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Ryan White Programming that primarily supports clinical care falls short when core people needs are not met: Further evidence from the Medical Monitoring Project

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In the paper by Dasgupta et al., the authors examine the unmet needs for ancillary services for people living with HIV (PLWH). These services were categorized as HIV clinical support services (ie. medication coverage), other medical services (ie. dental) or subsistence services (ie. food). The authors utilize information from the 2017–2019 cycles of the CDC Medical Monitoring Project (MMP) and then explore how unmet needs vary by insurance type and Ryan White HIV/AIDS Program (RWHAP) participation. As would be expected, nearly half of PLWH reported having at least one ancillary care need and those uninsured experienced high levels (58.7%) of at least one unmet need. In addition, unmet need for subsistence services were not improved by RWHAP participation among those uninsured or those with any health care coverage.

Profound social and economic barriers often prevent PLWH from deriving full benefit from efficacious biomedical interventions.[1,2] Efforts to interrupt transmission routinely focus on (re)connecting patients to health systems that they are not currently engaging, for testing and PrEP/ART uptake and adherence. Some innovative approaches seek to use public health surveillance data or clinic-based patient retracing, as the authors suggest. Unfortunately, such strategies have demonstrated minimal effect on viral suppression when tested in controlled trials.[3–5] When PLWH care engagement interventions have been successful[6,7] and other mobile/virtual interventions,[8] they often miss those with significant economic and social disadvantage. Those with these disadvantages include PLWH who are without social support, have sporadic internet or phone access or ability to engage in resource counseling.[9] Maslow Hierarchy's of Needs outlines overlapping barriers and needs (housing, employment, food) that are drivers of lack of care entry and/or care disengagement.[10–13] These are precisely the needs outlined by the authors as subsistence needs. Prior research actually finds lower engagement among Medicaid beneficiaries than among uncovered Ryan White HIV/AIDS Program (RWHAP)-supported PLWH.[14,15] However, evidence suggests that variation in viral suppression persists after transitions between RWHAP-supported coverage, Medicaid, and private insurances. Such patterns suggest that variations likely arise from socioeconomic rather than program factors.[15,16] Economic hardship (i.e., living at or below the poverty line) is one of several risk factors that contribute to HIV transmission

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and non-uptake of PrEP, followed by housing instability and employment.[11,17,18] Health decisions, such as ART and PrEP uptake and persistence, are often pushed to the side in favor of developing economic survival techniques around housing and/or food insecurity. Previous work has found, for example, that food security is linked to incomplete viral suppression. [19,20] Without addressing foundational needs, downstream care continuum outcomes will continue to be negatively impacted.

Engaging community members first around financial well-being has the potential to impact downstream care continua outcomes. Communities of color in the US have been persistently economically disadvantaged due to longstanding practices of structural, institutional, and individual racism and discrimination.[21,22] Collectively, these mechanisms of social, economic and political exclusion and disadvantage produce and deepen severe health disparities.[6,23–25] Unemployment rates among Black adults are 2 times that of White adults, a factor that is also evident among sexual minority men.[30] Furthermore, ethnoracial disparities in employment and layoffs have worsened during the COVID-19 pandemic.[31,32] For sexual minority men of color living with HIV, these disadvantages deepen health inequities and exacerbate the risk of falling out of integrated care continua.[33] Several studies have documented that PLWH who have greater social and economic support (e.g. stable housing, employment, and positive peer relationships) report higher rates of engagement, including testing and less unrecognized HIV infections.[34–37] Other examples leading with foundational needs exist, such as HPTN 073, a social work intervention that prioritized resource counseling for foundational needs over PrEP linkage in order to impact downstream PrEP engagement.[38] More recently, we used a *Flipping the Script* approach to engage clients in COVID-19 contact tracing whereby subsistence resources, i.e., cash transfers, employment support and health insurance, were initiated *prior* to asking about recent close contacts.[39,40] While ‘resources first’ is an intuitive approach, operationalization and attention to specific intervention agents and ingredients have not been systematically explored within rigorous implementation science frameworks. Yet such supports are pivotal for ensuring equitable and sustained access, uptake, and retention in treatment modalities necessary to achieve Getting to Zero’s goal of no new infections by 2030–2040.[41,42]

Existing Ryan White Case Management (CM) models, which could address core needs, are hampered by several factors, including limitations in amounts that can be allocated to subsistence needs.[43,44] Innovation and attention is needed to support the HIV care workforce. Ryan White case managers and other social service professionals, for example, working with PLWH experience frequent burnout (e.g. emotional exhaustion, reduced professional accomplishment, and apathetic tendencies towards clients and coworkers).[45–47] Intense client and administrative demands also lead to higher stress environments, which can hinder CMs’ abilities to provide effective supportive services.[45] Maintaining professional boundaries can become especially difficult when clients are experiencing crises, or when CMs enter unfamiliar spaces or are taking work-related calls/request late into the evening.[45,48,49] These boundary challenges are often exacerbated by lack of quality supervision, poor support from the larger team, and an ever-increasing caseload with limited resources.[45,50] Administrative workload for social service and healthcare workers has increased over the years, which may limit time with clients to address barriers to care continua engagement.[45,47,48,51] Of particular relevance, Ginossar et al.[49] examined

HIV provider burnout and found that organizational culture (i.e., inter-team collaboration) directly impacted burnout, while effective communication reduced emotional exhaustion. In addition, Garner et al.[52] found that providing staff with training, coaching and technical assistance was associated with improved implementation and intervention effectiveness in a hybrid type 2 trial of a substance use intervention for PLWH. These studies highlight the importance of organizational investments and implementation strategies for supporting the HIV workforce, a current gap in the extant research.[53–55] Successful interventions should intensify existing case management resource support systems, which has the potential to not only impact the lives and care continua of PLWH, but also to fulfill an ending the epidemic priority of revitalizing and sustaining the HIV frontline workforce.

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References

1. Auerbach J. Transforming Social Structures And Environments To Help In HIV Prevention. Health Aff (Millwood). 2009;28(6):1655–1665. doi:10.1377/hlthaff.28.6.1655 [PubMed: 19887406]
2. Roberts ET, Matthews DD. HIV and chemoprophylaxis, the importance of considering social structures alongside biomedical and behavioral intervention. Soc Sci Med 1982. 2012;75(9):1555–1561. doi:10.1016/j.socscimed.2012.02.016
3. Dombrowski JC, Hughes JP, Buskin SE, et al. A Cluster Randomized Evaluation of a Health Department Data to Care Intervention Designed to Increase Engagement in HIV Care and Antiretroviral Use. Sex Transm Dis. 2018;45(6):361–367. doi:10.1097/OLQ.0000000000000760 [PubMed: 29465679]
4. Bove JM, Golden MR, Dhanireddy S, Harrington RD, Dombrowski JC. Outcomes of a Clinic-Based Surveillance-Informed Intervention to Relink Patients to HIV Care. J Acquir Immune Defic Syndr 1999. 2015;70(3):262–268. doi:10.1097/QAI.0000000000000707
5. Buchacz K, Chen MJ, Parisi MK, et al. Using HIV Surveillance Registry Data to Re-Link Persons to Care: The RSVP Project in San Francisco. PLoS ONE. 2015;10(3):e0118923. doi:10.1371/journal.pone.0118923
6. Bouris A, Jaffe K, Eavou R, et al. Project nGage: Results of a Randomized Controlled Trial of a Dyadic Network Support Intervention to Retain Young Black Men Who Have Sex With Men in HIV Care. AIDS Behav. 2017;21(12):3618–3629. doi:10.1007/s10461-017-1954-8 [PubMed: 29079949]
7. Bouris A, Voisin D, Pilloton M, et al. Project nGage: Network Supported HIV Care Engagement for Younger Black Men Who Have Sex with Men and Transgender Persons. J AIDS Clin Res. 2013;04(09). doi:10.4172/2155-6113.1000236
8. Garofalo R, Kuhns LM, Hotton A, Johnson A, Muldoon A, Rice D. A Randomized Controlled Trial of Personalized Text Message Reminders to Promote Medication Adherence Among HIV-Positive Adolescents and Young Adults. AIDS Behav. 2016;20(5):1049–1059. doi:10.1007/s10461-015-1192-x [PubMed: 26362167]
9. Garofalo R, Kuhns LM, Hotton A, Johnson A, Muldoon A, Rice D. A Randomized Controlled Trial of Personalized Text Message Reminders to Promote Medication Adherence Among HIV-Positive Adolescents and Young Adults. AIDS Behav. 2016;20(5):1049–1059. doi:10.1007/s10461-015-1192-x [PubMed: 26362167]
10. Maslow AH. A theory of human motivation. Psychol Rev. 1943;50(4):370–396. doi:10.1037/h0054346
11. Wenzel SL, Rhoades H, La Motte-Kerr W, et al. Do HIV risk and prevention behaviors change over time among adults in permanent supportive housing? AIDS Care. 2019;31(9):1172–1177. doi:10.1080/09540121.2019.1576849 [PubMed: 30724581]

12. Wenzel SL, Rhoades H, Harris T, Winetrobe H, Rice E, Henwood B. Risk behavior and access to HIV/AIDS prevention services in a community sample of homeless persons entering permanent supportive housing. AIDS Care. 2017;29(5):570–574. doi:10.1080/09540121.2016.1234690 [PubMed: 27654072]
13. Singer AW, Weiser SD, McCoy SI. Does Food Insecurity Undermine Adherence to Antiretroviral Therapy? A Systematic Review. AIDS Behav. 2015;19(8):1510–1526. doi:10.1007/s10461-014-0873-1 [PubMed: 25096896]
14. Yehia BR, Fleishman JA, Metlay JP, Moore RD, Gebo KA. Sustained Viral Suppression in HIV-Infected Patients Receiving Antiretroviral Therapy. JAMA. 2012;308(4):339–342. doi:10.1001/jama.2012.5927 [PubMed: 22820781]
15. Bradley H, Viall AH, Wortley PM, Dempsey A, Hauck H, Skarbinski J. Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes. Clin Infect Dis Off Publ Infect Dis Soc Am. 2016;62(1):90–98. doi:10.1093/cid/civ708
16. Muthulingam D, Chin J, Hsu L, Scheer S, Schwarcz S. Disparities in engagement in care and viral suppression among persons with HIV. J Acquir Immune Defic Syndr 1999. 2013;63(1):112–119. doi:10.1097/QAI.0b013e3182894555
17. Ayano G, Tsegay L, Solomon M. Food insecurity and the risk of depression in people living with HIV/AIDS: a systematic review and meta-analysis. AIDS Res Ther. 2020;17:36. doi:10.1186/s12981-020-00291-2 [PubMed: 32571426]
18. Pettifor A, MacPhail C, Nguyen N, Rosenberg M. Can Money Prevent the Spread of HIV? A Review of Cash Payments for HIV Prevention. AIDS Behav. 2012;16(7):1729–1738. doi:10.1007/s10461-012-0240-z [PubMed: 22760738]
19. Aibibula W, Cox J, Hamelin AM, Mamiya H, Klein MB, Brassard P. Food insecurity and low CD4 count among HIV-infected people: a systematic review and meta-analysis. AIDS Care. 2016;28(12):1577–1585. doi:10.1080/09540121.2016.1191613 [PubMed: 27306865]
20. Walters SM, Platt J, Anakaraonye A, et al. Considerations for the Design of Pre-exposure Prophylaxis (PrEP) Interventions for Women: Lessons Learned from the Implementation of a Novel PrEP Intervention. AIDS Behav. 2021;25(12):3987–3999. doi:10.1007/s10461-021-03353-2 [PubMed: 34138377]
21. Williams DR. Race, Socioeconomic Status, and Health The Added Effects of Racism and Discrimination. Ann N Y Acad Sci. 1999;896(1):173–188. doi:10.1111/j.1749-6632.1999.tb08114.x [PubMed: 10681897]
22. Williams DR, Collins C. Racial residential segregation: A fundamental cause of racial disparities in health. Public Health Rep. 2001;116(5):404–416. doi:10.1016/S0033-3549(04)50068-7 [PubMed: 12042604]
23. Chan PA, Mena L, Patel R, et al. Retention in care outcomes for HIV pre-exposure prophylaxis implementation programmes among men who have sex with men in three US cities. J Int AIDS Soc. 2016;19(1):20903. doi:10.7448/IAS.19.1.20903 [PubMed: 27302837]
24. Comulada WS, Swendeman DT, Rotheram-Borus MJ, Mattes KM, Weiss RE. Use of HAART among young people living with HIV. Am J Health Behav. 2003;27(4):389–400. doi:10.5993/ajhb.27.4.11 [PubMed: 12882433]
25. DONENBERG GR, EMERSON E, BRYANT FB, WILSON H, WEBER-SHIFRIN E. Understanding AIDS-Risk Behavior Among Adolescents in Psychiatric Care: Links to Psychopathology and Peer Relationships. J Am Acad Child Adolesc Psychiatry. 2001;40(6):642–653. [PubMed: 11392341]
26. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. The Lancet. 2017;389(10077):1453–1463. doi:10.1016/S0140-6736(17)30569-X
27. Boynton-Jarrett R, Raj A, Inwards-Breland DJ. Structural integrity: Recognizing, measuring, and addressing systemic racism and its health impacts. EClinicalMedicine. 2021;36. doi:10.1016/j.eclinm.2021.100921
28. Geronimus AT, Hicken M, Keene D, Bound J. “Weathering” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States. Am J Public Health. 2006;96(5):826–833. doi:10.2105/AJPH.2004.060749 [PubMed: 16380565]

29. Oates GR, Juarez LD, Horswell R, et al. The Association Between Neighborhood Social Vulnerability and COVID-19 Testing, Positivity, and Incidence in Alabama and Louisiana. J Community Health. 2021;46(6):1115–1123. doi:10.1007/s10900-021-00998-x [PubMed: 33966116]
30. Gayles TA, Kuhns LM, Kwon S, Mustanski B, Garofalo R. Socioeconomic Disconnection as a Risk Factor for Increased HIV Infection in Young Men Who Have Sex with Men. LGBT Health. 2016;3(3):219–224. doi:10.1089/lgbt.2015.0102 [PubMed: 27002852]
31. Dias FA. The Racial Gap in Employment and Layoffs during COVID-19 in the United States: A Visualization. Socius Sociol Res Dyn World. 2021;7:2378023120988397. doi:10.1177/2378023120988397
32. Gemelas J, Davison J, Keltner C, Ing S. Inequities in Employment by Race, Ethnicity, and Sector During COVID-19. J Racial Ethn Health Disparities. 2022;9(1):350–355. doi:10.1007/s40615-021-00963-3 [PubMed: 33452573]
33. Myers JE, Braunstein SL, Xia Q, et al. Redefining Prevention and Care: A Status-Neutral Approach to HIV. Open Forum Infect Dis. 2018;5(6):ofy097. doi:10.1093/ofid/ofy097
34. Scott HM, Pollack L, Rebchook GM, Huebner DM, Peterson J, Kegeles SM. Peer Social Support is Associated with Recent HIV Testing Among Young Black Men Who Have Sex with Men. AIDS Behav. 2014;18(5):913–920. doi:10.1007/s10461-013-0608-8 [PubMed: 24065436]
35. Carlos JA, Bingham TA, Stueve A, et al. The Role of Peer Support on Condom Use among Black and Latino MSM in Three Urban Areas. AIDS Educ Prev. 2010;22(5):430–444. doi:10.1521/aeap.2010.22.5.430 [PubMed: 20973663]
36. Lauby JL, Marks G, Bingham T, et al. Having Supportive Social Relationships is Associated with Reduced Risk of Unrecognized HIV Infection Among Black and Latino Men who Have Sex with Men. AIDS Behav. 2012;16(3):508–515. doi:10.1007/s10461-011-0002-3 [PubMed: 21805191]
37. Mashburn AJ, Peterson JL, Bakeman R, Miller RL, Clark LF, for Youth (CITY) Study Team TCIT. Influences on HIV testing among young African-American men who have sex with men and the moderating effect of the geographic setting. J Community Psychol. 2004;32(1):45–60.
38. Wheeler DP, Fields SD, Beauchamp G, et al. Pre-exposure prophylaxis initiation and adherence among Black men who have sex with men (MSM) in three US cities: results from the HPTN 073 study. J Int AIDS Soc. 2019;22(2):e25223. doi:10.1002/jia2.25223 [PubMed: 30768776]
39. Schneider JA, Pollack HA. Flipping the Script for Coronavirus Disease 2019 Contact Tracing. JAMA Health Forum. 2020;1(9):e201129. doi:10.1001/jamahealthforum.2020.1129
40. COVID-19 Contact Tracing Conundrums: Insights From the Front Lines | AJPH | Vol. 111 Issue 5. Accessed January 6, 2022. 10.2105/AJPH.2021.306200
41. Khanna AS, Edali M, Ozik J, et al. Projecting the number of new HIV infections to formulate the “Getting to Zero” strategy in Illinois, USA. Math Biosci Eng. 2021;18(4):3922–3938. doi:10.3934/mbe.2021196 [PubMed: 34198418]
42. KHANNA AS, SCHNEIDER JA, COLLIER N, et al. A modeling framework to inform PrEP initiation and retention scale-up in the context of Getting to Zero Initiatives. AIDS Lond Engl. 2019;33(12):1911–1922. doi:10.1097/QAD.0000000000002290
43. López JD, Shacham E, Brown T. The Impact of Clinic Policy Attendance and the Ryan White HIV/AIDS Medical Case Management Program on HIV Clinical Outcomes: A Retrospective Longitudinal Study. AIDS Behav. 2020;24(4):1161–1169. doi:10.1007/s10461-019-02738-8 [PubMed: 31768689]
44. López JD, Shacham E, Brown T. The Impact of the Ryan White HIV/AIDS Medical Case Management Program on HIV Clinical Outcomes: A Longitudinal Study. AIDS Behav. 2018;22(9):3091–3099. doi:10.1007/s10461-018-2124-3 [PubMed: 29691681]
45. Rehder K, Adair KC, Sexton JB. The Science of Health Care Worker Burnout: Assessing and Improving Health Care Worker Well-Being. Arch Pathol Lab Med. 2021;145(9):1095–1109. doi:10.5858/arpa.2020-0557-RA [PubMed: 34459858]
46. Kristensen TS, Borritz M, Villadsen E, Christensen KB. The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. Work Stress. 2005;19(3):192–207. doi:10.1080/02678370500297720

47. Lee RT, Seo B, Hladkyj S, Lovell BL, Schwartzmann L. Correlates of physician burnout across regions and specialties: a meta-analysis. Hum Resour Health. 2013;11:48. doi:10.1186/1478-4491-11-48 [PubMed: 24074053]

48. Benevides-Pereira AMT, Das Neves Alves R. A study on burnout syndrome in healthcare providers to people living with HIV. AIDS Care. 2007;19(4):565–571. doi:10.1080/09540120600722775 [PubMed: 17453599]

49. Ginossar T, Oetzel J, Hill R, Avila M, Archiopoli A, Wilcox B. HIV health-care providers' burnout: can organizational culture make a difference? AIDS Care. 2014;26(12):1605–1608. doi:10.1080/09540121.2014.936819 [PubMed: 25025453]

50. Walters JE, Brown AR, Jones AE. Use of the Copenhagen Burnout Inventory with Social Workers: A Confirmatory Factor Analysis. Hum Serv Organ Manag Leadersh Gov. 2018;42(5):437–456. doi:10.1080/23303131.2018.1532371

51. Wirth T, Mette J, Prill J, Harth V, Nienhaus A. Working conditions, mental health and coping of staff in social work with refugees and homeless individuals: A scoping review. Health Soc Care Community. 2019;27(4):e257–e269. doi:10.1111/hsc.12730 [PubMed: 30821875]

52. Garner BR, Gotham HJ, Chaple M, et al. The implementation and sustainment facilitation strategy improved implementation effectiveness and intervention effectiveness: Results from a cluster-randomized, type 2 hybrid trial. Implement Res Pract. 2020;1:263348952094807. doi:10.1177/2633489520948073

53. Mody A, Geng EH. Conceptualising implementation strategies in HIV research. Lancet HIV. 2020;7(6):e382. doi:10.1016/S2352-3018(20)30142-9

54. Shangani S, Bhaskar N, Richmond N, Operario D, van den Berg JJ. A systematic review of early adoption of implementation science for HIV prevention or treatment in the United States. AIDS Lond Engl. 2021;35(2):177–191. doi:10.1097/QAD.0000000000002713

55. Smith JD, Li DH, Hirschhorn LR, et al. Landscape of HIV Implementation Research Funded by the National Institutes of Health: A Mapping Review of Project Abstracts. AIDS Behav. 2020;24(6):1903–1911. doi:10.1007/s10461-019-02764-6 [PubMed: 31845078]