



# HAART to HEART: A multidisciplinary adherence support and evaluation program in Ryan-White funded community health centers

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# Adherence at a CHC

- Dimock Community Health Center (DCHC) urban-based comprehensive CHC with Title IIIb-funded HIV primary and specialty care
- In 1997-8: Dimock Community Health Center (DCHC), 58% of pts on PI did not achieve durable suppression
- Toxicity and side effects were significantly associated with failure
  - (63% vs 30%) and poor adherence (61% vs 41%)
  - 30% of HAART failures were unable to tolerate Rx for 12 weeks
- In a larger study, the most common patient-reported reason for stopping HAART was side effects

# HAART to HEART concept

- For highly ACTIVE antiretroviral therapy (HAART) to be EFFECTIVE, you must be able to access, accept, take, tolerate and adhere
- HAART to HEART, initiated to improve adherence and treatment success by changing highly active antiretroviral therapy into highly effective antiretroviral therapy

# Changes in the clinic

- Interventions to improve the durability of PI and HAART response were strengthened to include aggressive side effect and toxicity management
- Efforts included the development of a more aggressive and comprehensive adherence program to improve treatment success (education, adherence, optimal regimen design etc.)
- Target population was ~200 HIV patients in primary care
  - 85% communities of color, 45% women
  - ~60% HCV (+), >75% history of substance abuse and/or mental illness

# Program Design

- Multidisciplinary team integrated in to HIV primary care clinic
- Educate of all team members on treatment, side effects and management and adherence
- Traditional adherence aids
- Nutritional support
- Mental health counseling
- Peer support and advocacy
- Patient education

# Adherence support team

- HIV specialist (team leader)
- PCP (if not the team leader)
- Nurse case manager/educator
- Peer educator/advocate
- Mental health counselor
- Nutritionist
- Psychosocial case manager(s)
- Psychiatrist
- Other (employment specialist, referral coordinator, interpreter)

# Design (continued)

- Peers received specialized training in adherence and treatment, and supervision from mental health counselor
- Develop and collect educational materials (English and Spanish) from web and publications to create permanent resources and patient manuals
  - Manual translated into 3 languages and updated regularly as collaboration between DCHC and JSI

# Protocol for HAART Initiation

- All patients met with their PCP for initial HAART discussion. Decision and initiation takes 2-3 visits
- After PCP visit, the patient meets with a nurse case manager/educator who reinforces education and provide additional information
- All patients are offered a peer educator. If they accept the peer support, peers contact regularly
- Psychosocial case manager is involved in >70% of cases
- Education and support includes use of a manual, regimen and adherence review, general HIV education, aggressive referrals for mental health, substance abuse, nutrition, psychosocial needs



# Results

- Over 75% of patients on HAART engaged in some aspect of the program
  - 85% from communities of color
  - 40% women
- High rates of comorbid conditions (HCV, mental illness, substance abuse) required most to access >1 service and needs changed over time
- Follow-up chart review in 1999 showed that >90% of individuals who achieved viral suppression remained suppressed for >1 year

# SPNS and HAART to HEART

- Funded in October 1999 including expansion of adherence program to second CHC and evaluation of efficacy of home-based component
- This has allowed a more intensive look at the program
- Preliminary results from DCHC are presented

# Preliminary SPNS data

- 43 patients on HAART enrolled into program and screened for problems with adherence
  - 57% women, 87% communities of color
  - 42% IDU risk, 61% substance abuse, 38% mental illness
- 63% had viral loads below level of detection
- 65% reported 100% 3 day adherence and 56% reported missing < 1 time/week
- Lower levels of HIV-related knowledge was associated with missing doses
- Both substance abuse and difficulty taking medications on time were associated with not achieving undetectable plasma viral load

# Role of Peer Adherence Counselor

- 2 peers hired and trained by the clinic to provide education and adherence support
- In the first 7 months of SPNS evaluation, 46% of enrolled clients accepted a PAC (67% women, 67% minority)
- 2 PACS initiated 168 encounters (range 1-25/client) with 83% resulting in contact by phone or face-to-face

# Role of Peer Continued

- Direct services included education and adherence, but also included referrals for mental health or substance abuse treatment, housing, utilities and advocacy for care and treatment
- Women had high rates of chaos, with intervention provided in mean of 2.8 areas in addition to adherence and education

# Lessons Learned

- Establishment of a multidisciplinary adherence support program integrated into a CHC HIV primary and specialty care program can be done, but it takes time and effort
- Adherence needs change with time therefore, the program must also be flexible and responsive to needs
- It is hard to collect data
- Peers are an effective and valuable part of the team, but require training to include boundaries, triage and self-support

# Future Directions

- Further funding through SPNS grant in collaboration with John Snow and new CHC to continue evaluation
- Continue training in clinic and through NEAETC to ensure state-of-the-art care and side effect management
- Continue to address new challenges: hepatitis C, aging, lipodystrophy, lactic acidosis, etc.
- Continue to monitor effectiveness as people survive longer and medications change