3 **Outcome:** Decrease in the percentage of patients who did not have a medical visit during the measurement year.

Indicator: Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year.

Target: 15% of patients **or less** will not have had a medical visit during the measurement year.

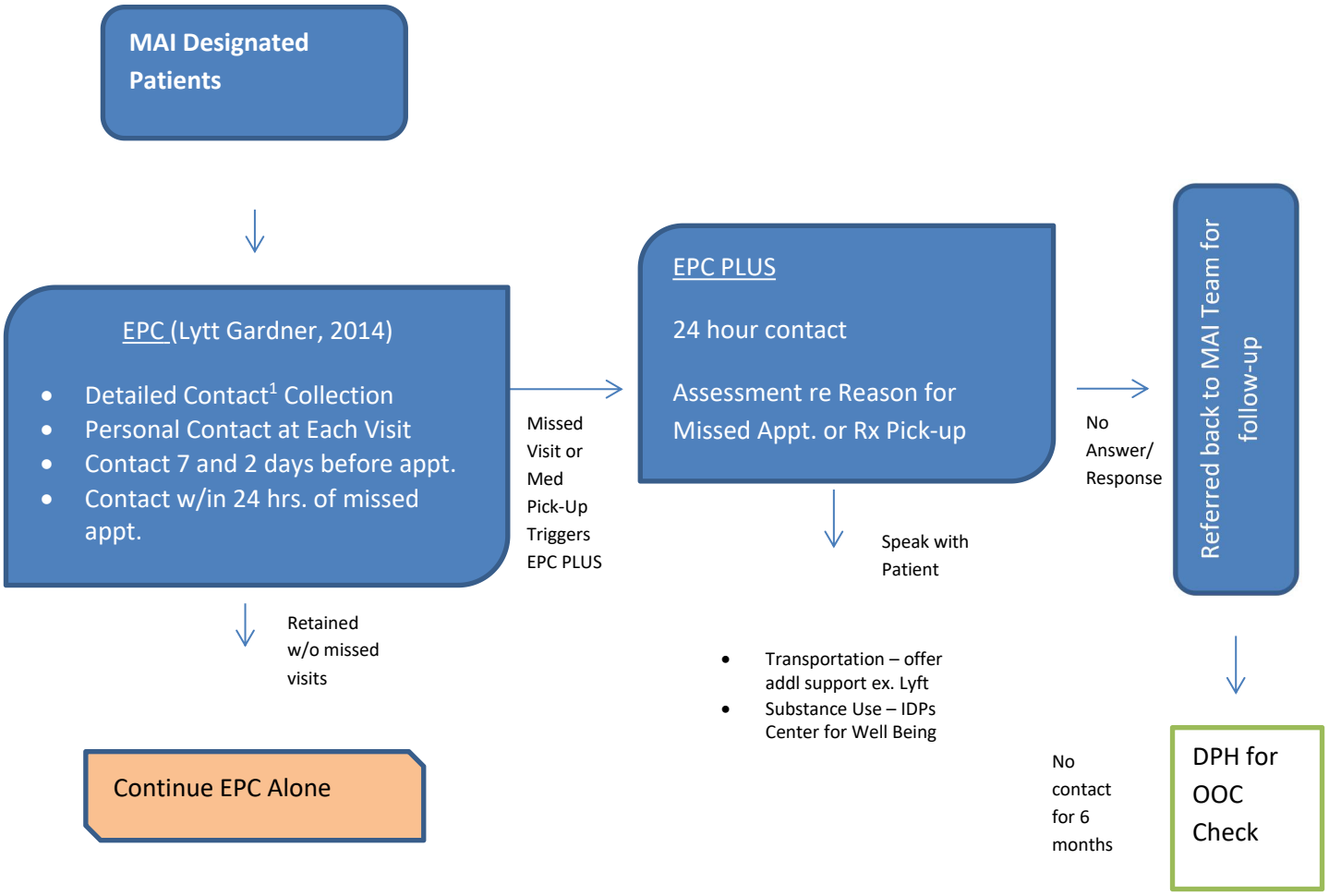
Table 3: Patients expected to be served through MAI using CAREWare Re-enrollment and Initial Primary Care Visits – FY 16

Race/Ethnicity	Re-enrollment	Initial OAHS Visit	Total
Black or African-American	493	506	999
Men	338	293	631
Transgender	3	6	9
Women	108	122	230
Youth	44	85	129

IDP will follow the FY 16 cohort of new and re-enrolling patients. As patients are removed from the cohort due to discharge, death or confirmation of care by another provider newly enrolling patients that meet the required MAI demographics will be added.

[10] HIV antiretroviral therapy is described as the prescription of at least one US Food and Drug Administration approved antiretroviral medication.

Attachment A – IDP Proposed MAI Intervention – Enhanced Personal Contact PLUS (EPC PLUS)



1. 'Contact' refers to a variety of modes of communication based on the needs of the patient.

- Description of Data:

In the United States, HIV is concentrated in men who have sex with men (around 2% of the population but 61% of new infections) and in Black/AA people (14% of the population but 44% of new infections). There is a particular concentration in men who belong to both categories – compared to the general Black/AA population, Black/AA MSM have 22 times the odds of being HIV positive. In one cohort of Black/AA MSM, 3% of men acquire HIV every year.[11]

a) **The most impacted population** is Black/AA MSM particularly the subpopulations of YBMSM 13-24 years of age, Black/AA MSM 25-44 years of age, and Black/AA Women (all ages). The below table compares these populations with the overall care continuum for the EMA. Areas in which the population group had better outcomes are indicated in red blocks, areas in which the population group compared more or less equally are in yellow blocks, and areas in which the population group compared more favorably are in green.

Comparison of subpopulation against overall Care Continuum

ATLANTA EMA CARE CONTINUUM				
All				
L	E	R	VS	VSR
74% (1,400/1,896)	61% (21,433/35,244)	46% (16,082/35,244)	49% (17,101/35,244)	85% (13,728/16,082)
Black/African American MSM, Age 13-24				
69% (573/829)	73% (464/637)	49% (314/637)	46% (295/637)	73% (230/314)
Black/African American MSM, Age 25-44				
70% (344/491)	62% (4,917/7,892)	44% (3,459/7,892)	44% (3,459/7,892)	78% (2,700/3,459)
Black/African American Female				
80% (151/189)	63% (3,637/5,731)	48% (2,743/5,731)	49% (2,830/5,731)	83% (2,279/2,743)

Legend:	Better	Same	Worse

YBMSM: prevalence of HIV and increase in AIDS incidence cases reported over last three years; unmet need of 51% and 46% viral suppression; MSM are over forty times more likely to become infected with HIV compared with other men, and young Black men are the only population in the U.S. in which the rate of new HIV infections are increasing.

Black/AA MSM 25-44: identified based on analysis of prevalence data and the unmet need of 56% and viral suppression at 44%; gay and bisexual men continue to be most affected by the HIV epidemic in the U.S. At current rates, 1 in 6 MSM will be diagnosed with HIV in their lifetime, including 1 in 2 Black/AA MSM.[12]

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[11] http://www.aidsmap.com/The-paradox-of-HIV-in-black-MSM-in-the-US-very-high-infection-rates-despite-no-more-risky-sex-and-more-precautions/page/2450837/

[12] http://www.cdc.gov/hiv/group/racialethnic/africanamericans/

Black/AA Females: African Americans are by far the most affected racial or ethnic group with a lifetime HIV risk of 1 in 48 for females (compared to 1 in 880 for White females; unmet need is 52% and viral suppression is at 49%).

MAI funds are directed to the OAHS priority category to provide culturally appropriate services to improve HIV care access, retention and treatment adherence leading to viral suppression among minority populations disproportionately impacted by HIV in the EMA. Minority populations targeted with MAI funds in the Atlanta EMA appropriately are Black/AA (all sexes and ages), YBMSM 13-24 years of age, and Hispanic (all sexes and ages). MAI-supported programming and service delivery are designed to respond to unique barriers and challenges faced by minorities and vulnerable populations most severely impacted by HIV. Successful engagement of the target populations with MAI-funded activities yields increased viral suppression rates and other improved health outcomes, contributing towards decreased health disparities among PLWH in the Atlanta EMA.

- Unique Barriers and Challenges:

Black MSM: Stigma, homophobia, and discrimination put MSM of all races and ethnicities at risk for multiple physical and mental health problems, poverty, and lack of insurance affect whether MSM seek and obtain high-quality health services. Negative attitudes about homosexuality (including complacency), discriminatory acts, bullying and violence can make it difficult for some MSM to be open about same-sex behaviors with others, which can increase stress, limit social support, and negatively affect health.[13] A meta-analysis, presented to the 19th International AIDS Conference shows that the exceptionally high rates of HIV infection seen in Black/AA MSM cannot be explained by the factors very often thought to drive HIV epidemics – frequency of having sex without a condom, number of sexual partners, drug use and so forth. In comparison with MSM of other ethnic groups, Black/AA men have either comparable rates of risky behavior, or less. But they are much more likely to report socioeconomic problems and barriers to accessing care, suggesting that the explanation may lie at the structural rather than individual level. Opportunities for working with this population include engagement with Part D clients, the YBMSM advisory group, Thrive SS, the Young Black Gay Men's Leadership Institute, the consumer caucus of the Planning Council, the Fulton County HIV Task Force and support groups to determine issues, barriers and opportunities to increase success along the care continuum.

Black/AA Females: Not recognizing risk of HIV infection; being unaware of their sexual partners' HIV risks is a primary factor placing Black/AA females at risk for infection; competing needs (e.g., child care, substance use, mental health, lack of self-care, etc.); no regular health care or health insurance; intimate partner violence; and, HIV medical care not tailored to the needs of women. Opportunities include working with Part D clients, SisterLove, the Center for Black Women's Wellness, and the Women's Interagency HIV Study, the Women's advisory

[13] http://www.cdc.gov/hiv/group/msm/brief.html

group, the Fulton County HIV Task Force and support groups to determine issues, barriers and opportunities to increase the bars of the care continuum.