Improving Access to HIV Care in the East Bay

October 25, 2022
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Discussion Overview

• HIV ACCESS background and structure
• Strategies for improving access to care:
  o Linkage and rapid ART efforts
  o Other clinic-level efforts
  o Local collaborations with East Bay Getting to Zero and Public Health Department
HIV ACCESS Collaborative Network Structure

- Diverse staff: race/ethnicity, gender identity, age, class, languages.
- Lots of collaborative learning, training and projects.
- Many access points and opportunities for connection with clients.
HIV ACCESS History & Overview

• Founded in 1992
• Mission: to provide coordinated, comprehensive, high quality primary health care for people living with HIV/AIDS (PLWH) with the goal of ensuring early access to treatment, mitigating health disparities, and reducing the spread of HIV.
• Multi-site HIV primary care network serving 1,333 clients as of 6/2022, constituting 27% of PLWH in care in Alameda County.
• HIV primary care, case management, behavioral health, oral health, substance use treatment and medical nutrition services are available.
HIV ACCESS Network Locations: Alameda County

- 4 community health centers
- 1 public hospital
- 12 clinic locations
HIV ACCESS Client Demographics

- 83% people of color (42% Black, 31% Latinx)
- 75% cis male, 21% cis female, 4% transgender
- 50% over the age of 50
- 49% MSM, 33% Heterosexual, 10% PWID
HIV ACCESS Care Continuum
All sites Q2 2021 vs. 2022

1333 active patients

<table>
<thead>
<tr>
<th>Service</th>
<th>2021 (%)</th>
<th>2022 (%)</th>
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</thead>
<tbody>
<tr>
<td>Screened for HIV4</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td>Linked in 30 days (new)</td>
<td>80%</td>
<td>92%</td>
</tr>
<tr>
<td>Retained in care (1 visit)</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Prescribed ART</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>Virally suppressed1</td>
<td>83%</td>
<td>84%</td>
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Disparities in Highland ED linkages: 2020

25 people not linked from the Highland ED, Jan-Sept 2020:
- 86% substance use disorder (SUD)
- 56% phoneless; 44% phoneless + SUD
- 24% mental health diagnosis
- 12% houseless
Impact of interventions in ED linkages 2017 to 2022:

- Highland Hospital ED 30-day linkages: 51% → 85%
- Community Health Center 30-day linkages: 93% → 96%
HIV ACCESS Rapid ART Initiative

- Began rapid ART project in 2017 and started formally tracking in 2018
- Activities included:
  - Development of shared definition for Rapid ART: Rx within 1 business day of first in-person contact with HIV team
  - Creation of linkage tracking sheet
  - Rapid ART protocols and workflows tailored to each clinic
  - Clinic-level interventions to address structural barriers (e.g., prescriber coverage)
  - Problem-solving individual and systemic barriers as a team and network
HIV ACCESS Rapid ART Initiative

Linkages before Rapid ART: 90+ days

1. Diagnosis: confirmed HIV+ result
2. Disclosure +/- Partner counseling
3. Linkage referral +/- warm hand-off
4. Eligibility and enrollment
5. Intake for RW/HIV case management
6. Medical Visit
7. Labs
8. ART prescription
HIV ACCESS Rapid ART Initiative

Linkages with Rapid ART: ≤6 days
Other Access to Care Activities

• Direct access to linkage navigators via work cell phones (referring agency staff and new patients)
• Protecting HIV provider drop-in slots
• HIV provider on-call schedule and/or training PCPs to provide back-up for rapid ART starts on days when there is no HIV provider available
• Offering hybrid in-person linkages with navigators and virtual provider visits to ensure coverage even when providers are not on-site
• Providing periodic reminders to PCPs re: testing and linkage via agencywide provider meetings
Impact of strengthening outreach for people experiencing homelessness: 2020-2021

- HIV ACCESS LifeLong Trust Clinic viral load suppression: 35% → 68%
- 344 people experiencing homelessness screened for HIV
- 96% PLWH experiencing homelessness linked to care
11 years of regional collaborations!

- **2011-12:** First linkage meeting and data analysis
- **2013:** First network meeting; contact list, warm hand-offs
- **2014-16:** Universal testing and PrEP launched
- **2017:** EBGTZ, Rapid linkages and Rapid ART launched
- **2018-22:** Trainings on racial bias, sex positivity, MI, trauma, substance use, housing, rapid ART

Logos and names of organizations:
- HIV Access
- AETC Pacific
- Alameda County Health Department
- East Bay Getting to Zero
HIV ACCESS Involvement with EBGTZ:
Steering Committee & POZ+ Members

CORE TEAM
- KEVIN LUONG, MD

COMMUNITY MESSAGING TEAM
- NANCY BROWN
- STEVEN JENKINS

ADVISORY BOARD
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- JAYDEE FLOYD, MPA
- ARIANNA SIVANAND
- MICHELLE TAYLOR, MD
EAST BAY HIV Strategic Activities for 2022

COMMUNITY MESSAGING:
- East Bae Love and Sexy Loteria campaigns
- Murals
- Transit Ads

IMPROVING COLLABORATIONS:
- HIV services in ED, Street/shelter, housing
- And substance use settings
- Substance use overdose prevention and safety Plans

INNOVATIVE MODELS:
- Home HIV/STD testing
- Mobile Clinic with HIV prevention & Care

YOUTH ENGAGEMENT:
- Low-barrier access to care
- Sex positive Education In Oakland Schools

HOUSING INITIATIVES:
- Housing 101 User’s Guide
- Share housing info across agencies

Biomedical interventions such as testing, Rapid ART, same-day PrEP, and injectable ART and PrEP are integrated into the activities above.
Key Communities:

Race/Ethnicity:
- People of color (non-white identified)

Age:
- Youth & Older Adults

Sexual Orientation & Gender Identity:
- MSM & Cis/Trans Women

Life Experience:
- Drug use, incarceration, homelessness, mental health conditions, lack of insurance, HIV diagnosis in the ER

Disparity trends:

Fewer HIV tests conducted in 2020 and fewer HIV diagnoses, not likely a significant drop in actual incidence.

Increasing disparity gaps in 2020:
- New diagnoses
  - Latinx people
  - Young people of color
- Retention and viral load suppression
  - Black/African American residents
  - People who inject drugs
  - Youth and young adults
  - Uninsured residents.

HIV ACCESS QI priorities
Improving Collaborations

Vision: A collaborative community of HIV service organizations, advocates and community members who work together on common goals and amplify each other’s work.

Key Activities of 2021:

1. New and revised online tools for collaboration: HIV ACCESS participated in improvements to the regional directory, local events, resources on EBGTZ.org.
2. Collaborative meetings: April workshop on online tools, August workshop on HIV ACCESS ED and substance use linkages, October workshop on housing.
3. Improvements in linkage rates: Highland ED linkage rates 44% → 85%; HIV ACCESS rapid ART rates 68% → 95% from 2020 to 2022.
HIV ACCESS involvement with Alameda County Public Health activities:

1. Close collaboration on the Ryan White client survey
2. HIV data-to-care project
3. HIV QM data sharing
4. The first Rapid ART program in the county, initiated in 2017
5. Healthcare for the Homeless HIV linkages and care coordination