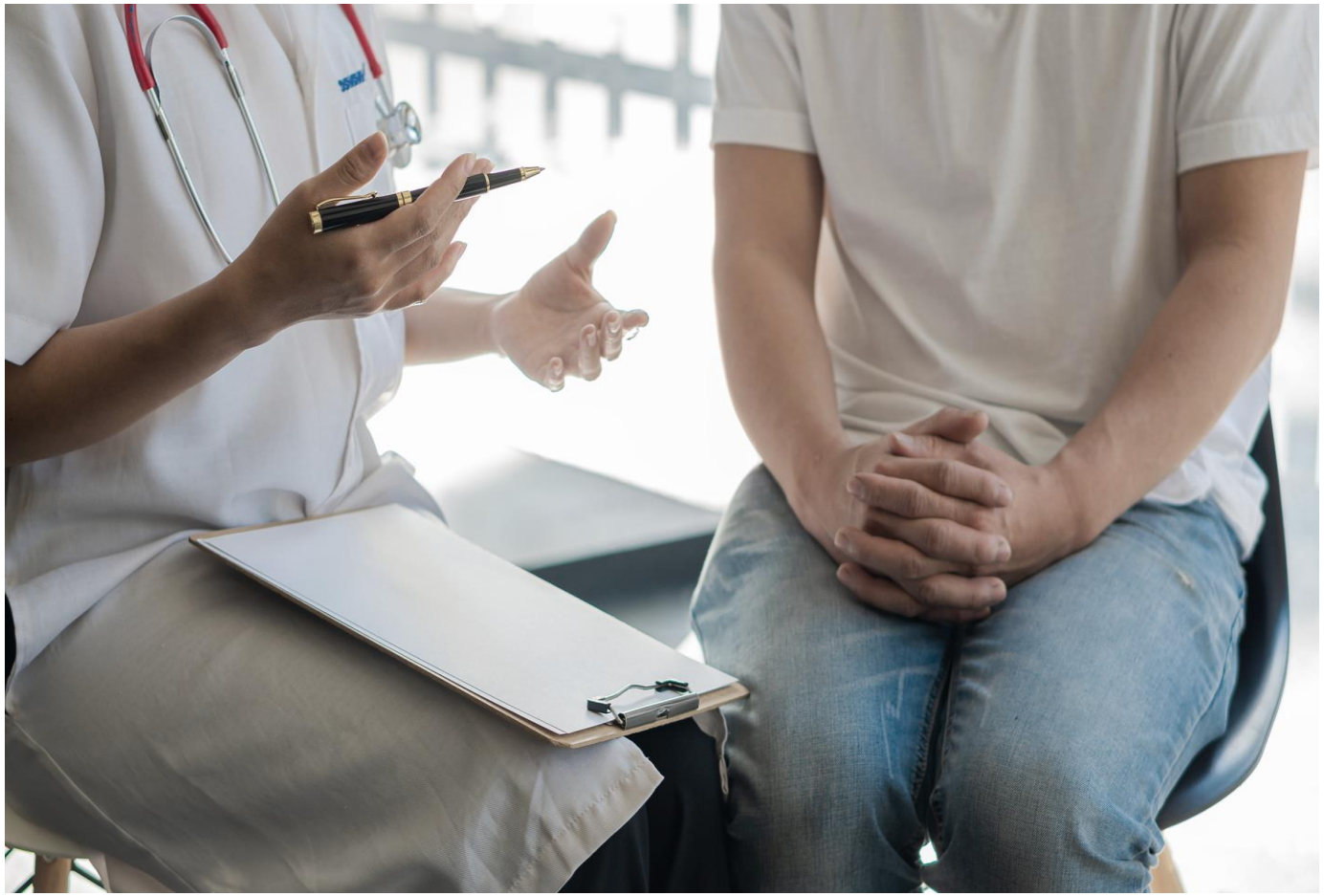
CARING FOR HIV IN THE HOME ENVIRONMENT: COORDINATING WITH COMMUNITY HEALTH WORKERS (CHWs)



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December 2, 2025

Housekeeping Items

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email

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Kevin Lombardi, MD, MPH, Director of Research, Policy and Health Promotion

- Serves as Director of Research, Policy and Health Promotion at NCHPH and Vice President for Research and Evaluation at NAM, leading national technical-assistance initiatives for health centers and public-housing health programs.
- Integrates clinical medicine, public health, and systems evaluation to enhance primary care quality, workforce development and policy alignment across the U.S. safety net.
- Directs national assessments and program evaluations and has published in major journals.
- Dr. Lombardi holds an MD and MPH from George Washington University, combining medical training with expertise in public health analysis, policy, and data-driven evaluation.

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Caring for HIV in the Home Environment

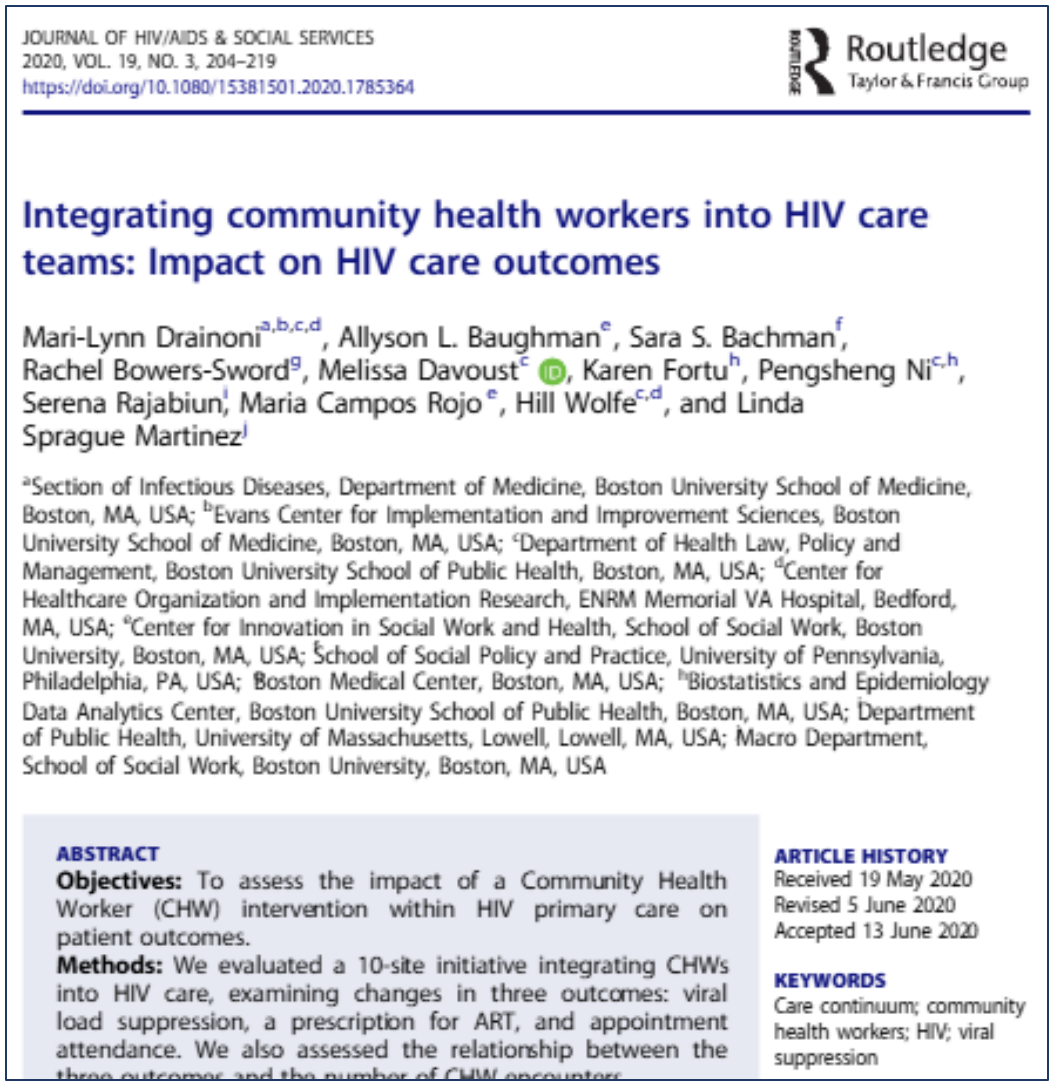
Dr. Kevin Michael Lombardi MD, MPH

Director of Research
The National Center for Health in Public Housing
North American Management

Learning Objectives

- **Describe** how Community Health Workers (CHWs) contribute to ending the HIV epidemic through prevention, education and referral strategies
- **Identify** key barriers to timely HIV and STI testing and linkage to care among public housing residents
- **Explain** how CHW-led outreach improves access, affordability,and the patient experience within health centers
- **Apply** best practices for CHW engagement in HIV prevention and linkage-to-care-workflows within community and clinical settings
- **Strengthen partnerships** with HUD and local agencies to improve patient safety

CHW Integration in HIV Care – National Evaluation Overview



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Routledge
Taylor & Francis Group

Integrating community health workers into HIV care teams: Impact on HIV care outcomes

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ABSTRACT

Objectives: To assess the impact of a Community Health Worker (CHW) intervention within HIV primary care on patient outcomes.

Methods: We evaluated a 10-site initiative integrating CHWs into HIV care, examining changes in three outcomes: viral load suppression, a prescription for ART, and appointment attendance. We also assessed the relationship between the three outcomes and the number of CHW encounters

ARTICLE HISTORY
Received 19 May 2020
Revised 5 June 2020
Accepted 13 June 2020

KEYWORDS
Care continuum; community health workers; HIV; viral suppression

- **Context:** 10 demonstration sites, including health centers and Ryan White clinics across the U.S.
- **Evaluation period:** 2016-2019
- **Participants:** 600 people with HIV engaged through CHW programs.

Link to publication: [*Drainoni et al, 2020*]

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The Impact of CHWs on HIV Care Outcomes

	Baseline	6 months
▪ Primary care visit in past 6 months	49.9%	84.7%
▪ Anti Retroviral Therapy (ART) prescription	66.9%	91.3%
▪ Viral suppression (<200 copies/mL)	22.4%	43.7%

Link to publication: Arnold et al, 2024

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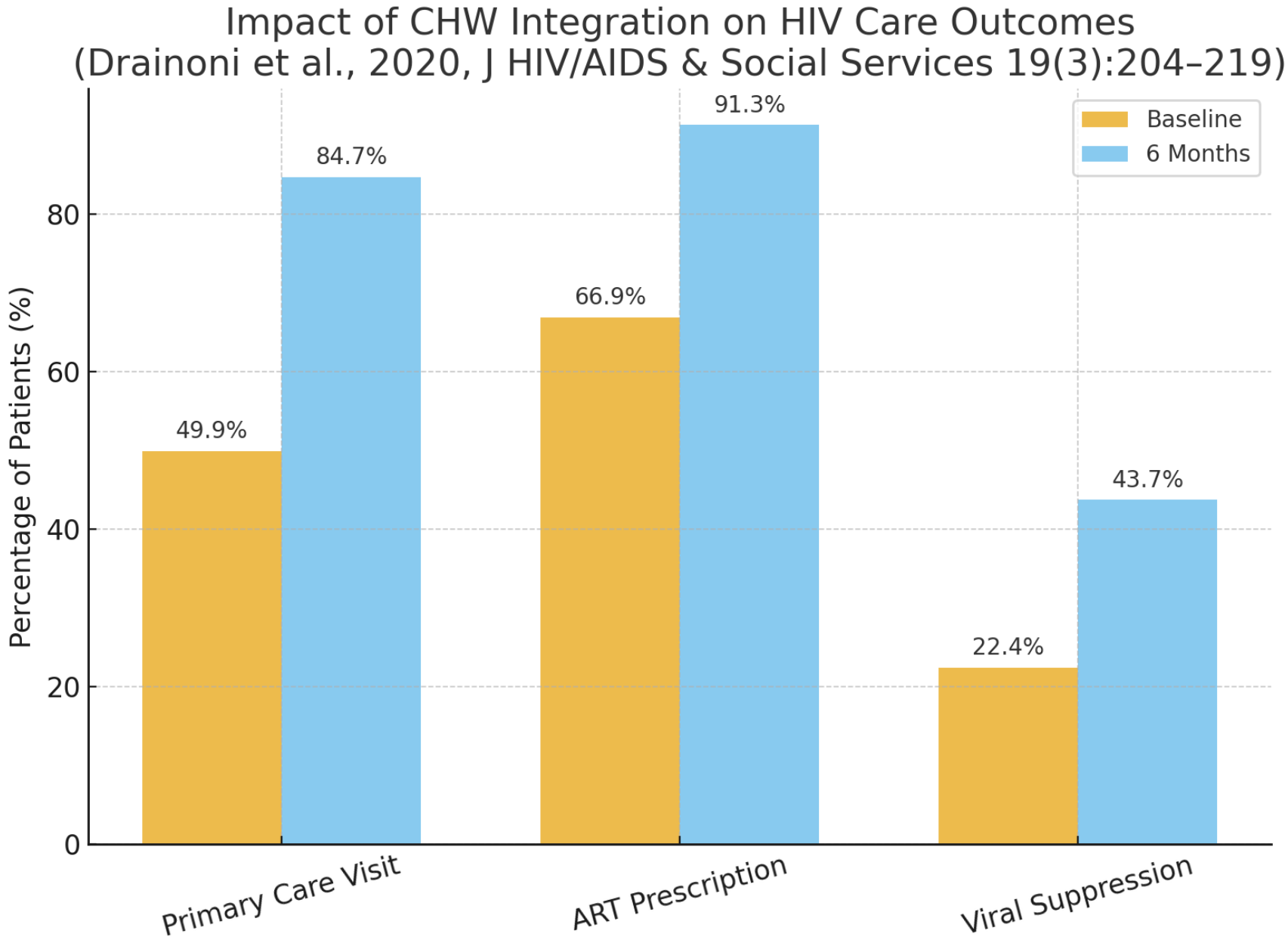
The Impact of CHWs on HIV Care Outcomes



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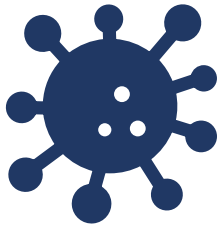
CHW Integration in HIV Care – Barriers to Integration

Unclear CHW roles and responsibilities within teams

Need for ongoing coaching and supervision amongst CHWs

Lack of standardized training for CHWs in HIV care



Lack of information about navigating aging and HIV

Weak or fragmented referral systems

Link to publication: ***HIV Implementation Science Coordination Initiative***

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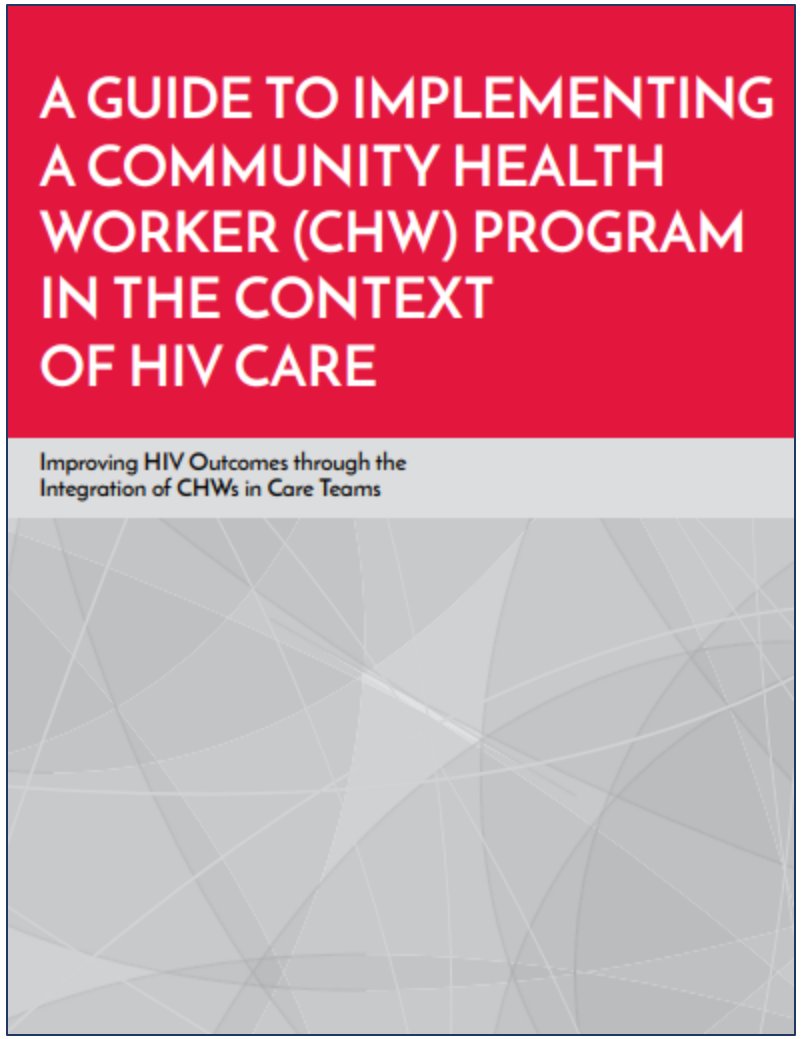
Setting up CHW Systems to Deliver HIV Care and Treatment



- **Operational Framework:** Step-by-step guidance for integrating CHWs into HIV care teams (recruitment, training, supervision, etc.)
- **Best Practices:** For HIV prevention and linkage to care.
- **Performance and Sustainability Tools:** Includes templates, checklists, and metrics that can be used to monitor CHW program outcomes.

Link to publication: ***Guide to implementing a CHW program in HIV care***

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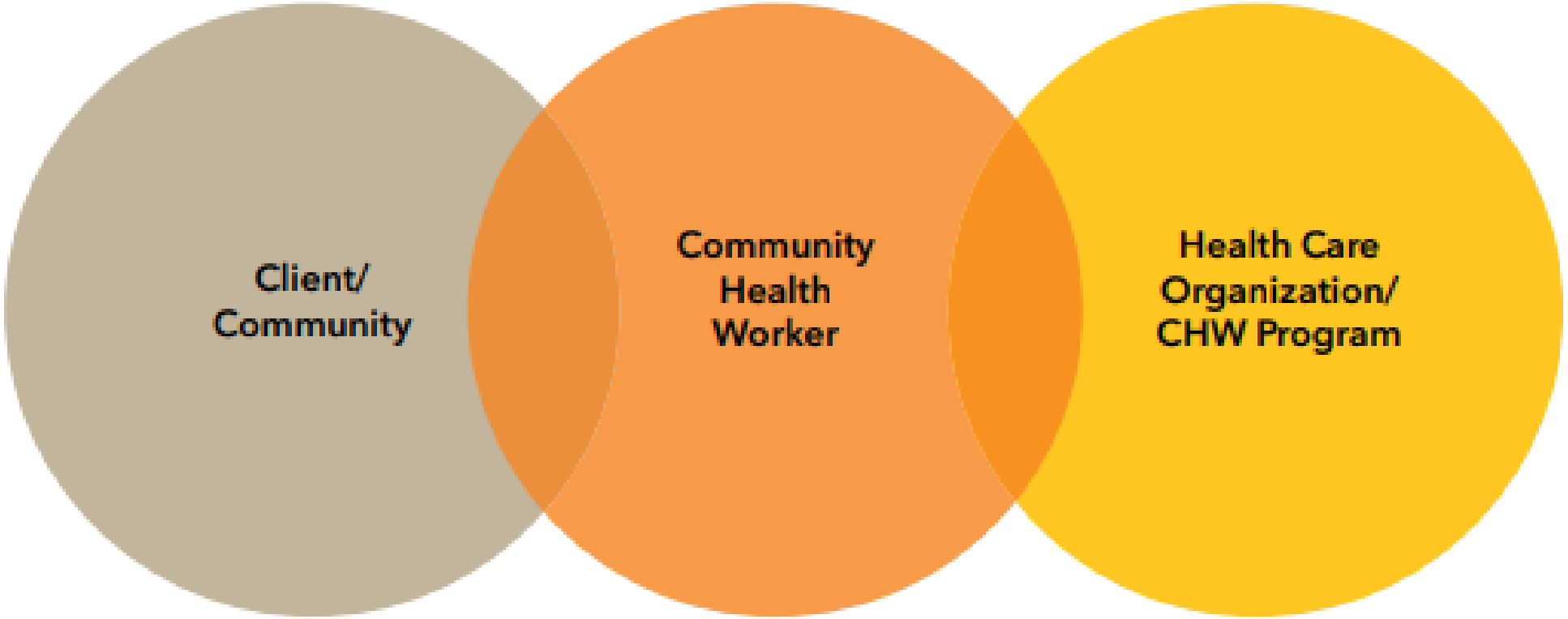
Relationship Overlap: CHW HIV Community Care



Link to publication: *Guide to implementing a CHW program in HIV care*

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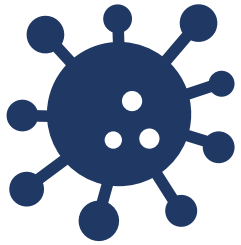
Priority Patients for CHW HIV Interventions

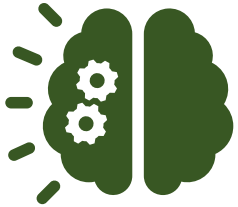


Patients who are not virally suppressed

New onset HIV diagnosis

Unsuitable housing or homeless individuals

Hx or missing or late appointments



Patients with mental health disorders

The recently incarcerated

Patients with SUD

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Locating Priority Patients: Example Sources

Program Data: Search program rosters of past HIV linkage-to-care programs at your institution and partner organizations to identify priority patients.

Surveillance Data: Contact your local department of health and state public health offices to obtain lists of clients who have had a viral load test in the past six months.

Review Testing Data: Review clinic testing data to identify eligible people who are newly diagnosed and have never linked to care. Review lists at weekly team meetings.

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How Can CHWs Enhance HIV Care Teams

Assisting people with HIV to become aware of their status

Linking and engaging people with HIV into medical care

Helping people with HIV adhere ARV to treatment

Explaining health benefits and other types of available assistance to people with HIV

Link to publication: ***Guide to implementing a CHW program in HIV care***

Suggested CHW Tasks and Activities

1

Weekly client check-ins to measure progress, these should include:

1. Medication compliance check
2. Appointment reminders and compliance check
3. Follow-up on and provide additional referrals as needed

2

Conduct regular education sessions with patients. Subjects can include:

1. HIV Transmission
2. Patient safety
3. ARV medication basics
4. Chronic disease-HIV connections
5. Wellness and lifestyle

3

Document each patient encounter as a separate note on the EHR, this ensures better collaboration with the rest of the care team

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Example CHW Note: Weekly Encounter

Encounter Date and Time: Oct 15, 2025, 10:30 AM
Encounter Type: Phone outreach and care coordination
Client: J.L. MRN 102938
CHW: K. Rivera
Consent and ROI: Confirmed and current
Attempted Contacts for Follow Up Appointments

- Oct 14, 2025, 3:15 PM. No answer. Voicemail left requesting call back.
- Oct 15, 2025, 9:10 AM. Reached client successfully.

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Example CHW Note: Weekly Encounter

Referral Activity

- Mental health counseling. Warm handoff to behavioral health, referral placed today. Intake scheduled Oct 20, 2025 at 2 PM.
- Substance use treatment. Client requested information only. Provided contact for outpatient program. Client declined referral today and will revisit next week.
- Food support. Referred to on-site pantry and community partner. Voucher issued for pickup Oct 16, 2025.

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Example CHW Note: Weekly Encounter

Client Reported Services or Circumstances Impacting Care

- Client reports job loss two weeks ago and is temporarily staying with parents.
- Client reports missing evening ART doses on two days last week due to grief and disrupted routine after grandmother's death.
- Transportation is limited. Client relies on rides from family.

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Example CHW Note: Weekly Encounter

Medication Notes

- ART regimen BIC FTC TAF. Last fill due Oct 12, 2025. Called preferred pharmacy during call with client on Oct 15. Thirty-day refill authorized and ready.
- Arranged pharmacy delivery to parents' address for Oct 16, 2025.
- Reviewed simple adherence plan. Client set phone reminder for 9 PM daily. Pillbox provided at last visit.

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Example CHW Note: Weekly Encounter

Follow Up Appointments

- HIV primary care follow up scheduled Oct 28, 2025, 11 AM. Client confirmed attendance.
- Lab draw to be completed same day before visit. Client understands fasting is not required.

Example CHW Note: Weekly Encounter

Education and Counseling Provided

- Brief adherence counseling and stress management tips.
- Reviewed importance of not sharing medications and of keeping meds in original containers.
- Discussed safe storage at parents' home.

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Example CHW Note: Weekly Encounter

Plan and Next Steps

- CHW to confirm medication delivery on Oct 16.
- CHW to conduct check in call on Oct 18 to assess adherence and mood and to revisit SUD referral interest.
- If two missed doses in a week recur, escalate to RN case manager for rapid follow up.

Example CHW Note: Weekly Encounter

Care Team Communication

- EHR message sent to PCP Dr. Ahmed and RN case manager at 11:05 AM summarizing missed doses, new referrals, and delivery plan.
- Behavioral Health intake note link added to care plan.
- Social work alerted to food support referral and transportation need for Oct 28 visit.

Client Understanding and Agreement

- Client verbalized understanding of plan and agrees to next steps.

Case Study: HIV Home Care

Mr. Williams is a 53 year-old man with a past medical history of hypertension, type-2 diabetes mellitus and hyperlipidemia. The patient has been living with HIV since 2017 and has maintained virologic suppression since 2022, with the most recent HIV viral load test indicating <200 copies/ml.

He presents at the clinic today for his annual physical.

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Case Study: HIV Home Care

Review of the patients' medical records indicate the following details regarding his HIV history:

- The patient was previously followed by Dr. Jones, an ID physician who manages his ART therapy. He is noted to have last seen him in June 2024.
- Mr. Williams is noted to have missed his last two PCP appointments.
- Past records for viral load indicate consistent results <200 copies/ml and CD4 levels have ranged from 700-1300 copies/ml.

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Please take a moment to type your response to the following:

What is your initial assessment of Mr. Jones' medical records?

Case Study: HIV Home Care

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

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1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

☑ Yes ☐ No

2. Are you homeless or worried that you might be in the future?

☐ Yes ☑ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)?

☑ Yes ☐ No

4. Do you have trouble finding or paying for a ride?

☑ Yes ☐ No

5. Do you need daycare, or better daycare, for your kids?

☐ Yes ☑ No

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Link: To Resource

Case Study: HIV Home Care

6. Are you unemployed or without regular income?
☑ Yes ____ No

7. Do you need help finding a better job?
☑ Yes ____ No

8. Do you need help getting more education?
____ Yes ☑ No

9. Are you concerned about someone in your home using drugs or alcohol?
____ Yes ☑ No

10. Do you feel unsafe in your daily life?
____ Yes ☑ No

11. Is anyone in your home threatening or abusing you?
____ Yes ☑ No

Link: To Resource

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Please take a moment to type your response to the following:

What additional questions do you have for Mr. Williams after reviewing his nonmedical needs questionnaire?

Case Study: HIV Home Care

You perform a comprehensive physical examination and a focused interview with the patient. When asked about the results of his nonmedical needs questionnaire the patient notes the following:

- **He has been unemployed for two years. For income he performs odd jobs and drives Uber but is consistently late on his bills.**
- **He is a resident of public housing.**
- **He notes poor compliance with his ARV therapy and missed appointments with providers due to "stress" and difficulty managing his schedule.**
- **He experienced a temporary insurance lapse after his unemployment; he is now enrolled in Medicaid.**

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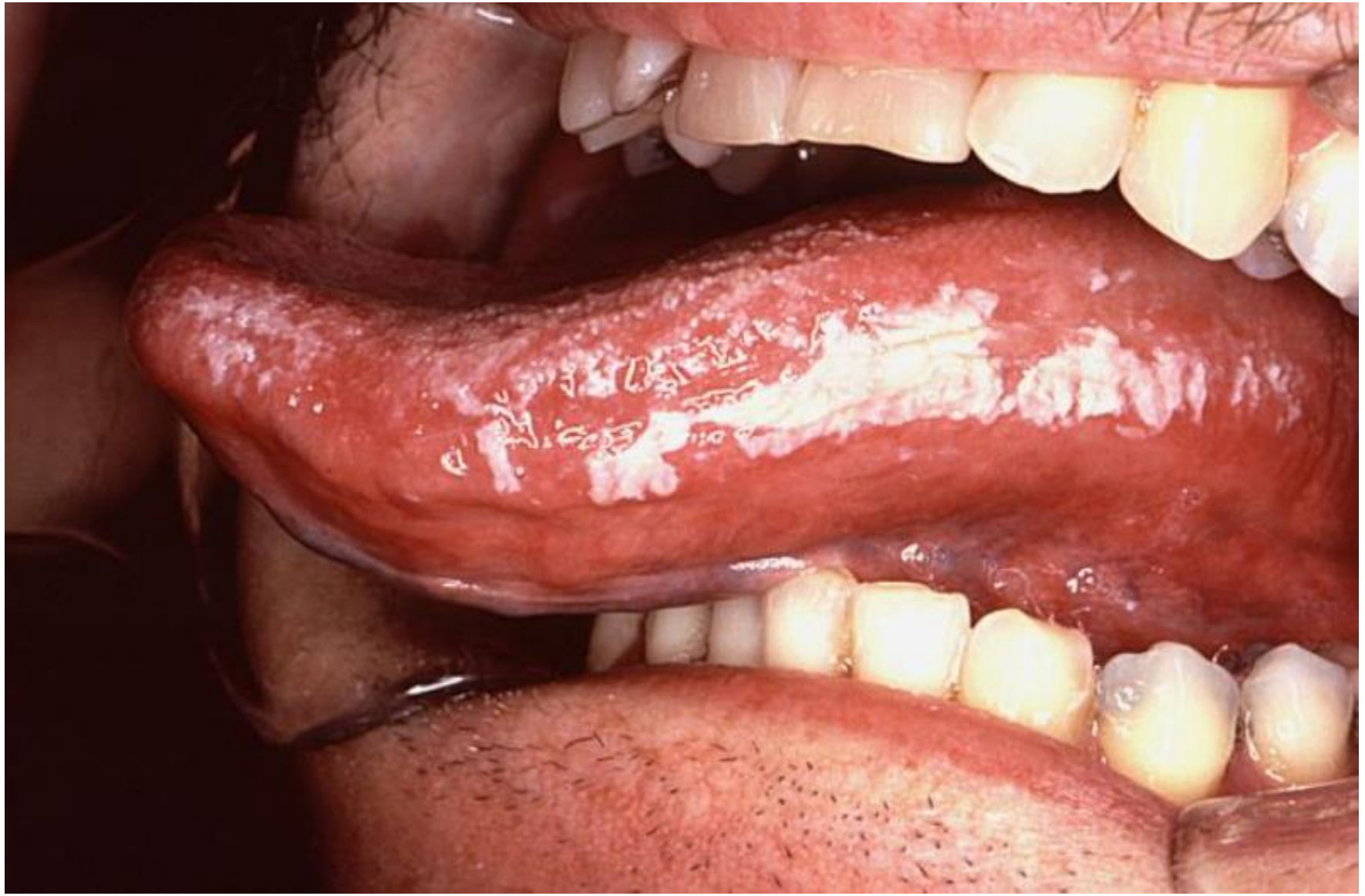
Intraoral view of a HIV/AIDS-positive Patient



Source: [CDC Public Health Image Library]

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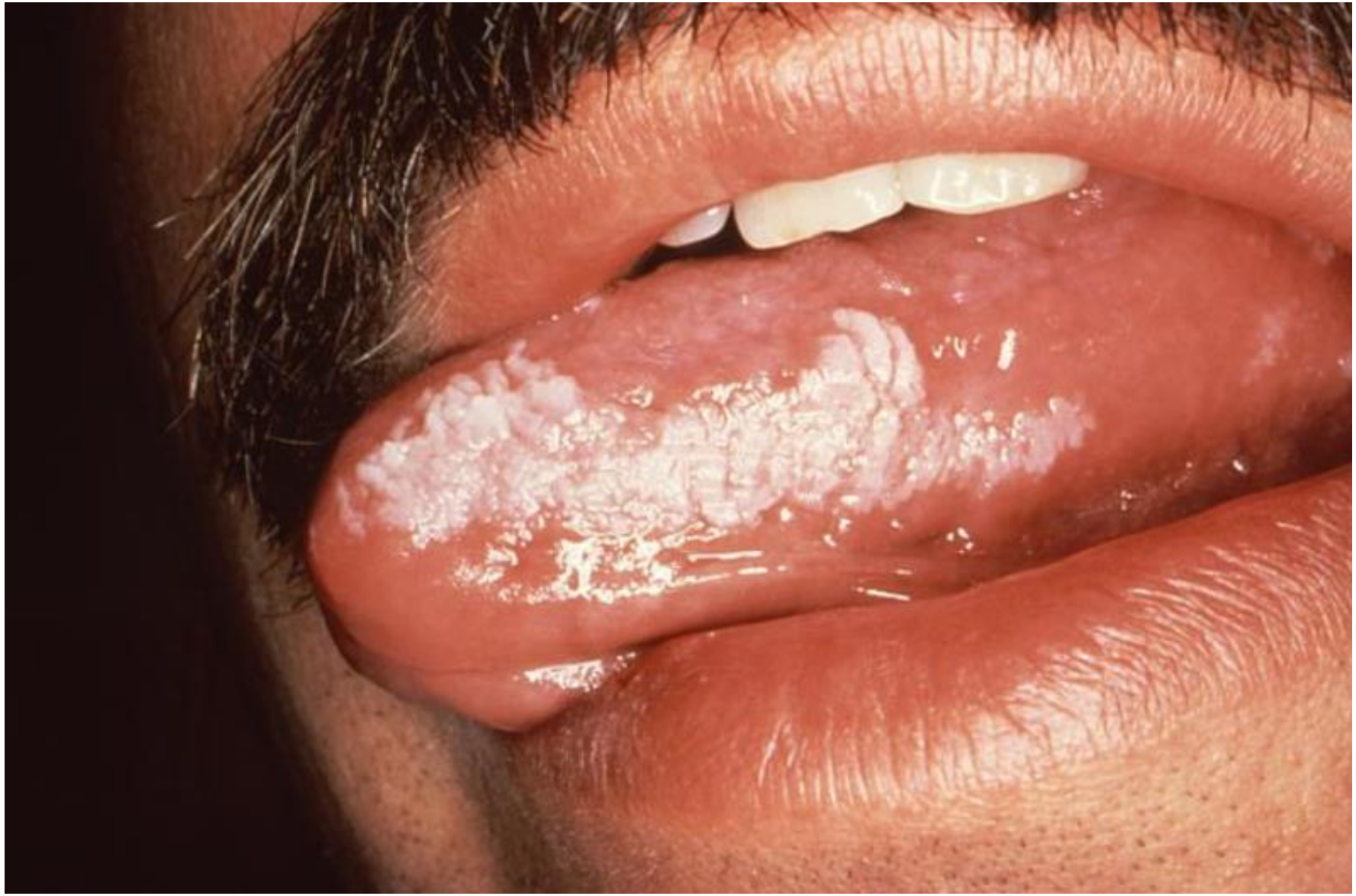
Intraoral view of a HIV/AIDS-positive Patient



Source: [CDC Public Health Image Library](#)

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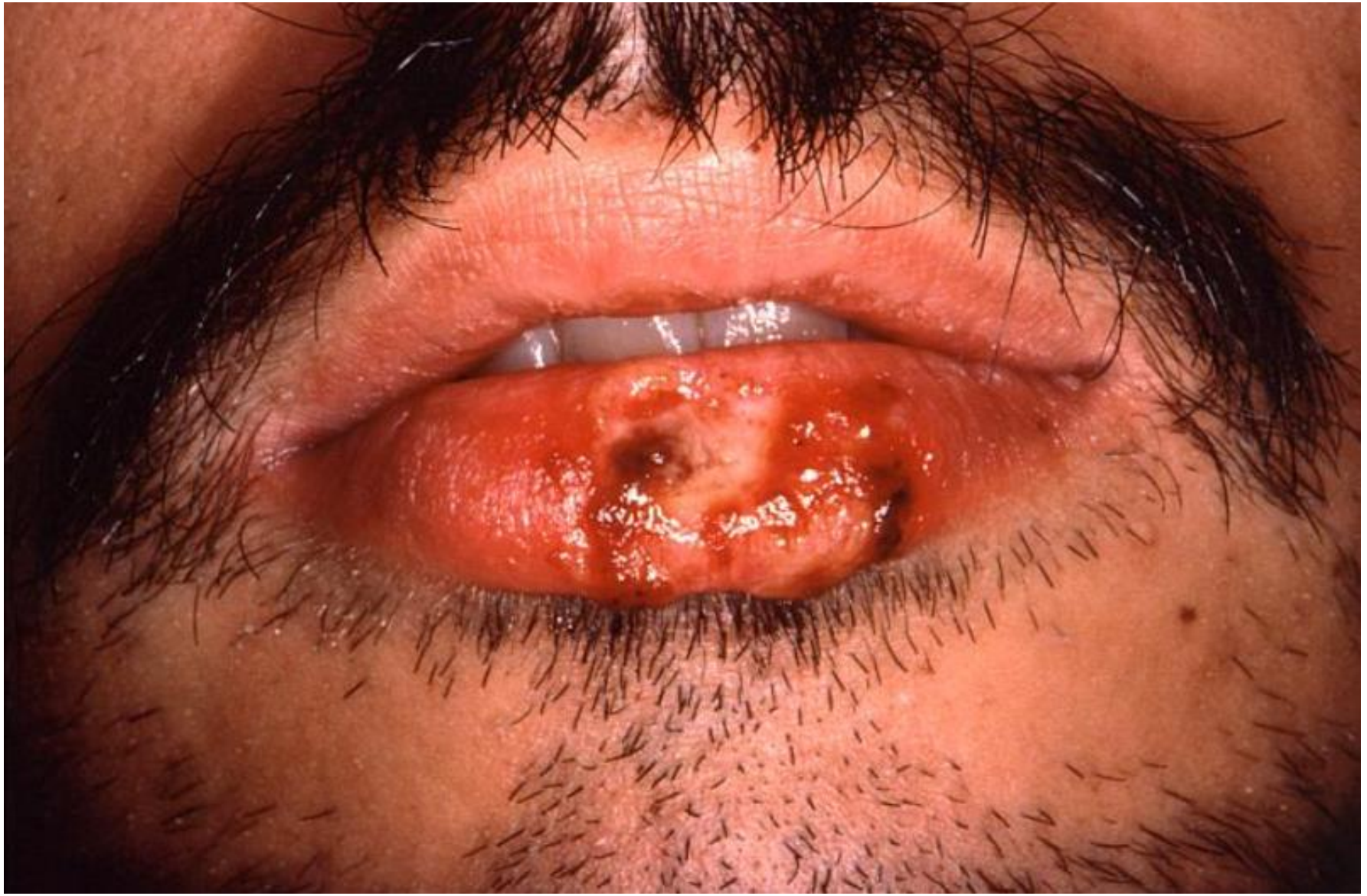
Close view of the lips of a HIV/AIDS-positive Patient



Source: [CDC Public Health Image Library](#)

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Please take a moment to type your response to the following:

What additional resources would be appropriate for Mr. Williams at this time?

What programs or services does your health center have to support patients like Mr. Williams?

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Q & A Session

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Upcoming Events

Understanding and Addressing the Childhood Chronic Disease Crisis: Prevention and Action in Primary Care Practice	December 9, 2025 at 2:00 pm EDT	https://us02web.zoom.us/webinar/register/WN_N3AbSZ_0TMayaBH0724AtQ#/registration

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- The Impact of Tobacco and Cigarette Smoking in Oral Health Among Residents of Public Housing
- The Importance of Support Services for Older Adults with HIV Experiencing Community Isolation
- Introduction to the National Center for Health in Public Housing 2025

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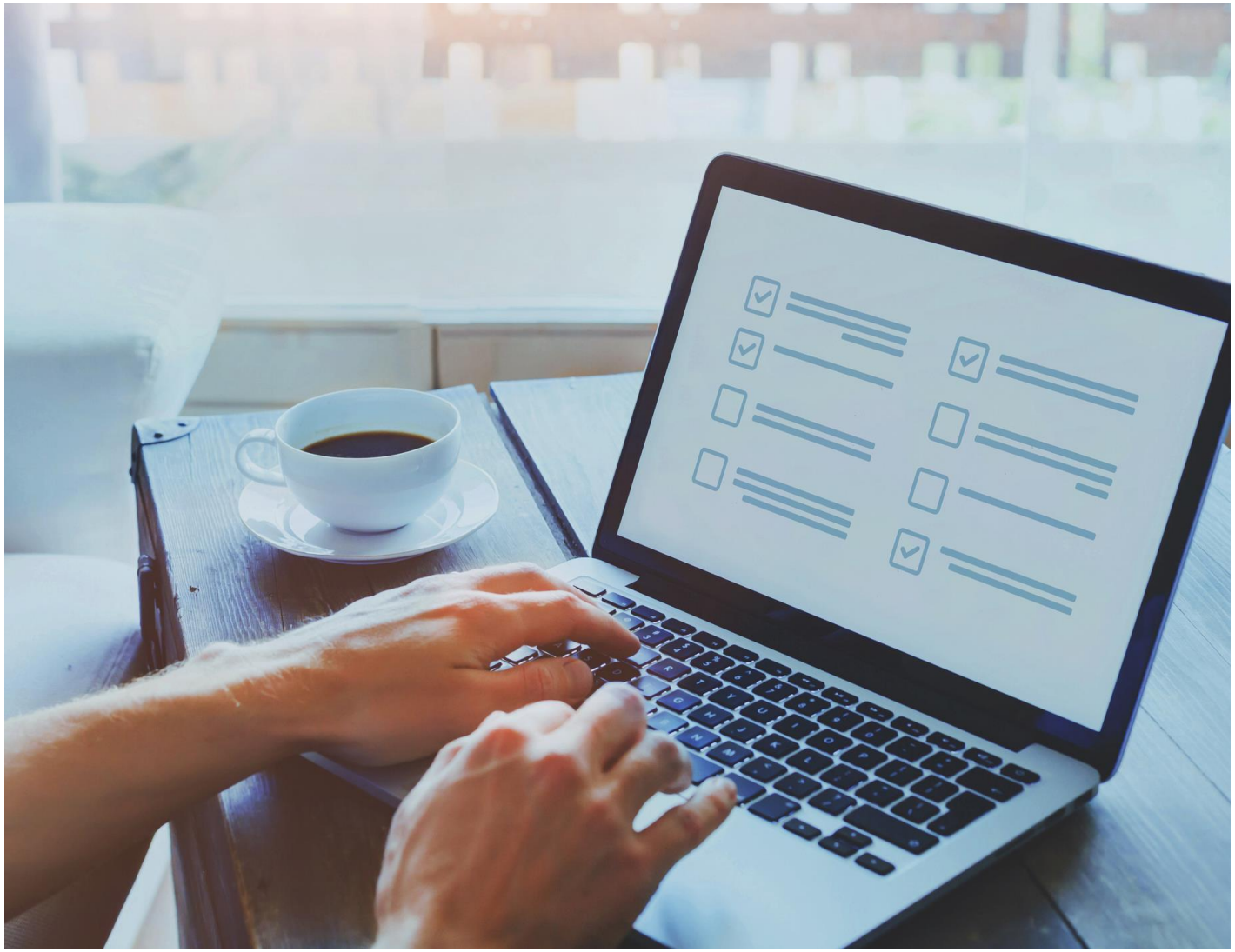
COMPLETE OUR POST EVALUATION ASSESSMENT



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THANK YOU!