Key Stakeholder Perceptions of a Mobile HIV Care Model to Re-engage and Retain Out-of-care People Living with HIV in Atlanta, Georgia

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BACKGROUND
- Nationally, approximately 51% of 581,000 people living with HIV (PLWH) are out of care (1)
- The South has the greatest burden of HIV-related deaths and new HIV diagnoses out of any region in the U.S. (2)
- Atlanta is an epicenter of the HIV epidemic (40,000 PLWH and second highest rate of diagnoses in metro areas) (3,4)
- Retention in HIV care is important to improving individual and population level HIV outcomes (5,6)
- Mobile health clinics have been used to reach vulnerable populations for other health services and overcome barriers to health care access: transportation barriers, financial costs, absence of patient-centered care, hours of operation, complexity of healthcare system, feelings of intimidation by healthcare setting (7,8)
- Limited published literature on the use of mobile health clinics for HIV treatment (limited to: HIV testing and counseling, as an addition to another primary health service goal, in international settings to reach rural populations)
- Formative research is needed to describe potential challenges of a mobile HIV care model as well as facilitators to effective implementation

OBJECTIVE
To understand the potential of mobile HIV treatment as an alternative treatment model for PLWH who have fallen out of care and to explore various stakeholder perspectives of how this model could be implemented in Atlanta, Georgia.

METHODS
- 36 in-depth interviews conducted June 2019 - December 2019 as part of a larger mixed-methods study that also examined patient perspectives
- Six participant categories: clinic providers and staff, Community Advisory Board Members, Aids service organization staff, hospital regulatory officials, city officials, staff of existing mobile health clinics
- Average interview time: 47 minutes
- Setting: large Infectious Diseases clinic that receives Ryan White Program funding and surrounding Atlanta Metropolitan Area
- Thematic analysis using MAXQDA
- Ethical Considerations: Consent was obtained from all participants. Data were de-identified prior to analysis; Emory IRB approved the study

RESULTS
Key themes emerged representing the advantages of mobile HIV clinics (MHCs) at the patient-, clinic-, and environmental-level (1)

Table 1: Justification and Advantages of Mobile HIV Clinics

<table>
<thead>
<tr>
<th>Patient</th>
<th>Convenience</th>
<th>Perceived effectiveness for those with social and functional barriers</th>
<th>Confidentiality</th>
<th>Reducing shame of falling out of care that prevents re-engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td>Greater community reach</td>
<td>Ability to provide more care options for those that have fallen out of traditional models</td>
<td>Increased ability to provide patient-centered care</td>
<td>Opportunity for clinic to engage in different, more meaningful way</td>
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<tr>
<td>Environment</td>
<td>Greater potential to partner with city and community organizations</td>
<td>Could decrease community-level stigma by reframing care</td>
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</table>

Participants described potential barriers to an MHC (separated into patient-, clinic-, and environmental-levels in table 2) that, if not addressed, would decrease the effectiveness of the model as an alternative care option for PLWH who are out of care

Table 2: Barriers to an Effective Mobile HIV Clinic Model

<table>
<thead>
<tr>
<th>Patient</th>
<th>Confidentiality and Stigma</th>
<th>Patients’ lack of physical and emotional comfort with the model (affected by potential stigma)</th>
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<td></td>
<td>Hesitancy to trust clinic/new providers (unfamiliarity or bad experience with HIV testing vans)</td>
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<td>Accessibility concerns of different locations (and parking availability)</td>
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<td></td>
<td>Potential that patients fall out of other necessary medical care</td>
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<td>Decreasing patients’ responsibility and self-efficacy in their care (seen as enabling; sends message it is always the clinic’s job to track them down)</td>
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<tr>
<td>Clinic</td>
<td>Potential high cost (start-up cost, costs of potential underutilization, cost-effectiveness for number of patients)</td>
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<td></td>
<td>Limited capacity (number of patients seen at one time, service limits, scheduling limits)</td>
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<td>Ability to adhere to privacy/confidentiality policies and practices</td>
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<td></td>
<td>Safety concerns (target for theft for equipment, medications, and prescription pads; target for stigma-related hate; possible irate patients; safety concerns affected by location and community acceptance)</td>
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<td>Staffing/time limitations</td>
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<td>Ability to handle urgent/emergency situations</td>
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<td>Adequate awareness of the MHC among the target population (reaching them and being able to communicate about the model in an appropriate, acceptable way)</td>
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<td>Potential lack of HIV care provision of equal quality to clinic setting</td>
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<td></td>
<td>Fragmentation of existing patient-provider relationships and discontinuity of care</td>
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<tr>
<td>Environment</td>
<td>Community acceptance and safety (permissions to park, generator noises, community attitudes, effects of potential stigma connected to MHC)</td>
<td></td>
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</table>

Participants described ways these potential barriers could be addressed in the design and implementation of an MHC model. Key facilitators include:
- Providing non-HIV services alongside HIV services to mitigate stigma and protect confidentiality
- An appropriate outside appearance to facilitate welcoming environment and protect confidentiality
- Scheduling appointments to limit waiting, promote privacy, and limit cost of underutilization
- Parking in an accessible, well-trafficked location that blends into community
- Considering multiple dimensions of safety in MHC design (i.e. working with police to determine locations, provider training, security personnel, encrypted electronics, panic buttons)
- Promoting community acceptance and/or partnering with trusted community organizations

DISCUSSION
- Five key considerations to an effective mobile HIV clinic emerged from the data (figure 1)
- Development of an MHC should be responsive to these factors in order to be acceptable and successful
- Next steps: evaluate patient perspectives, develop MHC model integrating findings, allow for feedback and revision from stakeholders, solicit community feedback, pilot test and refine, study effectiveness vs. clinic-based care
- If proven effective, an MHC model has potential to be adapted and scaled to RWP clinics across the U.S. to help foster reengagement and retention of the 581,000 (1) PLWH who are out of care

Figure 1: Key Considerations to Implementation of an Effective Mobile HIV Care Model to Reach People Living with HIV who are Out of Care

ADDITIONAL INFORMATION

References:

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