# NATIONAL PARAMETER STREAMENT



## Improving Engagement in HIV Care in a Part D Setting

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## **Project CAATCH**

Project CAATCH (Consumer Access and Adherence to Care for HIV) is an initiative of the Massachusetts Department of Public Health (MA DPH) MassCARE Ryan White Part D Funded Program.

#### **Project Goal:**

Increase the HIV primary care **retention rate** and rate of **viral load suppression** among enrolled HIV+ women and transitioning youth by implementing an **educational intervention using peers and care coordinators.** 



## **Project CAATCH**

#### The sites

Three community health center sites were selected to participate

## The staffing

Each site includes a Peer and a MassCARE Coordinator

#### The training and support

- The Coordinators and Peers attended a one day intensive training
- Attend quarterly follow-up trainings
- Participate in monthly conference calls



## **Project CAATCH Intervention**

#### **Population**

Primarily Black and Latina women of childbearing age and youth over 18 who are transitioning to adult HIV primary care and/or at risk of falling out of care

#### **Eligibility:** (at least one)

- Not retained in care
- Not virally suppressed
- Youth of transition age
- New to HIV care at the clinic (this includes newly diagnosed and new to the clinic)

#### Building a list for the intervention and outreach

- Using EMR, CareWare, and interviews with the clinic team
- Peers/Coordinators conduct outreach by phone, email, text or in person including home visits
- Work with HIV intake and clinic staff to identify new clients



## **Project CAATCH Intervention**

#### **Key Components**

#### Educational sessions

- HIV, the Life Cycle and Medications at Work
- Communicating with Your Health Care Provider
- Understanding Lab Tests
- Managing Stigma and Disclosure
- Substance Use
- HIV and Well Being



## **Project CAATCH Intervention**

#### **Key Components**

Stipends provided on a tiered approach

Sessions location convenient to consumers (home, clinic, community)

Supportive services

- Weekly contact and check-ins
- Appointment reminders
- Coordination of transportation
- Accompaniment to appointments
- Emotional and practical support
- Follow up, follow up, follow up!



## **Project CAATCH Partners**

#### **Community Sites:**

- Brockton Neighborhood Health Center
- Lowell Community Health Center
- Family Health Center of Worcester

### **Training/Evaluation:**

Abt Associates



## **Project CAATCH Activities**

#### N = 73 clients

- 416 Trying to locate/reach clients (when enrolled)
- 175 Appointment reminders
- 120 Assist with making appointment (housing/other services)
- 109 Mentor/coach around specific need/emotional support
- 86 Coordinate transportation
- 56 Assist with making health care appointment
- 11 Assist with making mental health/substance use health appt.
- 36 Accompany client to a medical appt.
- 5 Accompany client to MH/SU appointment



## **Performance Measurement**

#### **HRSA Core Measures**

- VL Suppression
  - o numerator: VL < 200 copies/mL at last test during measurement year
  - o denominator: one medical visit in the year
- Medical Visit Frequency
  - o numerator: one visit in each 6 month period of 24 month period
  - o denominator: one visit in first 6 months of 24 month period



## **Project CAATCH Outcomes**

	<b>VL Suppression</b>	Retained in care
CY2013 (pre-intervention	<b>n)</b> 78%	79%
CY2014	81%	87%
CY2015	84%	87%
CY2016	85%	91%
CY2017	84%	90%
FY2018	<b>87</b> %	93%



## **Project CAATCH Data**

As of FY18 a total of **57 clients across three currently funded** sites were identified

98% have completed the required sessions

19% were youth

Of the originally identified clients

- > 89% are now engaged in care
- 81% are now virally suppressed with another 5% showing improvement



## **Challenges and Opportunities**

- Engagement takes LOTS of time contacting clients, again and again
  - Phone, text, home visits and/or community locations
- Continually identify new creative approaches
- Peers included in model a PLUS
- Team approach to follow up within health system all hands on deck approach
- Collaborative monthly calls with other sites



## **Next Steps**

- Continue to use the model with all newly enrolled women and youth over 18
- Continue outreach to those not meeting the measure, or at risk
- Develop patient based adherence module



## **Case Study**

Case study presentation/discussion



## Resources

#### **Project CAATCH Manual**

- Curriculum updated fall 2019
- Designed to support replication of the CAATCH intervention
- Includes two project case studies

#### **Contact us:**

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