Modified Community-Based Accompaniment Model for ART Delivery at a Free Clinic for the Homeless: Cases Identifying Program Need and Development

Kathryn Johnson, DO, MA[1], Christian Neal, MD, MPA[1], Helen Ferguson, MPH[2]
(1)Virginia Tech Carilion School of Medicine - Carilion Clinic, Roanoke, VA, (2)Rescue Mission Ministries, Roanoke, VA

Background

In 2014 there were 24,962 people living with HIV (PLWH) in Virginia, 763 were newly diagnosed. Approximately 40% of the PLWH in Virginia are retained in HIV care and 35% are virally suppressed. Over the past decade, antiretroviral therapy (ART) has improved. Regimens are less complex, better tolerated and more potent. Early identification and treatment could lead to reduction in the incidence of HIV infections. Most PLWH who receive combination ART can achieve viral suppression. Achieving high ART coverage in an area decreases incidence of HIV infections. Barriers to testing and care effect virological outcomes on the local, state and national levels. Homelessness, substance use and mental illness are common factors that negatively affect adherence. Psychiatrists at the Fralin Free Clinic identified patients who demonstrate difficulty with HIV treatment adherence. Integrating principles from assertive community treatment (ACT) for severe mental illness and the community-based accompaniment model for ART delivery, psychiatric providers developed an intervention to improve medical and psychiatric outcomes. The following are representative of the patients that prompted the development of our program.

References

Gardner, E. M., Mclees, M. P., Steiner, J. F., Rio, C. D., & Burman, W. J. (2011). The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clinical Infectious Diseases, 52(6), 793-800.

HIV-AIDS. (n.d.). Retrieved June 24, 2016, from http://www.vdh.virginia.gov/Epidemiology/DiseasePrevention/Programs/HIV-AIDS/index.htm

Cases

•Mr K. is a 29 yo AA male, diagnosed with HIV in 2012. Due to his untreated schizophrenia, poor treatment adherence, lack of insight and homelessness, he was not retained in HIV care or treated with ART until 2016.

•Mr. C is a 40 yo AA male, diagnosed with HIV in 1992. He struggles with severe substance use disorders, co-morbid mental illness, multiple incarcerations, numerous hospitalizations and chronic homelessness. He frequently reports lost or stolen medications due to his psychosocial instability, leading to poor adherence.

•Mr B. is a 50 yo AA male, diagnosed with HIV in 1992 and started on ART in 1995. He currently resides at the Rescue Mission affiliated with our clinic. Staff expressed concern about risky sexual behaviors with other shelter guests. His illness has progressed to AIDS, based on CD4<200. Although he is new to the area, he is retained in HIV treatment and reports compliance with ART.

Program Components

•Frequent follow-up appointment for mental health
•Transportation to infectious disease appointments
•Collaboration and communication between Fralin Clnic and Cariliion ID
•Medication administration, storage and compliance monitoring
•Bi-monthly support group at clinic with lunch provided
•Management of finances in addition to payee services
•Assistance obtaining housing
•Outreach in ED and if hospitalized at other facilities
•Frequent education about medication adherence, interpretation of lab results and safe sex practices
•Calls and mission visits if concerns about compliance, mental health or program attendance
•Confrontation and intervention for treatment interfering behaviors
•Unique, comprehensive and creative treatment plans for each PLWH

Challenges

•Recruitment of program participants
•Patient retention
•Collaboration with other organizations
•Financial limitations and funding sources
•Anticipating patient needs
•Educating other providers about the unique needs of our patient population
•Allowing ID to have patient's labs drawn at our clinic
•Brining ID provider to the clinic for f/u visists

Future Plans

•Incorporation of home visits for patients that obtain housing
•More involvement and collaboration with Carilion ID and ID departments/providers at other institutions
•Additional medication adherence monitoring strategies for patients who leave mission and clinic
•Working with VDH and others to determine PLWH in the area that have detectable viral load and inviting them to participate in our program
•Additional funding for more meals and monthly bus passes

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