2014 Federal Recommendations for HIV Prevention Services for Persons with HIV: Promoting Synergies Between Clinicians, CBOs, and Health Departments

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**Disclaimers and Declaration of Interest**

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the Health Resources and Services Administration.
Overview

• Growing burden of HIV disease in the United States

• Forthcoming federal recommendations for prevention with persons with HIV that consolidate many effective interventions which can lower this burden

• Models of cross-sector collaboration between health facilities, community-based organizations (CBOs), and health departments (HD) to implement these recommendations

• Funding and reimbursement strategies to help promote cross-sector collaboration
The number of people living with HIV has grown because incidence is relatively stable and longevity has increased

Forthcoming Guideline for HIV Prevention with Adults and Adolescents with HIV in the United States

- Update and expansion of 2003 CDC, HRSA, and HIVMA clinical guidelines, *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV* prompted by:
  - 2010 National HIV/AIDS Strategy
  - Advances in prevention strategies
  - Changes in public and private health systems

- New update - collaborative effort

- Publication expected in 2014

*CDC, HRSA, HIVMA. *Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003;52(RR-12):1-24*
Forthcoming Guidelines for HIV Prevention with Adults and Adolescents with HIV in the United States

- Describes strategies for
  - ↓ infectiousness of persons with HIV
  - ↓ risk of exposing others to HIV

- Includes 7 new topics

- Consolidates all recent federal guidance on these topics & makes new recommendations

- Emphasis on
  - New effective interventions
  - Existing effective interventions, some may be underused

- **Expanded audience**: clinicians, and staff of CBOs, HD, and HIV planning groups
Summary of Guideline Development Process

- Conscious effort made to seek broad input and ensure recommendations are: evidence-based, acceptable and feasible to implement

**EXTERNAL INPUT**
(Clinicians, CBOs, HDs, policy experts, persons with HIV, advocates)

- Literature review & drafting of recommendations by CDC/HRSA
- Consultation of >60+ external experts to review first draft
- External expert review
- Consultation participants review & peer review
- HHS clearance

• 2010 • 2011 • 2012 • 2013-2014 • 2014
COLLABORATION & SERVICE INTEGRATION

Linkage to & Retention in care
HIV Treatment
ART Adherence
Partner Services
Risk Reduction

Persons with HIV
STD Services
Pregnancy Care
Reproductive Health
Other Medical /Social Services

Collaborative models of care allow:
- Efficient use of resources
- Shared goal of improving population health
IOM advocates cooperation, collaboration, and partnerships, not mergers

- Achieving mutual awareness will mark a significant step forward

Linkage to Care
Collaborative Models in Demonstration Project

- **HD linkage coordinators are embedded in clinical sites in San Francisco**:  
  - Clinical sites diagnosed HIV+ person and notified HD linkage coordinator  
  - HD linkage coordinator followed up with patient and helped make initial HIV medical appointment, apply for health insurance, provide partner services, and referral to other services  
  - 79% of 160 initiated HIV care $\rightarrow$ 88% entered care within 3 months

- **Anti-Retroviral Treatment and Access to Services (ARTAS)**
  - Linkage coordinators (case managers, social workers, testing counselors) embedded in clinical and nonclinical testing sites or available “on-call”  
  - Provided 1-5 sessions to client/patient to motivate to start care including appointment coordination and providing transportation  
  - $\sim78\%$ started HIV care within 6 months


**Gardner et al, 2005. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care.*
Linkage to Care
Collaborative Models in Practice

- ARTAS\(^1\) intervention implemented in two private clinics: Kansas City Free Health Clinic\(^2\) and Alabama Health Services Center\(^3\):
  - HIV+ persons referred from hospitals, health departments, clinical and nonclinical testing sites, private physician practices
  - Linkage coordinators in clinics:
    - Helped HIV+ persons access to community providers for HIV care and support services (including partner services)
    - Engaged case manager to support long-term HIV care for patient (i.e., retention in care)

1. ARTAS intervention can be found on [http://www.effectiveinterventions.org/](http://www.effectiveinterventions.org/) under “High Impact Prevention”
Linkage to Care
Collaborative Models in Practice

DC’s Health Department Red Carpet Entry and Navigator Program*

- Provider network (clinical and community) enroll HIV+ persons (including preliminary positive) in care within 48 hours:
  - Step 1: CBO/clinical testing sites identifies HIV+ person and refer them to Red Carpet program
  - Step 2: Health department navigator links client to HIV medical care
  - Step 3: Health department track labs and monitors care outcomes

- > 90% HIV primary medical care providers in DC use this service

*Red Carpet Entry Program. http://doh.dc.gov/service/red-carpet-entry-program
Linkage to and Retention in Care: Collaborative Model of “Data to Care”

- CDC released set of best practices for HDs and providers to use HIV surveillance data to support HIV care → Data to Care

- Washington State HD is using strategy to help persons diagnosed with HIV in private and public clinics and CBOs link or re-engage in care
  - Identify persons with no CD4 counts or those with marginal gaps in care

Effective, evidence-based Adherence interventions can be delivered by staff of health facilities or CBOs

<table>
<thead>
<tr>
<th>Name</th>
<th>Delivered by</th>
<th>Population</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project HEART</td>
<td>CBO staff (e.g., Health educators, HIV case managers, social workers)</td>
<td>ART-naïve or changing regimen</td>
<td>Sessions focus on social support, problem-solving, enlisting support partner, and making individual adherence plan. 5 sessions + 5 phone calls over 6 mos</td>
</tr>
<tr>
<td>Partnership for Health</td>
<td>Medical staff at CBO</td>
<td>ART-naïve or ART-experienced</td>
<td>Brief adherence counseling session at routine medical visits emphasizes the patient-provider relationship to promote healthy behaviors. Posters and brochures reinforce adherence messages. 3-5 minute adherence counseling at each visit</td>
</tr>
<tr>
<td>Peer Support</td>
<td>CBO staff (e.g., peers)</td>
<td>ART-naïve or ART-experienced</td>
<td>Persons with HIV with high adherence provide individualized peer support. 6 group sessions + weekly phone calls over 3 mos</td>
</tr>
<tr>
<td>SMART Couples (Discordant Couples)</td>
<td>CBO staff (e.g., Health educators, HIV case managers, social workers)</td>
<td>HIV+ person has low adherence</td>
<td>Sessions focus on adherence, safer sex, and mutual support 4 sessions over 5 wks</td>
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All interventions have been translated into eLearnings


HIV Partner Services
Models of Collaboration in Practice

Traditional model of partner services (PS)
- Only confirmed case (any stage of infection) activates PS
- May overlook most infectious cases with acute infection

Expedited, collaborative model
- New model supported by 2014 CDC HIV surveillance case definition*
  - allows activation of partner services after preliminary HIV+ test
  - routinely flags cases of acute infection
- New model can be effective: HD PS specialists embedded in clinic**
  - Preliminary + test triggers partner services on same day
  - Confirmatory test triggers partner services when return for results

Partnerships used by primary care providers who deliver HIV care

- Survey of > 370 MD, DO, NP, and PA
- Many rely on other service providers to deliver care and treatment services

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Percent of Respondents</th>
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<tr>
<td>Local/State Health Departments</td>
<td>62%</td>
</tr>
<tr>
<td>AIDS Service Organizations</td>
<td>53%</td>
</tr>
<tr>
<td>CBOs</td>
<td>48%</td>
</tr>
<tr>
<td>Social Service Providers</td>
<td>42%</td>
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</tbody>
</table>

*HealthHIV and Medscape, LLC. HealthHIV’s Third Annual State of HIV Primary Care National Survey, 2014. www.healthhiv.org
Public Funding Drives HIV Services

- Providers strongly reliant on public funding to cover services

**HIV Revenue Source Data**

- Medicaid: 76%
- Medicare: 70%
- Ryan White Program Funding: 61%
- AIDS Drug Assistance Program: 59%
- Private Insurance: 47%
- Patient Self-pay: 34%

*HealthHIV and Medscape, LLC. HealthHIV’s Third Annual State of HIV Primary Care National Survey, 2014. www.healthhiv.org*
Andee Krasner, MPH. JSI Research and Training Institute. Presentation on Third-party billing for Public Health STD Services: A Summary Of Needs Assessment Findings

STD Clinics - Billing Status (N=1,935)

- Yes, billing Medicaid and other third party payers (n=865)
- Yes, billing Medicaid only (n=587)
- No, not billing Medicaid or other third party payers (n=477)
Conclusions

- Forthcoming CDC/HRSA recommendations emphasize cross-sector collaborations to ↑ access, speed, or quality of services

- Collaborative models have the potential to
  - Use staff more efficiently
  - Tap into providers that receive public sector funding (e.g., HDs)
  - Improve range and coordination of services
  - Use alternative funding or billing methods

- CDC is working to catalog and disseminate successful collaborative models
www.cdc.gov/hiv/pwp
Cross-sector collaboration to support retention in care and ART adherence

- **Retention in care and ART adherence are synergistic**
  - Continuous care provides opportunity to
    - Monitor and support high adherence
    - Adjust regimens to ↑ adherence
  - Need to monitor drug efficacy and assess possible adherence problems (viral load and CD4 count) prompts need for regular HIV visits

- **Cross-sector collaborations can promote adherence support**
  - HD that collect all CD4 and viral load measures and routinely monitor these measures over time can identify persons with poor treatment outcomes who may benefit from follow up care or adherence support*

Retention in Care and Adherence Tool

- Clinicians, staff of CBOs and HDs, and peer educators can provide patient navigation and adherence services

- Services include:
  - Linking to HIV care
  - Re-engaging in HIV care
  - Supporting ART adherence

- Booklet contains practical information:
  - Examples of job description for peer educators & patient navigators
  - Information about HIV care and guidelines
  - Interactive case studies

http://www.effectiveinterventions.org/Libraries/Patient_Navigation/Peer_educators_role_to_patient_navigation_manual.sflb.ashx
Insurance Billing Practices: Limits on Third-Party Billing

- 46 states + DC: explicitly address “free” health care services
- 15 states: expressly prohibit charging of the patient for services
- 12 states: expressly prohibit clinic or facility from charging third-party payors
- 8 states: require the state, or any department of the state or local government, to provide free treatment specifically for STDs

Advocacy to support collaboration and need for new billing models

- 2009 survey by HIVMA and Forum for Collaborative HIV Research found that Ryan White Part C clinical providers need **innovative payment structures that adequately support the delivery of comprehensive, coordinated care**

- Other organizations also advocate provider collaboration:
  - NASTAD Policy Recommendations → increase funding for service integration
  - Association of Council and State Territorial Health Officials → co-locate public health/primary care systems or develop partnership with those in close proximity