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

Dieterich M, Du Mond J, Henn S, Jue J, Sadler M, Saperstein S, Wickham C, Walsh B, Coleman, M.
Whitman Walker Health

1525 14th st NW

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
DC HIV Care Continuum

Current Local HIV Care Continuum Estimates vs. Gap to Achieve 90/90/90/50 Targets, District of Columbia, 2015

People Living with HIV: 15,571
Diagnosed: 14,014
Retained in Care: 12,613
Prescribed Treatment: 12,613
Virally Suppressed: 11,352

- 86% of HIV+ Know Their Status
- 73% of Those Diagnosed are in Care
- 66% of Those Diagnosed are On Treatment
- 78% of Those in Care are Virally Suppressed

Notes:
1 Local estimate based on back-calculation methodology
2 ≥1 viral load and/or CD4 laboratory result documented during calendar year
3 Estimate assumes 90% of individuals in care have been prescribed treatment based on information from local Ryan White Program
4 Viral load ≤ 200 copies/mL
Reported Barriers to Care

GW Milken Institute, DC

4 most reports barriers:
• Transportation
• “Didn’t feel like it”
• Forgot Appointment
• Competing priorities

Baligh et al, Philadelphia

<table>
<thead>
<tr>
<th>High</th>
<th>-Competing Life Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-Feeling Sick</td>
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<tr>
<td></td>
<td>-Stigma</td>
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<tr>
<td></td>
<td>-Mental Illness</td>
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<tr>
<td></td>
<td>-Transportation</td>
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<td></td>
<td>-Insurance issues</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Med</th>
<th>-Forgetfulness</th>
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</thead>
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<tr>
<td></td>
<td>-Negative Experience with clinic</td>
</tr>
<tr>
<td></td>
<td>-Scheduling challenges</td>
</tr>
<tr>
<td></td>
<td>-Difficult relationships with staff</td>
</tr>
</tbody>
</table>

| Low                        | -unstable housing                       |

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. (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

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

Total More enrollment
n=202

>2 viral load results
n=108

VL <20
baseline
n=42

VL <20
n=36

VL >20
n=6

VL >20
n=44

VL >20:
50/108 (46%)

<2 viral load results
n=94

VL >20 baseline
n=66

VL >20
n=44

VL <20
n=22
## Potential Contributing Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>VL &gt;20</th>
<th>VL &lt; 20</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 20-34 35+</td>
<td>14 (19.4%)</td>
<td>8 (11.1%)</td>
<td>0.478</td>
</tr>
<tr>
<td>Race: non-AA AA</td>
<td>9 (12.5%)</td>
<td>5 (6.9%)</td>
<td>0.641</td>
</tr>
<tr>
<td>Housing: unstable stable</td>
<td>22 (30.6%)</td>
<td>6 (8.3%)</td>
<td>0.180</td>
</tr>
<tr>
<td>Insurance: non-medicaid medicaid</td>
<td>26 (36.1%)</td>
<td>7 (9.7%)</td>
<td>0.113</td>
</tr>
<tr>
<td>Mental health (MH)/Subs abuse (SA): no yes</td>
<td>12 (16.7%)</td>
<td>12 (16.7%)</td>
<td>0.011</td>
</tr>
<tr>
<td># visits: 2-10 visits 11+ visits</td>
<td>27 (37.5%)</td>
<td>12 (16.7%)</td>
<td>0.766</td>
</tr>
<tr>
<td>Missed doses Wk: 0 doses 1+ doses</td>
<td>19 (44.2)</td>
<td>8 (18.6%)</td>
<td>0.911</td>
</tr>
<tr>
<td>Enrollment group: low medium Full</td>
<td>21 (29.2%)</td>
<td>8 (11.1%)</td>
<td>0.900</td>
</tr>
</tbody>
</table>
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

DOING MORE

MOBILE OUTREACH RETENTION AND ENGAGEMENT (MORE) PROGRAM

Bringing HIV-related care to your home and community.
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