



HIV CARE COLLABORATIVE

In the U.S. alone, there are about 50,000 new HIV infections each year, and slightly over one-third of people living with HIV are receiving in care.^{1,2}

In 2012, to help address remaining barriers to HIV care, especially among underserved populations, our company's Foundation (the "Foundation"), launched the HIV Care "Collaborative" for Underserved Populations in the U.S. (the Collaborative) with the goal of connecting more people living with HIV to the care they need to stay healthy. The Foundation committed \$3 million to support local health departments in Atlanta, Georgia; Houston, Texas; and Philadelphia, Pennsylvania. These are among the 28 cities with the highest HIV burden in the U.S.³

Research shows that when you are able to connect HIV-positive individuals with ongoing care, it not only reduces HIV risk behaviors but also reduces viral load from antiretroviral therapy (ART), all of which contributes to overall decreases in HIV transmission.⁴ This is why the U.S. National HIV/AIDS Strategy (NHAS) calls for the establishment of "seamless systems to link people to care immediately after diagnosis, and support retention in care to achieve viral suppression that can maximize the benefit of early treatment and reduce transmission risk."⁵ Over three and a half years, in alignment with this overall NHAS goal, the Collaborative tackled this challenge head on, working to improve access to available health care for HIV-positive people by:

- Integrating innovative, community-based approaches with local public health systems to enable timely access to high-quality HIV care for underserved adult populations
- Helping to reduce new HIV infections among populations at greatest risk
- Sharing important findings and lessons learned to further the development of innovative programs that connect people living with HIV to needed care and treatment

The Collaborative built on efforts already underway at the three program sites:

- **Atlanta/Fulton County Department of Health and Wellness:** Bridging the Gap implemented a community-based care linkage coordination and referral program for HIV-positive clients referred to, and enrolled in, the county's HIV primary care clinic.
- **Houston Department of Health and Human Services:** The Expanded Linkage to Care Initiative brought together health care providers, community groups and researchers to implement communitywide system-navigator and data-matching programs to help identify and reengage all those living with HIV who had fallen out of care.
- **The City of Philadelphia Department of Public Health:** The Engaging HIV+ Patients in Care Initiative used system navigators to help guide HIV patients through the local health care system to improve access to HIV care and management.

The George Washington University (GWU) Milken Institute School of Public Health served as the National Program Office for the HIV Care Collaborative. GWU provides overall technical assistance

to each of the program sites and helped foster a “peer-learning” network among the health departments and local partners through regular meetings, site visits and forums for sharing best

practices, lessons learned and key challenges. GWU also completed a cross-site evaluation of the Collaborative programs. The Collaborative concluded operations at the end of 2015.

¹ Centers for Disease Control and Prevention. “Prevalence of Diagnosed and Undiagnosed HIV Infection—United States, 2008–2012.” *MMWR* 2015; 64:657–662.

² Centers for Disease Control and Prevention. “Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2014.” *HIV Surveillance Supplemental Report*. 2015; 20(2). <http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf>

³ Centers for Disease Control and Prevention. *HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2014; vol.26*. www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf. Published February 2015.

⁴ Mugavero, MJ, Amico, KR, Horn, T, Thompson, MA. “The State of Engagement in HIV Care in the United States: From Cascade Continuum to Control.” *Clinical Infectious Diseases*. 2013 Oct;57(8): 1164–71.

⁵ The White House Office of National AIDS Policy. “National HIV/AIDS Strategy for the United States: Updated to 2020,” July 2015. www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.

PERFORMANCE

The Foundation worked with George Washington University (GWU) Milken Institute School of Public Health to conduct a three-and-a-half-year (2012–2015) cross-site evaluation of the HIV Care “Collaborative” (the Collaborative) programs.

A cohort of newly identified and previously lost-to-care HIV-positive adults were enrolled in a medical care linkage and engagement intervention that deployed community health workers in public health settings. The cohort’s medical care utilization was followed over time to assess clinical outcomes and process measures associated with the Collaborative.

Previously designed client-level data systems were used to track patient characteristics, service utilization, quality of care and clinical outcomes. Client-level data systems include electronic health records and administrative databases designed to document federally funded health and support services utilization, processes and clinical outcomes.

The results of the evaluation provide an overview of enrollment and outcome measures for clients who were enrolled in the Collaborative intervention across the three program sites. From January 2013 through June 2015, 1,340 HIV-positive adults were enrolled in the Collaborative for linkage to HIV medical care and patient navigation services provided by community health workers for an average of three months. The Collaborative sites enrolled participants on a rolling basis since the program

was first implemented in January 2013. Enrollment was ongoing through June 30, 2015. Note that the data below are not site-specific, but rather were aggregated across the three program sites (Fulton County, City of Houston, City of Philadelphia).

Among Collaborative clients, 15 percent were newly identified HIV-positive adults, 76 percent were HIV-positive adults who had previously dropped out of medical care, 6 percent were at high risk for dropping out of medical care due to frequent broken or cancelled appointments, and 4 percent had unknown status as they had not completed an initial assessment before being lost to care. Almost one-third of clients had AIDS upon enrollment in the Collaborative.

Among the clients enrolled by the Collaborative between January 1, 2013, and June 30, 2015, 78 percent were successfully linked to medical care through the Collaborative intervention. Among clients linked to care, 69 percent were linked within the three-month target period set by the Common Core Indicators of the U.S. Department of Health and Human Services (HHS) for HHS-funded HIV programs and

services. Barriers to timely linkage to care included: limited or no access to a telephone, employment in a job that did not offer medical leave, incarceration, paperwork required to become eligible for free medical care, and lack of transportation to clinic appointments. One of the Collaborative sites also had a substantial waiting time for a first medical appointment, which delayed completion of the linkage process.

Among Collaborative clients enrolled from January 1, 2013, through June 30, 2015, and then followed for six months: 57 percent were retained in medical care for at least six months after their first medical visit, 57 percent were prescribed antiretroviral (ARV) therapy, and 68 percent achieved HIV viral suppression.

PATIENT PROCESS MEASURES TO ASSESS LINKAGE TO HIV MEDICAL CARE

MEAN LINKAGE RATES (LOW-HIGH RANGES)

HIV+ adults enrolled in the Collaborative who were linked to care ¹	78%
	(76%–86%)
HIV+ adults enrolled in the Collaborative who were linked to care within three months of enrollment in the Collaborative ²	69%
	(28%–92%)

¹ Clients were enrolled on a rolling basis in the Collaborative intervention from January 1, 2013, through June 30, 2015, and followed for six months after enrollment to calculate process and outcome measures. Adults were 18 years of age or older and newly identified as HIV+ at the Collaborative sites, or another HIV-counseling and testing site that referred the individual to the Collaborative site for linkage to care and patient navigation services. Includes newly identified HIV+ individuals, those individuals that had dropped out of care, and individuals that were identified by the Collaborative site as being at risk for dropping out of care due to high rates of broken or cancelled appointments. Linkage to care was defined as one or more medical visits following enrollment in the Collaborative.

² Common Core Indicators were adopted by the U.S. HHS in 2012 for use in assessing HHS-funded HIV programs conducting linkage to medical care for HIV+ individuals. The numerator is the number of persons who attended a routine HIV medical care visit within three months of HIV diagnosis. The denominator is the number of persons with an HIV diagnosis in the 12-month measurement period. The Common Core Indicators were adapted for use in evaluating the Collaborative as no Common Core Measure was adopted by HHS for use in evaluating programs relinking HIV+ individuals to care.

OBJECTIVELY MEASURED PATIENT PROCESS AND QUALITY OF CARE MEASURES^{1,2}
**MEAN RATES
(LOW-HIGH RANGES)**

Six-month retention rate of HIV+ adults in the observation period³	57%
	(44%–70%)
Six-month rate of HIV+ adults prescribed HIV antiretroviral (ARV) therapy⁴	67%
	(53%–82%)
Prescribed ARVs in the observation period	57%
	(1%–82%)

¹ Objectively measured patient process and clinical outcomes data were gathered from the health records of clients enrolled in the Collaborative between January 1, 2013, and June 30, 2015, and followed in health records for at least six months. Quality measures adopted by the Collaborative are based on measures established by the federal Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which can be found at: <http://hab.hrsa.gov/deliverhivaidscore/coremeasures.pdf>.

² Information from Collaborative clients' health records was reported for the six-month period following completion of the Collaborative intervention. The denominator used to calculate the rates excluded clients who did not complete or were lost to follow-up during the Collaborative intervention, those who were deceased or incarcerated, and those who had moved out of the area served by the participating sites.

³ The numerator is defined as clients who had at least one medical visit in the six months following completion of the Collaborative intervention.

⁴ The numerator is defined as the number of clients who were prescribed HIV antiretroviral medication in the six months following completion of the Collaborative intervention. HIV antiretroviral therapy consists of any combination of HIV medications, other than the regimens or components identified as not recommended at any time by the Panel on ARV Guidelines for Adults and Adolescents. Guidelines for the use of ARV agents in HIV-1-infected adults and adolescents. DHHS. Available at: <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

OBJECTIVELY MEASURED PATIENT OUTCOMES^{1,2}
**MEAN RATE
(LOW-HIGH RANGES)**

Twelve-month rate of HIV+ adults with HIV viral suppression in the observation period.³	68%
	(57%–78%)

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² Information from Collaborative clients' health records was reported for the six-month period following completion of the Collaborative intervention. The denominator used to calculate the rates excluded clients who did not complete or were lost to follow-up during the Collaborative intervention, deceased, incarcerated or moved out of the area served by the participating sites. Only data from the Fulton County Health and Wellness Department and City of Philadelphia were included in the analysis, as complete clinical data were not available to the City of Houston.

³ The numerator is defined as the number of clients with an HIV viral load less than 200 copies/mL at least once in the observation period.