

HRSA's Ryan White HIV/AIDS Program

Engaging People with HIV in Care and Rapid Antiretroviral Therapy Programs to Help End the HIV Epidemic

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ENTRY INTO CARE AND ART AS KEY INTERVENTIONS

The HIV care continuum, from diagnosis through viral suppression, includes the critical steps of linking people with HIV to care and beginning antiretroviral therapy (ART), preferably as soon after diagnosis as possible for those entering care for the first time. Rapid and effective treatment for all people with HIV to help them get and

stay virally suppressed is one key strategy of the President's *Ending the HIV Epidemic: A Plan for America* initiative.¹ Rapid initiation of ART results in a shorter time to attain an undetectable viral load and improved health outcomes for both individuals who receive a new diagnosis of HIV and those reengaging in care. Because ART results in viral suppression, it has been proven to be an effective method of preventing HIV transmission. Research has shown that when people with HIV take ART daily as prescribed and achieve and maintain an undetectable viral load, they have effectively no risk of sexually transmitting the virus to an HIV-negative partner.² Linking people with HIV to care, including ART, and retaining them in care are therefore vitally important to ending the HIV epidemic.

The barriers to care must be addressed to engage people with a new diagnosis of HIV and reengage those who have fallen out of care. As many as 40 to 50 percent of people with HIV who once were in HIV care no longer receive care.³ Approximately 80 percent of new HIV transmissions are from individuals who are not receiving HIV care and treatment.⁴

Director's Note

Research has shown that achieving and maintaining viral suppression through antiretroviral therapy (ART) allows people with HIV to live long, healthy lives, with essentially no risk of sexually transmitting the virus to their partners. Through innovative programs, such as the Red Carpet Entry Program and the Rapid ART Demonstration Project, service providers funded by the Ryan White HIV/AIDS Program (RWHAP) of the Health Resources and Services Administration (HRSA) increasingly are linking people with HIV to care shortly after diagnosis, starting them on ART as soon as possible to improve their health outcomes.

Of course, ART is effective only if a person with HIV adheres to the treatment regimen. Engaging people with HIV in care and reengaging those who have fallen out of care are crucial to the success of ART. RWHAP recipients provide a range of supportive services to address the barriers that keep people with HIV from seeking and remaining in treatment.

This issue of *CAREAction* highlights important features of entry or reentry to care and rapid ART programs and offers "Stories From the Field" from two RWHAP recipients whose model programs will play a critical role in ending the HIV epidemic.

Laura W. Cheever, M.D., Sc.M.
Associate Administrator for the HIV/AIDS Bureau, Health Resources and Services Administration

IMPLEMENTING RAPID ART PROGRAMS

HRSA's RWHAP supports early intervention services and provides a comprehensive system of HIV primary medical care, essential support services, and medication to people with HIV. RWHAP recipients have been early adopters of rapid care/ART models. Initiating ART on the first clinic visit after HIV diagnosis has become the standard of care in many clinics and jurisdictions.

Among other initiatives, RWHAP funding supports early intervention services. RWHAP also supports clinician training around rapid ART initiation through its Part F AIDS Education and Training Centers (AETC) Program. In the past, people with HIV receiving care through RWHAP could not begin treatment without first meeting certain eligibility criteria, including providing documentation that they are underinsured

Barriers to Care

- ♣ Lack of transportation to medical appointments or pharmacies
- ♣ Unstable housing
- ♣ Untreated or undertreated substance use and/or mental disorders
- ♣ Institutional barriers, such as cumbersome entry criteria and limited appointment availability

or uninsured. The HRSA HIV/AIDS Bureau recently updated the policy to allow rapid initiation of HIV care before eligibility is documented.^{5,6}

Clinician guidelines and HIV treatment programs have identified best practices for starting rapid ART programs,^{7,8} including the following:

- **Develop a referral system.** Have an efficient and reliable system in place to receive referrals from HIV-testing sites and other community sites to link people who have a new HIV diagnosis to care or to reengage those previously lost to care. An HIV care navigator or linkage coordinator can serve as a single point of contact to facilitate the process.
- **Mobilize a multidisciplinary team to see the client on a same-day basis, if possible.** Goals of the initial appointment should include medical evaluation, insurance enrollment or optimization, emotional support, counseling, initial HIV education, baseline laboratory tests, and initiation of ART with starter packs when available.
- **Ensure follow-up care.** A telephone check-in two to three days after the initial appointment and a follow-up appointment one to

two weeks later help ensure that the individual is continuing ART. Follow-up care also offers the opportunity to continue education and support.

- **Engage patients through high-intensity support.** Provide intensive patient services and support to engage and reengage people with HIV, such as case management, counseling, mental health services, substance misuse treatment, and education on the importance of remaining in care; offer strategies to address multiple needs, such as transportation and housing assistance.⁹

Stories From the Field: The D.C. Department of Health Red Carpet Entry Program and Rapid Antiretroviral Therapy Demonstration Project

The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) of the Washington, D.C., Department of Health (DC Health) has been implementing its *90/90/90/50 Plan: Ending the HIV Epidemic* in the District of Columbia. The Plan's four goals are to ensure that by 2020, 90 percent of D.C. residents with HIV know their HIV status, 90 percent are in treatment, 90 percent of those in treatment achieve viral suppression, and new cases of HIV decline by 50 percent.

To meet the goal of getting 90 percent of HIV-positive District residents into treatment, DC Health is reinvigorating its 10-year-old Red Carpet Entry (RCE) program to connect people with a new diagnosis of HIV with a provider within 48 hours. To recharge the RCE Program, DC Health plans to update materials and introduce the program to new providers, as well as offer a refresher session to providers who are more familiar with the program.

To further meet its treatment goal and the goal of achieving 90 percent viral suppression among those in treatment, DC Health also is launching a Rapid ART program. The program ensures that all people with a new diagnosis of HIV are seen and evaluated quickly by providers and that they start ART within seven days of diagnosis so they can reach viral suppression within 60 days of starting ART.

The RCE and Rapid ART programs are separate, but closely connected. "You get [clients] in the door, you get them on ART, and you get them suppressed," said Ms. Lena Lago, HAHSTA's Deputy Chief for the Care and Treatment Division.

DC Health also is piloting a 30-day ART starter pack that clients receive during their first clinic visit. According to Ms. Lago, "We've learned that clients gain a sense of empowerment when they are actually handed the medication after diagnosis and before they leave the clinic."

Although DC Health's plan goals are ambitious, progress has been made, especially among RWHAP clients. "Clients who receive Ryan White HIV/AIDS Program services always have better outcomes than our clients who don't access Ryan White HIV/AIDS Program services," Ms. Clover Barnes, HAHSTA's Chief, Care and Treatment Division, stated. "I think that's something we can really be proud of as a health department."



For example, among RWHAP clients, 96 percent of people with HIV in the District were prescribed ART, 83 percent were retained in care, and 82 percent reached viral suppression as of 2017. In comparison, viral suppression among all people with HIV in the city was 65 percent.¹⁰ “I don’t think we would be able to make any headway on our epidemic if we didn’t have HRSA support,” Ms. Barnes noted.

Stories From the Field: The Max Clinic, Seattle, Washington

The Max Clinic (“maximum assistance” clinic), a collaboration between the University of Washington (UW) and Public Health—Seattle & King County’s HIV/Sexually Transmitted Disease Program, provides a walk-in, incentivized care intervention designed to engage the hardest-to-reach people with HIV for whom traditional HIV care models have not been effective. “In our health care system in the United States, HIV care can be hard for people with extensive barriers to engage in,” explained Dr. Julia Dombrowski, an infectious disease physician at UW and Public Health—Seattle & King County. The Max Clinic created a new model of care to help address those barriers and provide care that fits the reality of clients’ lives.

Clients are eligible to enroll in the Max Clinic if they were not virally suppressed at the time of their last viral load measurement or they are no longer taking ART and have failed to engage in care through traditional HIV programs.

The Max Clinic’s approach has three key elements. First, people enrolled in the clinic have walk-in access to HIV primary care physicians and medical and nonmedical case managers, eliminating the need to plan for and schedule an appointment. Allison Moore, a Max Clinic program coordinator, described a typical opening conversation with potential clients. “One of the first things I say is, ‘We are a drop-in clinic, so you get to control and decide when you come in; you’re driving the boat.’” This approach helps patients feel in control of their medical care and allows them to reach out for support when they need it. All clients are offered ART on their first visit, and most start or restart ART on the same day.

The second element involves incentives funded by non-RWHAP resources to increase the priority of clinic visits in the face of competing needs and help ensure that clients complete laboratory tests. The Max Clinic offers its clients meal vouchers; cell phones, if needed, to facilitate communication between clients and the clinic; unrestricted bus passes to overcome transportation barriers; and contingency management. Clients receive \$25 every two months for taking a blood test and \$50 if they have a suppressed viral load.

The third element is intensive case management to provide personalized support. The Max Clinic has a low patient-to-case-manager ratio and coordinates with multiple service providers. “We know details about their lives that they are happy to share with us, and we celebrate with them, and we comfort them when they’re upset, and that goes a long way,” explained Ms. Moore. Case managers also connect clients with other resources that provide medication

adherence support, housing support, and mental health and substance use treatment services.

Dr. Dombrowski noted that 84 percent of people with HIV in Seattle–King County are virally suppressed. “To get that remaining 15 or 16 percent, it is going to be time- and cost-intensive. We need to offer new models of HIV care for the highest-need patients. Speaking from the King County perspective, the Max Clinic is really crucial to efforts to end the epidemic.” She added, “If it wasn’t for Ryan White HIV/AIDS Program funding, we would not be able to do it, without a doubt.”

References

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