Reducing HIV-related disparities and inequities by integrating Community Health Workers in HIV Clinical Care Teams

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INTRODUCTION

The Southern Nevada Health District (SNHD), through funding from the Secretary's Minority AIDS Initiative with technical assistance from Boston University, developed and implemented a program to improve linkage and retention in HIV care utilizing Community Health Workers (CHWs). Utilizing the team approach, the program demonstrated increased patient engagement and viral suppression among both newly diagnosed and out-of-care clients. These successful outcomes led to the recognition of CHWs as key care team members in the delivery of HIV care services and expansion into two additional program areas. The first additional program was Transitional Case Management (TCM) in Southern Nevada Prisons. SNHD, alongside The Office of HIV Nevada Department of Health and Human Services, partnered with The Nevada Department of Corrections to develop a workflow for referring and following-up with inmates living with HIV after they have been discharged from the facility. The second program, Rapid stART, was implemented for newly diagnosed patients with the goal to initiate early antiretroviral treatment (ART) regardless of CD4 count. SNHD partnered with Nevada State Ryan White Part B to pilot Rapid Eligibility Determination to give patients access to medication within 30 days of their HIV diagnosis.

METHODS

Team Approach to Care Coordination

- Lead Community Health Nurse – receives and reviews referral
- Referrals assigned to appropriate team member or care team
- CHW receives referral
- CHW contacts client, introduces the program and offers services
- CHW works with the patient and care team to created an individualized care plan with goal to move patients through the HIV Care Continuum
- CHW transitions patient to other case management according to patient's preference (SNHD case manager, community partner, etc.)

CHW Roles and Goals

- Provide culturally sensitive, client-centered services from a consumer perspective
- Assist patients in navigating health care system
- Coordinate with the RW care team to help patients meet goals
- Participate in team conferences to present client perspectives, strengthen team rapport, and promote ongoing learning and self-improvement
- Collaborate with community partners to maximize use of available resources
- Patient-centered approach - *Meets client where they are:* physically, culturally, financially etc.

CHALLENGES/ LIMITATIONS

- Sustainability. Funding is essential to achieve success.
- Transportation continues to be a challenge for some clients in case management. Due to health conditions that prevent them from utilizing public transportation. Situation aggravated by change in company policy averting case managers to transport clients.
- Lack of residential addresses and phone numbers complicates the process of locating clients. Due to HIPPA laws clients can not be contacted in day shelters.
- Predominantly clients share multiple underlying conditions in addition to HIV/AIDS: socioeconomic, substance abuse, mental health etc.

LESSONS LEARNED

- Leave open slot on provider schedule. Three Rapid patients in one day.
- Initial Visit may take 2-4 hours if 4-5 appointments are consolidated. Have snacks available.
- Effective marketing of the project through partner CBOs leads to higher community engagement.
- Family dynamics: disclosure of HIV status is affected by fear of being stigmatized by family and friends.
- There is fear that using public resources may affect application for legal status.
- Language issues: Participants benefit by being assigned a CHW that spoke their native language.
- Psychosocial support is important for client to achieve self-efficacy.

Figure 1: Number of unduplicated clients by Race/Ethnicity
October –December 2019

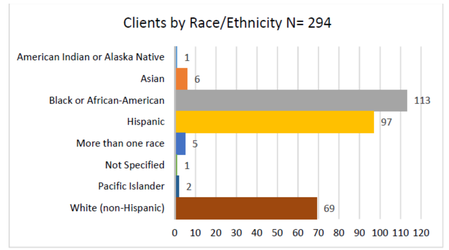
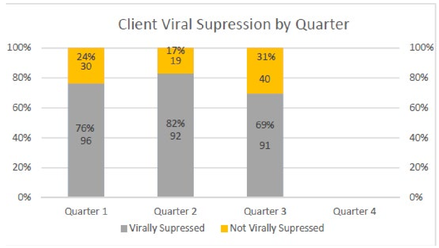


Figure 2: Client Viral Suppression by Quarter
October –December 2019



RESULTS

- The program saw increased linkage, retention, and viral suppression rates among those enrolled in the CHW Program.
- Clients verbalized that reason for them linking, adhering, and staying in care is partly or largely due the supportive relationships with the RW interdisciplinary team, which include the CHW's.
- The program served 40% African-American with the second most being the Latinx group 33%. Please see figure 1.