AmidaCONNECT

Intensive Outreach and Re-engagement Services to Improve Health Outcomes

AmidaCONNECT COMBINES FIELD-BASED SERVICES WITH ACCESS TO REAL TIME HEALTH INFORMATION TO PROVIDE TARGETED SERVICES TO MEET MEMBERS WHERE THEY ARE

Background

The stages of HIV care, also known as the HIV care continuum, demonstrate significant gaps in HIV services, and efforts are underway at the federal, state, and local levels to develop and implement strategies to improve health outcomes for people living with HIV (PLWH). The HIV care continuum can be described by the following sequential steps: (1) diagnosis of HIV infection, (2) linkage to care, (3) retention in care, (4) receipt of antiretroviral therapy (ART), and (5) achievement of viral suppression (a very low level of HIV in the body). In the United States, there are 1.2 million people living with HIV, and according to the Centers for Disease Control and Prevention (CDC), 66% have been linked to HIV-specific medical care.[1] Engagement in care is a critical step in ensuring access to highly effective HIV treatment, which can ultimately lead to viral suppression. Viral suppression results in significantly improved health outcomes as well as dramatically decreased likelihood of HIV transmission (96% reduced risk of transmission).[2] According to the CDC, 30% of people living with HIV had achieved viral suppression, which means that only 3 out of 10 people living with HIV had the virus under control. Barriers to engagement in care include lack of stable housing, poverty, mental health and substance use issues, lack of access to culturally competent care, transportation, and other competing needs; interventions to engage people in HIV care must address these needs at the point of engagement in care as well as in subsequent support for retention in care. Improvements along the HIV continuum of care hold great promise for both treatment as well as prevention.

What Are We Doing?

AmidaCONNECT, a program of Amida Care, utilizes an Assertive Community Treatment (ACT) model in employing three field-based Mobile Engagement Teams (METs) to provide intensive outreach, care navigation, case management, and reengagement services to the most difficult to reach populations living with HIV — those dually and triply diagnosed with mental health and/or substance use issues that are unconnected to care (or at risk of becoming so) — and connect them to long-term community service providers. The clients of AmidaCONNECT are not only living with HIV and un/under-treated, but are often facing additional challenges that affect overall health and well-being, such as homelessness, poverty, lack of nutritious food, and legal issues. The METs engage members in appropriate and ongoing primary and behavioral health care and substance use treatment in an effort to suppress the amount of HIV virus present in their body, reduce health disparities and generate positive health outcomes, which leads to decreased use of costly hospitalizations and long-term care that is often preventable.

UNIQUE FEATURES OF AmidaCONNECT

- The Mobile Engagement Team (METs) don't wait for individuals who are struggling to come into the office — they go find them, help them, and reconnect them to **life-saving medical care**, mental health services, and medications.
- The METs address immediate needs to **mitigate barriers to receiving care**, such as securing access to transportation to and from appointments and access to nutritious food.
- The patient navigator, case manager, and licensed social worker of each MET have extensive work experience addressing the complex needs of individuals that have **multiple chronic health conditions**, and they have the resolve necessary to connect them to appropriate medical care and behavioral health services.

[1] "HIV/AIDS Care Continuum." AIDS.gov. U.S. Department of Health & Human Services, 6 Mar. 2015. Web. 11 May 2015.
[2] "Prevention Benefits of HIV Treatment." Centers for Disease Control & Prevention, 2013. Web. 11 May 2015.

Initial Trends of AmidaCONNECT

Amida Care's role as a Health Plan uniquely positions the Plan to connect individuals in need of complex services to care in a timely manner due to access to insurance claims. Since 2011, over 800 members have been enrolled in the MET program. Of program enrollees, 94% were re-engaged in care during enrollment (over 70% were re-engaged within 60 days). According to the latest HIV care continuum data from the AIDS Institute of the New York State Department of Health, 65% of New Yorkers living with an HIV diagnosis had an HIV care visit during the year, with just 56% maintaining continuous care during the year. While it is difficult to compare the program's statistics that represent a snapshot in time with statewide data that includes a larger population of people living with HIV/AIDS in New York State who may not have the same complex co-morbidities of the population of AmidaCONNECT, the great difference between these figures demonstrate the value of this intervention.

CLIENT STORY

"Jane" was referred to AmidaCONNECT due to inconsistency seeing her primary care provider/HIV specialist, as well as keeping her behavioral health appointments. Utilizing motivational interviewing skills, MET staff encouraged Jane to seek medical and behavioral health support services and discussed the importance of treatment adherence. The MET Patient Navigator assisted the member in making medical and behavioral health appointments and followed up with Jane and her providers to ensure she was able to keep appointments, which, with support from the MET, she has been consistently attending. Jane, who has a long history of substance use, communicated that she wished to continue her abstinence, so the MET Case Manager referred her to a recovery support group within the agency, which she regularly attended. In addition, Jane successfully completed several on-site substance use trainings, and reported wanting to get her GED. The MET Case Manager linked her to an educational opportunity center, and Jane enrolled and is still attending GED classes. Jane is receiving both medical and behavioral health services and her most recent labs confirm that she is adherent to her antiretroviral medication, allowing her to be virally suppressed and achieving the goal of antiretroviral therapy.*

**Jane is a pseudonym for a client at Amida Care.*

Unique Aspects of AmidaCONNECT

Amida Care, as a health plan, is able to obtain information about psychiatric and substance use inpatient admissions and hospitalizations in real-time for its members. As such, many referrals to AmidaCONNECT are made for members while they are hospitalized. This expedited referral process allows MET staff to meet potential enrollees while they are still in the facility and begin to build a relationship and arrange services to begin immediately upon discharge, ultimately ensuring that a person does not fall between the cracks.

Agency Overview

Amida Care is a community sponsored, not-for-profit, Medicaid Special Needs health plan that provides comprehensive medical, behavioral, pharmaceutical, and psychosocial support and quality of life enhancement services to over 6,000 individuals living with multiple chronic conditions, including HIV/AIDS, in New York City. Amida Care's unique model delivers the most effective care to populations needing intense services, and assists each member in receiving the right care, at the right time, and enough of it to improve health outcomes.

AMIDA CARE
ABOVE AND BEYOND FOR YOU

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