Bronx Health Connect

BOOM!Health's Integrated Services Create a Seamless Continuum of Care for the Most Marginalized Individuals in the Bronx

WE ADDRESS THE UNIQUE NEEDS OF PEOPLE LIVING WITH HIV THAT ALSO EXPERIENCE MENTAL HEALTH AND SUBSTANCE USE DISORDERS, AS WELL AS THOSE THAT ARE HOMELESS OR MARGINALLY HOUSED.

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), 30% had achieved viral suppression, which means that only 3 out of 10 people living with HIV had the virus under control. Viral suppression results in significantly improved health outcomes as well as dramatically decreased likelihood of HIV transmission (96% reduced risk of sexual transmission). The challenge of linking and retaining people living with HIV in care and treatment can be demonstrated by CDC data, which reveals that 14% of PLWH remain undiagnosed, and of those diagnosed, only 40% receive and stay in regular HIV medical care.[1] Successful retention in medical care is defined as one medical visit during each six month period of a 24-month interval, spaced more than 60 days apart, and this medical visit frequency improves survival, and allows people to be as healthy as possible.[2] Thus, the need to improve along the HIV care continuum plays a critical role in both care and prevention.

What Are We Doing?

BOOM!Health's Bronx Health Connect (BHC) program is an innovative harm reduction approach designed to maximize effectiveness along key points in the HIV treatment cascade, including linkage to care, engagement and retention in care, and access and adherence services. BHC provides intensive services such as outreach, health navigation, peer support, adherence reminders and counseling. In addition, the team also connects participants to onsite primary care, behavioral health and pharmacy services, as well as supportive services. The team works closely with BOOM!Health's Medicaid Redesign Team to ensure the participants address their housing needs, are appropriately housed, and maintain stable housing.

UNIQUE FEATURES OF BRONX HEALTH CONNECT

The BHC program offers unique features in order to strengthen the HIV continuum of care:

- **Health & Peer Navigation:** The Peer Navigators (PNs) chosen to work with this project play a critical role in the work with the participants. The PNs have the experience and skills necessary to connect with the participants on a deeper level; understanding their issues and reported barriers. BHC assesses the needs and barriers of each participant and ensures timely linkage to care and adherence services.
- **Co-located Medical Services:** Having access to on-site medical and psychiatric services with **Brightpoint Health** (FQHC formerly known as HELP/PSI) allows the team the opportunity to immediately link participants who are not in care with medical and mental health providers.
- **BOOM!Pharmacy:** Our on-site pharmacy provides participants with personalized attention and treatment adherence support when receiving their medications. The BHC team works closely with the pharmacist when participants need further treatment adherence services.
- **Medication Reminder Tool:** This tool has been instrumental in helping those participants who use it to manage their medications and keep track of their regimen.

[1] "HIV/AIDS Care Continuum." AIDS.gov. U.S. Department of Health & Human Services, 6 Mar. 2015. Web. 11 May 2015.
[2] "HAB HIV Performance Measures." Health Resources and Services Administration. U.S. Department of Health & Human Services, Nov. 2013. Web. 11 May 2015.

CLIENT STORY

BOOM!Health has seen improvement in the medical outcomes of many of the BHC participants. One of the participants is "C.B.," a 34 year old transgender female who enrolled in the BHC program in late 2014, and because of a cross-state move, experienced unstable housing. Upon enrollment in BHC, C.B's Viral Load (VL) was 20890 and her CD4 count was 455. The VL refers to the amount of HIV in the person's blood, having a high viral load increases the chances that C.B. can transmit HIV to someone else, as well as makes her prone to HIV related illnesses. The CD4 or T-cells are the white blood cells which helps the body fight infections. Therefore, in order to get her out of this dangerous zone, reducing the viral load was a top priority for the participant and the team. The participant was refusing to take her medication because she wanted to develop AIDS in order to qualify for HIV/AIDS Services Administrations (HASA) and get housing assistance. The Peer Navigator was able to obtain the medical records from her previous state of residence, and discovered that C.B. actually qualified for HASA benefits/services. The team was able to open the case, which entitled her to receive several benefits, including rental assistance. BHC worked closely with the HASA worker to ensure housing was obtained for the participant. C.B. was able to secure an apartment, which has helped significantly with her medication adherence. Less than six months later, C.B.'s VL was 230 and CD4 was 766, which reduces the chances of C.B. contracting any opportunistic infections and transmitting HIV. C.B. has expressed her gratitude to the BHC team and attributes securing housing and stabilizing her medical care to the support services she receives from the team.*

**C.B. is a pseudonym for a client at BOOM!Health.*

Initial Trends of Bronx Health Connect

The program has seen much success in helping to improve access and adherence to HIV services. One of the program highlights is that 100% of our participants are currently linked to medical care and are adherent to their antiretroviral therapy. Based on evaluation data from Year 2, 82% of enrolled participants were linked to care and 87% were retained in care. According to 2012 data from the New York State Department of Health (NYSDOH) AIDS Insitute, 65% of individuals living with HIV were retained in care after being connected to medical care. The goal of AIDS Institute was to increase retention rate to 86% by 2015, which means BHC has already exceeded that goal. In Year 1, only 47% of the participants received mental health services at Brightpoint Health. Year 2 data shows that 86% of our participants are receiving mental health services and are taking psychiatric medication.

What We Want You to Know

BHC is a valuable program to BOOM!Health and the participants receiving services. The BHC participants receive compassionate and coordinated care from the team with the goal of strengthening the HIV continuum of care and improving health outcomes for the community.

Agency Overview

In an effort to go beyond their original missions, Bronx AIDS Services and Citiwide Harm Reduction merged and formed BOOM!Health. BOOM!Health is a non-profit organization that supports low-income program participants on their journey to health, wellness and self-sufficiency in Bronx, NY. BOOM!Health services some of the most vulnerable populations in the Bronx, including chronically homeless adults, people living with HIV, at-risk youth, and individuals experiencing mental health and substance use issues. Through programs like Bronx Health Connect, BOOM!Health is transforming the lives of those in the community.

BOOM! HEALTH

PROGRAM CONTACT

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