Bristol-Myers Squibb Foundation Grantee Summit 2016

New Orleans, Louisiana | April 11-13, 2016

Bristol-Myers Squibb Foundation
Specialty Care for Vulnerable Populations
Care Collaborations & Patient Support

Bristol-Myers Squibb Foundation
Bridging Cancer Care™
Community Awareness, Prevention and Care

Serving up MORE:
mobile medicine for HIV in DC

Brittany Walsh, Manager of Retention and Engagement
Megan Dieterich, Mobile Physician's Assistant
Channing Wickham, Executive Director of the Washington AIDS Partnership

Whitman-Walker Health

Washington AIDS Partnership

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Mobile Outreach Retention and Engagement: MORE

- Washington AIDS Partnership (WAP) and DC Department of Health launch public-private partnership to reach residents living with HIV/AIDS who struggle to stay connected to traditional health care , with >25% identifying these barriers:
  - transportation
  - not going to appointments because they didn't feel like it
  - forgetting their appointment
  - having something else to do
- WWH awarded $470,000 to take health care beyond the four walls of the health center
  - Pop-up in community based orgs, homes, or pre-determined meeting places – we come to you!
  - Blood work in the field; extended hours (evening and weekend) and flexibility of the team
  - Individualized care plans, goal-setting, and even greater support
- Team includes 1 Community Health Educator, 2 Care Navigators, 2 part-time Medical Providers
- Funding made possible by Bristol-Myers Squibb Foundation and M-A-C AIDS Fund

Implementing MORE:

Setting the stage:	Living it out:	Ongoing :
Research best practices, prgm dev.	Interviews and enrollment	Retention
Engaging community partners	Individualized patient follow-up	Recruitment
Developing assessments	Medical visits in the field	Referrals
Recruiting, hiring, training staff	Support visits in the field	Identifying new sites
Identifying clients from chart review	Identifying resources	Re-evaluating records keeping
Triaging referrals	Phlebotomy training	Research with DBS
Engaging clients	Prepping pop-up sites	Prepping for Medicaid SPA

Snapshot of MORE:

- 662 patients identified as eligible based on detectable viral load OR sub-optimal visit attendance
  - 58% income of 0-100% of FPL
  - 80% reside in DC
  - 79% publicly insured or self-pay
  - 55% in stable or permanent housing
  - 71% male; 19% female; 10% transgender
  - Variety of ages (24% 51-60 yo, 24% 31-40yo – no obvious age group)

Participant interview – Part 1

- **Best contact information**
  - Additional phone number(s)
  - Email address
  - Location to be found during the day/where/how spending time
- **Current status of HIV care**
  - When did you last see a Doctor for your HIV (if not in EMR)?
  - What HIV medications were you last on or are on currently?
    - If necessary, show chart of current HIV meds and pt can self select
    - [If applicable] how many doses have you missed in the last week? Last month?
- **Ease of accessing care**
  - [If appropriate] What brought you in today/prompted you to call to schedule?
  - In the past year, how often was it easy to get the HIV-related care, tests, or treatment you needed? (Never, Sometimes, Usually, Always)
  - What keeps you from getting HIV-related care?
  - What would make it easier for you to receive HIV-related care?

Participant interview – Part 2

- **Patient Activation**
  - When all is said and done, I am the person who is responsible for managing my health condition
  - Taking an active role in my own health care is the most important factor in determining my health and ability to function
  - I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition
  - I know what each of my prescribed medications do
  - I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself
  - I am confident I can tell my health care provider concerns I have even when he or she does not ask
  - I am confident that I can follow through on medical treatments I need to do at home
  - I understand the nature and causes of my health condition(s)
  - I know the different medical treatment options available for my health condition
  - I have been able to maintain the lifestyle changes for my health that I have made
  - I know how to prevent further problems with my health condition
  - I am confident I can figure out solutions when new situations or problems arise with my health condition
  - I am confident that I can maintain lifestyle changes like diet and exercise even during times of stress

Part 2 ctd…

- **Care received in the past year** (if not available from CRISP or Medicaid)
- [How often in the past year…
  - Did you go to an emergency room for medical care?
    - If yes, how often? [None, once, twice, 3 or more times];
    - Why?
  - Did you go to an urgent care facility for medical care?
    - If yes, how often? [None, once, twice, 3 or more times];
    - Why?
  - Were you hospitalized?
    - If yes, how often? [None, once, twice, 3 or more times];
    - Why?
  - Please describe any other medical care you have received in the past year. [For Year 1-2 add] beyond what you've received through this program.
- **Satisfaction with previous care**:
- Using any number from 0 to 10, where 0 is the worst HIV-related health care possible and 10 is the best HIV-related healthcare possible, what number would you use to rate all your HIV-related health care in the last year?
- How satisfied are you with your current HIV treatment? (very dissatisfied to very satisfied)
- **Perceived Health Status: How would you describe your overall health in the last year? (excellent, very good, good, fair, poor)**

MORE: Evaluation

Process Evaluation Questions
1. How many participants are in the Mobile Access Initiative: Retention in Care program? 2. What are the characteristics of the participant visits? 3. What are the demographic characteristics of the participants? 4. What other health care services have participants received in the past year beyond those received through the Mobile Access Initiative? 5. How easy has it been for participants to get HIV-related medical care? 6. How satisfied are participants with their HIV-related medical care?
Outcome Evaluation Questions
1. Is there a significant change in viral load from baseline to 1 year/2 years? 2. Is there a change in patient activation related to participant's HIV self-management from baseline to 1 year? 2 years? 3. Is there a change in participant's perceived health status from baseline to 1 year? 2 years? 4. Is there a significant change in satisfaction with care from baseline to 1 year? 2 years? 5. What factors predict achievement of viral load suppression? What factors predict retention in care? 6. What are the costs associated with delivering a mobile access program? 7. Does the study population achieve comparable rates of viral load suppression as a comparison group receiving only onsite care? [This question only possible if comparison group data is available]

Goals for MORE

- Engage 300 patients each year in mobile, outreach, retention and engagement
- Increase access to care for HIV+ patients of WWH
  - more medical visits and blood draws
- Improve health outcomes for patients receiving services
  - lower community viral load
- Demonstrate effectiveness of health care outside the health center
- Make a case for non-traditional services (like home visits or mobile health care) with funders, including Medicaid via a State Plan Amendment
- Demonstrate effectiveness of dry blood samples for clinical use in monitoring HIV