



HIV and Health-Related Needs: Leveraging Community Interventions to Support Patients with HIV



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- Raise hand if you would like to unmute
- Meeting is being recorded
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National Center for Health in Public Housing

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- 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.

HIV and Health Related Needs: Leveraging Community Interventions to Support Patients with HIV

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Learning Objectives



Explain how health-related needs influence engagement in HIV care and treatment outcomes.



Describe community intervention models that support patients with HIV beyond the clinical setting.



Identify effective roles for Community Health Workers (CHWs) in addressing health-related needs among people living with HIV.



Case Study: HIV and Health-Related Needs

Mr. Stephens is a 45-year-old man with a past medical history of Chronic Obstructive Pulmonary Disease (COPD), asthma and type-2 diabetes mellitus. The patient has been living with HIV since 2007 and has maintained virologic suppression since 2019, with the most recent HIV viral load test indicating <200 copies/ml.

He presents at the clinic today to "*catch up on his annual exams*" and due to sores, that have recently appeared on his cheeks and the roof of his mouth.

Prior to seeing the patient, you perform a review of his Electronic Health Record. This indicates the following details:

- The patient received his HIV care, including antiretroviral prescription from Dr. Simon, an ID physician who retired in 2024.
- Pharmacy claims data are not available in the EHR, but records note that Mr. Stephens was previously prescribed and taking Tivicay and Descovy daily during Dr. Simons' last note in June 2024.

Looking at Mr. Stephens' primary care records, the following information is also reviewed.

- The patient was last seen in this office in April 2024.
- His last hemoglobin A1c is noted to be 9.3 in April 2024.
- The patient has been seen at this health center since 2012 and has been lost to care during one additional period (2014-2016).
- Per social worker, the patient is noted to have been unemployed during that period.

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

What is your initial assessment of the information in Mr. Stephens' medical records?

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

Are there any differences between Mr. Stephens' previous and current loss to follow-up?

What may have driven both instances?

Appendix

WellRx Questionnaire

DOB _____ Male ___ Female _____

WellRx Questions

-
- 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

[Link: To Resource](#)

Case Study: HIV and Health-Related Needs

- 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

The WellRx Toolkit was developed by Janet Page-Reeves, PhD, and Molly Bleecker, MA, at the Office for Community Health at the University of New Mexico in Albuquerque. Copyright © 2014 University of New Mexico.

[Link: To Resource](#)



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

What additional questions should you ask Mr. Stephens after reviewing his nonmedical needs questionnaire?



Case Study: HIV and Health-Related Needs

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 employment, 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”, loss of insurance and difficulty finding a new ID provider.
- When asked if he knew if he was eligible for Medicaid, the patient notes that he "hadn't thought about it".
- The patient is unaware of other safety-net resources that may be available to him.

Additional results include the following:

Today

BP: 110/80

HR: 62

Weight: 135

Skin: Pale, blotchy

2024

BP: 140/90

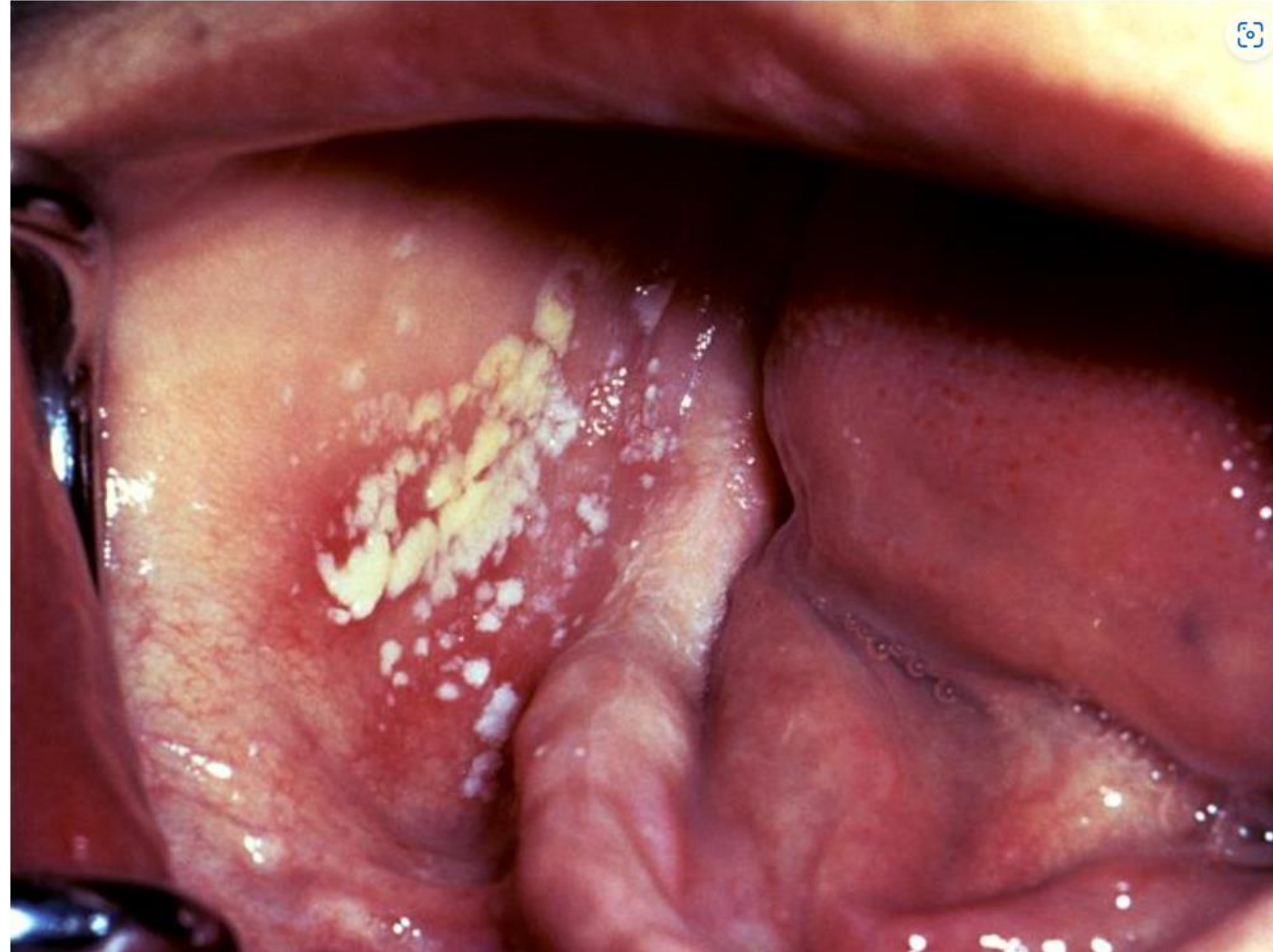
HR: 74

Weight: 175

Skin: Unremarkable

AIDS-defining Illnesses

Intraoral view of a HIV/AIDS-positive patient, who had presented with a chronic secondary opportunistic oral candidiasis infection.



Additional AIDS-defining Illnesses

Intraoral view of a HIV/AIDS-positive patient, who had presented with a chronic secondary opportunistic oral candidiasis infection.



[Link to source](#)

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

Considering Mr. Stephens' condition, what is the #1 priority for his care?

What next steps should be taken?

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

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

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

Additional AIDS-defining Illnesses

Intraoral view of a HIV/AIDS-positive patient, who had presented with an intraoral Kaposi's sarcoma lesion, along with an overlying candidiasis infection



Additional AIDS-defining Illnesses

Intraoral view of a patient, who had been ill with HIV/AIDS, and presented here, with a secondary oral pseudomembranous candidiasis infection.



Additional AIDS-defining Illnesses

Intraoral view of a HIV/AIDS-positive patient, who had presented with a chronic secondary opportunistic oral candidiasis infection.





CHW Integration in HIV Care – National Evaluation Overview

JOURNAL OF HIV/AIDS & SOCIAL SERVICES
2020, VOL. 19, NO. 3, 204–219
<https://doi.org/10.1080/15381501.2020.1785364>

 **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
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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](#)



The Impact of CHWs on HIV Care Outcomes

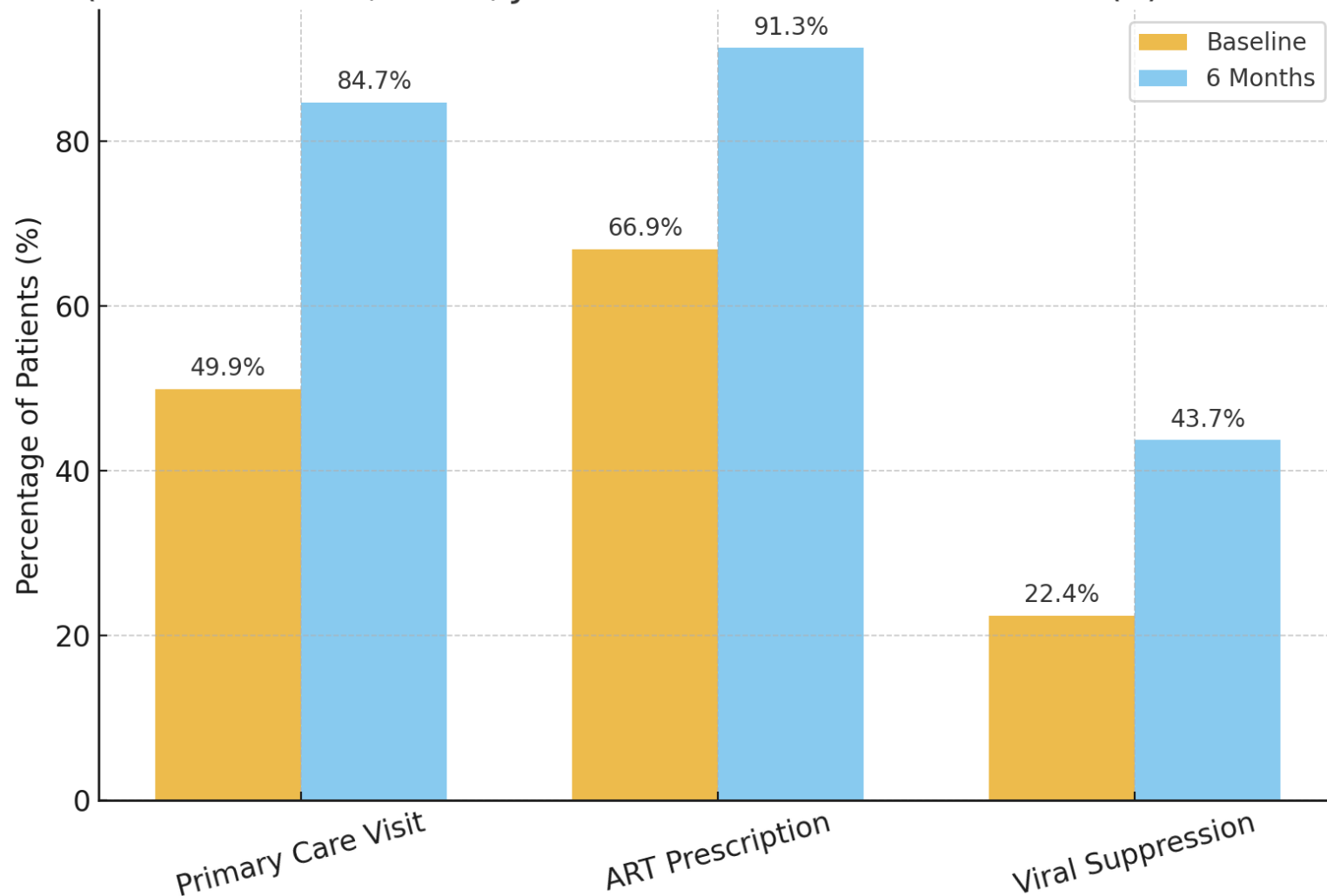
	Baseline	6 months
▪ Primary care visit in past 6 months	49.9%	84.7%
▪ ART prescription	66.9%	91.3%
▪ Viral suppression (<200 copies/mL)	22.4%	43.7%

Link to publication: [Arnold et al, 2024](#)



The Impact of CHWs on HIV Care Outcomes

Impact of CHW Integration on HIV Care Outcomes
(Drainoni et al., 2020, J HIV/AIDS & Social Services 19(3):204-219)





CHW Integration in HIV Care – Barriers to Integration



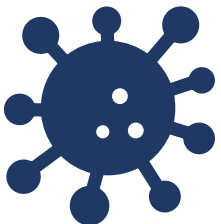
Unclear CHW roles and responsibilities within teams



Need for ongoing coaching, supervision and peer support 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](#)



Setting up CHW Systems to Deliver HIV Care and Treatment

A GUIDE TO IMPLEMENTING A COMMUNITY HEALTH WORKER (CHW) PROGRAM IN THE CONTEXT OF HIV CARE

Improving HIV Outcomes through the
Integration of CHWs in Care Teams

- **Operational Framework:** Step-by-step guidance for integrating CHWs into HIV care teams, including 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](#)



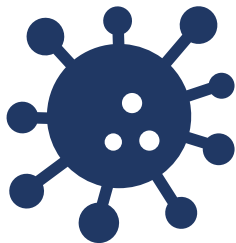
Relationship Overlap: CHW HIV Community Care



Link to publication: [Guide to implementing a CHW program in HIV care](#)



Priority Patients for CHW HIV Interventions



Patients who are not virally suppressed



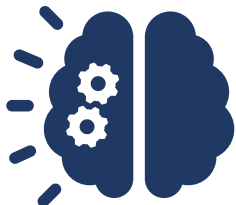
New onset HIV diagnosis



Unsuitable housing or unhoused



Hx or missing or late appointments



Patients with mental health disorders



The recently incarcerated



Patients with SUD



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.



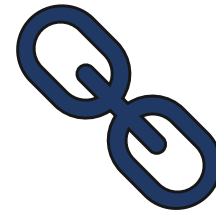
Review Testing Data: Review clinic testing data to identify eligible people who are newly diagnosed who never linked to care. Review lists at weekly team meetings.



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 to treatment



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



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



Q & A Session



COMPLETE OUR POST EVALUATION



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THANK YOU!

