Getting to Zero +
The View from Baltimore
-or-
A Tale of Two Cities

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Baltimore in the 1980s

HIV in Baltimore 1985-2010

Living HIV/AIDS Cases, Baltimore City
Change came to the Baltimore Epidemic - IDUs

Decreasing New HIV Cases

Getting to Zero + Increasing the Momentum

- In addition to decreasing cases, transmission patterns were changing – those living with HIV but not engaged in care were significant contributors to the epidemic.
- Engagement would not be easy - listening, engaging, creating and persisting were required.
- Incorporate critical feedback from consumers and stakeholders in our activities.
- Getting to Zero plus was born, building upon the JHU Bartlett Clinic experience.
• 136 eligible patients with a detectable viral load, 126 (90%) were reached by GTZ Navigator.
• N=126; 90% were male, 90% Black, 81% ≥ 35; 30% reported MSM- and 25% injection drug use as HIV exposure.
• Among patients with >1 repeat viral load, 70% (n=79) achieved viral suppression. 20% sustained viral suppression ≤100 for ≥6 months.
• Overall, 95% patients received ≥10 CHW encounters, with an average of 8 encounters (range 1–36) for patients ever virally suppressed and 7 (range 1–23) for patients not suppressed.

Pillars of The GTZ+ Plan:
• Education / Capacity Building / Information dissemination
• Technical Assistance to Clinics
  • HIV Testing, Linkage to care
  • Navigator support services using an IMB adherence model
  • Data management support
• Data Informed GTZ Provider Support
• Evaluation of intervention effect

“Unapologetically enabling”
• Removal of any potential barrier to:
  • Linkage / Access
  • Engagement
  • Retention
  • Adherence
• Focused on community solutions:
  • The program goes beyond the brick and mortar to:
    • Creates opportunity outside traditional clinical spaces
    • Facilitates communication outside traditional clinical hours
    • Supporting new type of client/navigator relationships

Bernard C. “Jack” Young, Mayor
Letitia Dzirasa, M.D.
Commissioner of Health, Baltimore City

GTZ Data - July 2019 – May 2020
Bartlett Specialty Clinic - Updated

Baltimore City Health Department

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The Overall Goal: Viral Suppression

- Community Health Workers (CHW) in clinical settings, and CHW/Disease Intervention Specialist (DIS) hybrids in mobile settings.
- Navigators link and engage individuals into HIV care with the goals of: (1) maintained care linkage; (2) improved health outcomes; (3) maintained viral suppression; (4) reduced HIV transmission and (5) faster response to new HIV cases.
- Getting to Zero Plus (GTZ+) targets the reservoir of undiagnosed, unengaged and virally unsuppressed individuals with a focus on youth, YMSM, racial and ethnic minority women, formerly incarcerated, and the marginally housed.
- The GTZ+ navigator-based linkage and engagement program is customized to meet the needs of each targeted population as described in our methodology.

GTZ Program Set up: The FQHC Collaboration

- Determine GTZ Site Champion(s)
- Define/Develop/Adapt protocols: link sharing and collaboration agreement
- CHW/DIS Data Sharing: reviews and updates: VL reports from Bartlett pilot project
- Determine staffing needs
- Monitor and evaluate

GTZ+ Navigator Interventions

Initial outreach:
- Via Phone:
  - Barriers assessment; schedule time to meet at location of patient’s choice; scheduling appointment(s)
- Standardized barrier assessment will be made available to all sites

In-person/In Community:
- Addresses immediate health and psychosocial needs: housing, shower, etc. access to resources/benefits: official identification, other referrals (HIV/MH, SUD); nutrition; emotional support: clothing/hygiene
- Coordinates with community partners for services.
Summary

- Getting to Zero + builds upon an existing model and expands it to respond to consumer feedback, as well as be nimble in mobile/street settings.
- The overall goal is viral suppression, but care engagement, enhancing trust and removing barriers to care are equally important.
- The team is a collaboration of new and existing partners, including novel housing services and established syringe support programs.
- Creativity to meet the needs of the population, such as a CHW/DS hybrid to accomplish mandated activities while meeting client need.
- CHW input can identify barriers to care engagement that may be overlooked or seem unimportant that have significant impact.
- In a city with so many challenges, this provides a structure upon which to build collaborations and interventions.

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