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Getting to Zero + The View from Baltimore -or- A Tale of Two Cities

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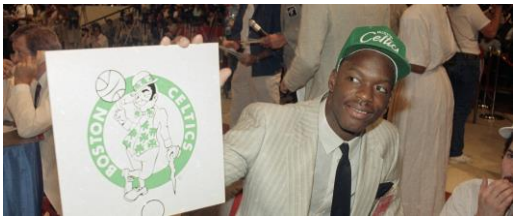
Baltimore in the 1980s



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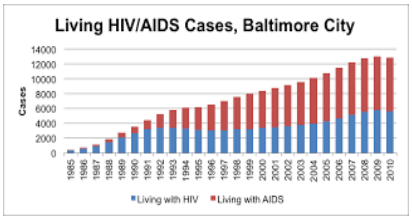
HIV in Baltimore 1985-2010



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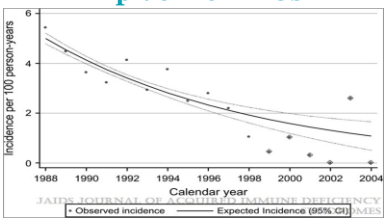
Change came to the Baltimore Epidemic - IDUs



Observed and expected incidence of HIV among individuals reporting injection drug use in the ALIVE study, 1988 through 2004

Mehta et al. JAIDS Journal of Acquired Immune Deficiency Syndromes43(3):368-372, November 1st, 2006. doi: 10.1097/01.qai.0000243050.27580.1a

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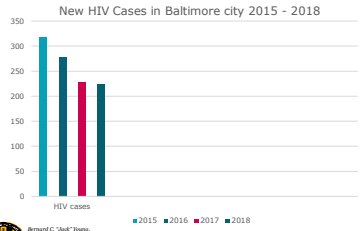
Decreasing New HIV Cases



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Getting to Zero + Increasing the Momentum

- In addition to decreasing cases, transmission patterns were changing – those living with HIV but not engaged in care were significant contributors to the epidemic.
- Engagement would not be easy - listening, engaging, creating and persisting were required.
- Opportunity - build new collaborations, expand existing ones. Engage across sectors, communities and agencies.
- Incorporate critical feedback from consumers and stakeholders in our activities.
- Getting to Zero plus was born, building upon the JHU Bartlett Clinic experience

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GTZ Data- July 2019 – May 2020 Bartlett Specialty Clinic - Updated

- 136 eligible patients with a detectable viral load, 126 (90%) were reached by GTZ Navigator.
- N=126; 90% were male, 90% Black, 81% ≥ 35; 30% reported MSM- and 25% injection drug use as HIV exposure.
- Among patients with >1 repeat viral load, 70% (n=79) achieved viral suppression. 20% sustained viral suppression <200 for > 6 months.
- Overall, (35%) patients received >10 CHW encounters, with an average of 8 encounters (range 1-36) for patients ever virally suppressed and 7 (range 1-23) for patients not suppressed.
  - Encounters were 30% face-to-face, 70% telephone contact, and primarily appointment scheduling/reminders, transportation, emotional support, and systems navigation and advocacy in clinic and community settings.

Pillars of The GTZ+ Plan:

- Education / Capacity Building / Information dissemination
- Technical Assistance to Clinics
  - HIV Testing, Linkage to care
  - Navigator support services using a IMB adherence model
  - Data management support
- Data Informed GTZ Provider Support
- Evaluation of intervention effect

"Unapologetically enabling"

- Removal of any potential barrier to:
  - Linkage / Access
  - Engagement
  - Retention
  - Adherence
- Focused on community solutions:
  - The program goes beyond the brick and mortar to:
    - Creates opportunity outside traditional clinical spaces
    - Facilitates communication outside traditional clinical hours
    - Supports a new type of client/navigator relationships

The Overall Goal: Viral Suppression

- Community Health Workers (CHW) in clinical settings, and CHW/Disease Intervention Specialist (DIS) hybrids in mobile settings. *
- Navigators link and engage individuals into HIV care with the goals of: (1) maintained care linkage; (2) improved health outcomes; (3) maintained viral suppression; (4) reduced HIV transmission and (5) faster response to new HIV cases.
- Getting to Zero Plus (GTZ+) targets the reservoir of undiagnosed, unengaged and virally unsuppressed individuals with a focus on youth, YMSM, racial and ethnic minority women, formerly incarcerated, and the marginally housed.
- The GTZ+ navigator-based linkage and engagement program is customized to meet the needs of each targeted population as described in our methodology.

GTZ Program Set up: The FQHC Collaboration

Determine GTZ Site Champion(s):

Define collaboration and processes:
- Data sharing and confidentiality agreement
- CAREWare Data Analyst mirrors and updates VL reports from Bartlett pilot project

Determine staffing needs:
- 1 onsite case manager will work with GTZ program

Monitor and Evaluate:
- Identify reporting structure to Provider, Clinic and BCHD – GTZ Provider Dashboard / Tracking report
- Review aggregate data for quality / program tweaks

Document Intervention:
- CareWare access using standardized tools already in use by clinic site

GTZ+ Navigator Interventions

Initial outreach:

-Via Phone:

- Barriers assessment; schedule time to meet at location of patient's choice; scheduling appointment(s)
  - Standardized barrier assessment will be made available to all sites

In-person/In Community:

- Assesses patient's environment and barriers to adherence

- Addresses immediate health and psychosocial needs (housing, shower, etc. apps for insurance/benefits, official identification, other referrals (incl MH, SUD); nutrition; emotional support; clothing/hygiene

- Coordinates with community partners for services

Summary

- Getting to Zero + builds upon an existing model and expands it to respond to consumer feedback, as well as be nimble in mobile/street settings.
- The overall goal is viral suppression, but care engagement, enhancing trust and removing barriers to care are equally important.
- The team is a collaboration of new and existing partners, including novel housing services and established syringe support programs.
- Creativity to meet the needs of the population, such as a CHW/DIS hybrid to accomplish mandated activities while meeting client need.
- CHW input can identify barriers to care engagement that may be overlooked or seem unimportant that have significant impact.
- In a city with so many challenges, this provides a structure upon which to build collaborations and interventions.

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All the patients and consumers

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