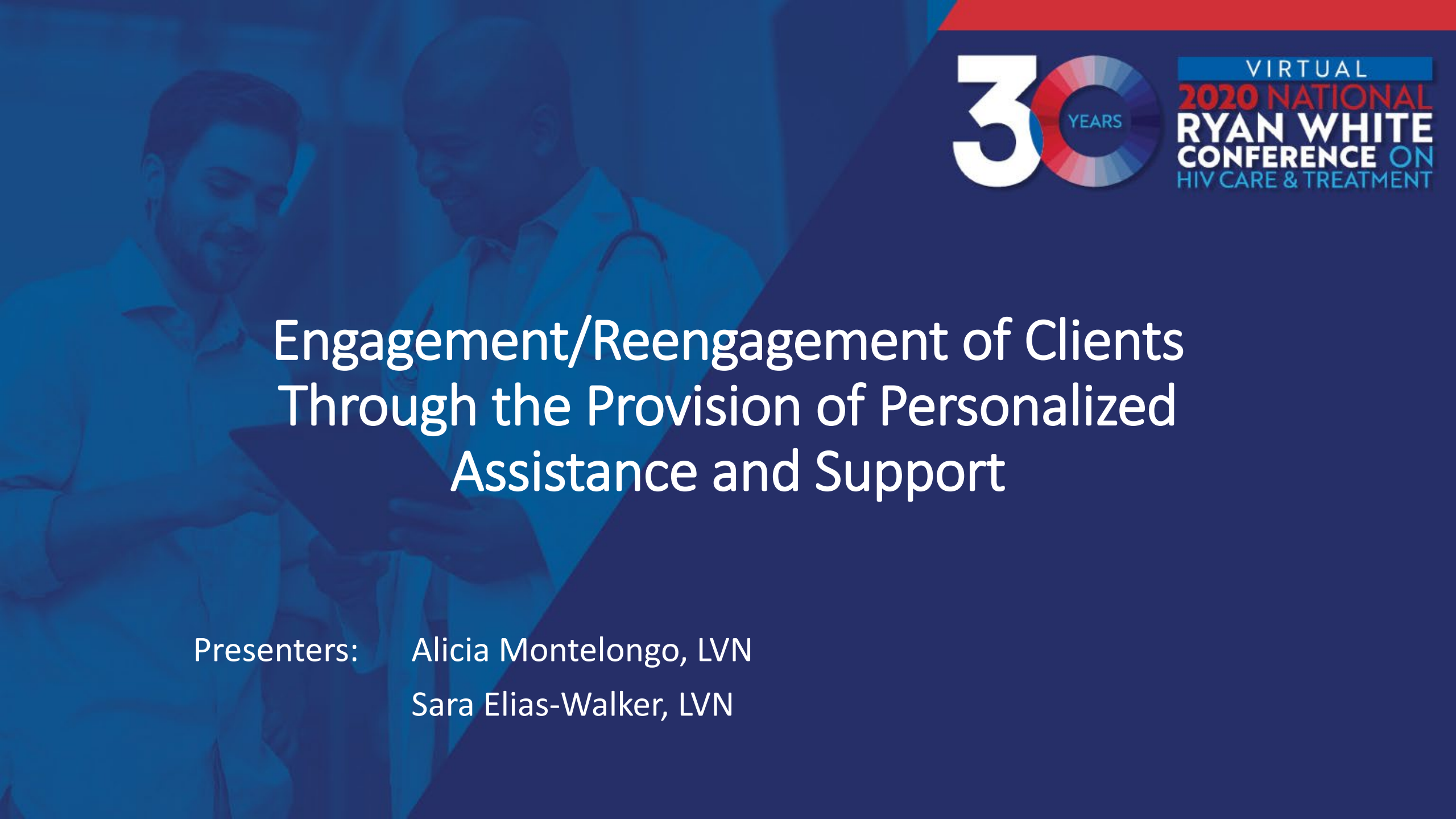


VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

# Engagement/Reengagement of Clients Through the Provision of Personalized Assistance and Support


Presenters: Alicia Montelongo, LVN

Sara Elias-Walker, LVN

# Disclosures

DISCLOSURES

Presenters have no relevant financial or non-financial interests to disclose.

Commercial support was not received for this activity.

# Introduction



University Health System

Thinking beyond

**Bexar County Hospital District**
**Over 100 Years of Service**
**San Antonio, Texas**

# Bexar County Hospital District dba University Health System



- South Texas' only safety net health system
- Texas' 3rd largest health system
- 28 County Service Region across South Texas
- More than 8,800 employees
- Level 1 Trauma Center
- South Texas' first and only health system to earn Magnet status from the American Nurses Credentialing Center

# Family Focused AIDS Clinical Treatment Services clinic (FFACTS)

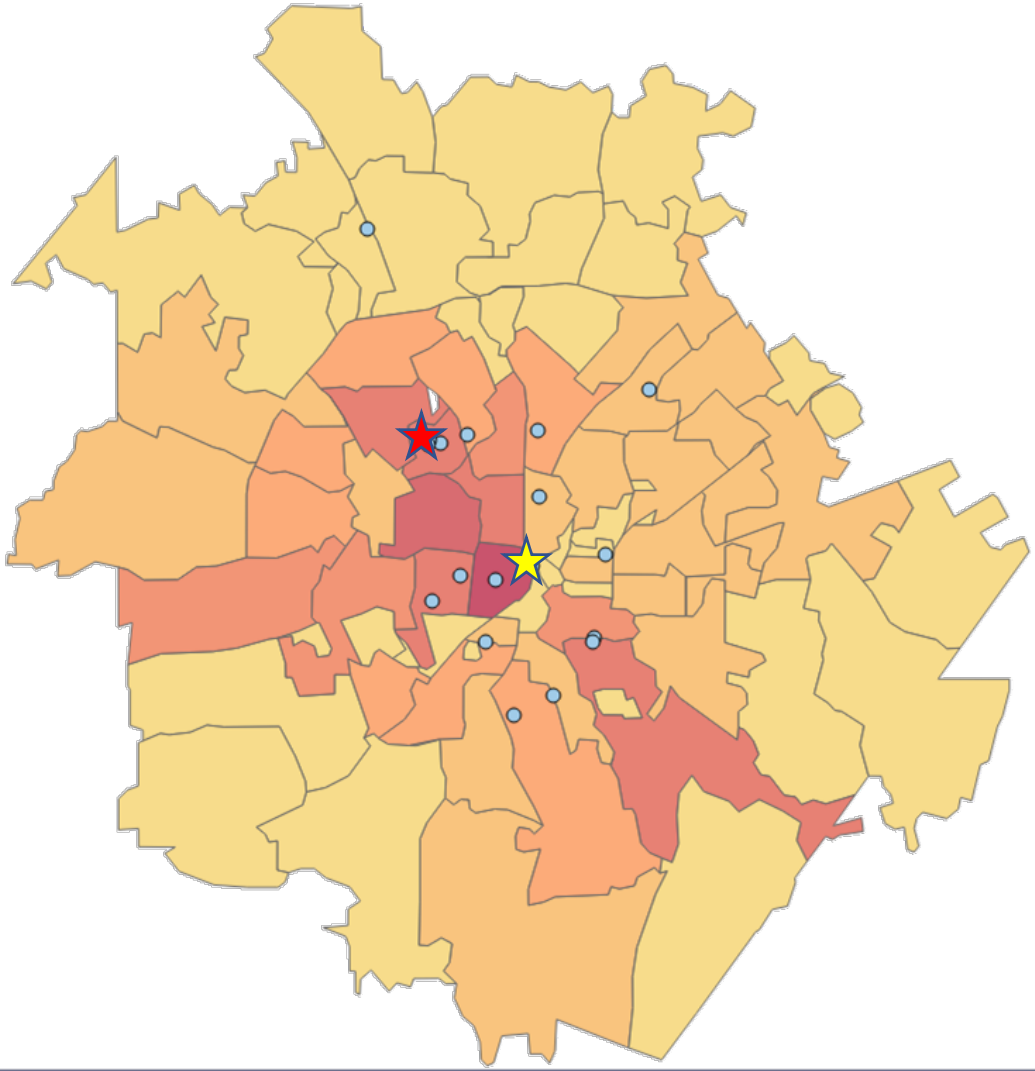


- A University Health System outpatient HIV/AIDS clinic funded in part by the Ryan White Program
- Strives to improve the health and well-being of PWH in San Antonio and South Texas by continuously providing the highest quality care
- Partners with UT Health San Antonio to offer comprehensive services

# Bexar County Hospital District dba University Health System

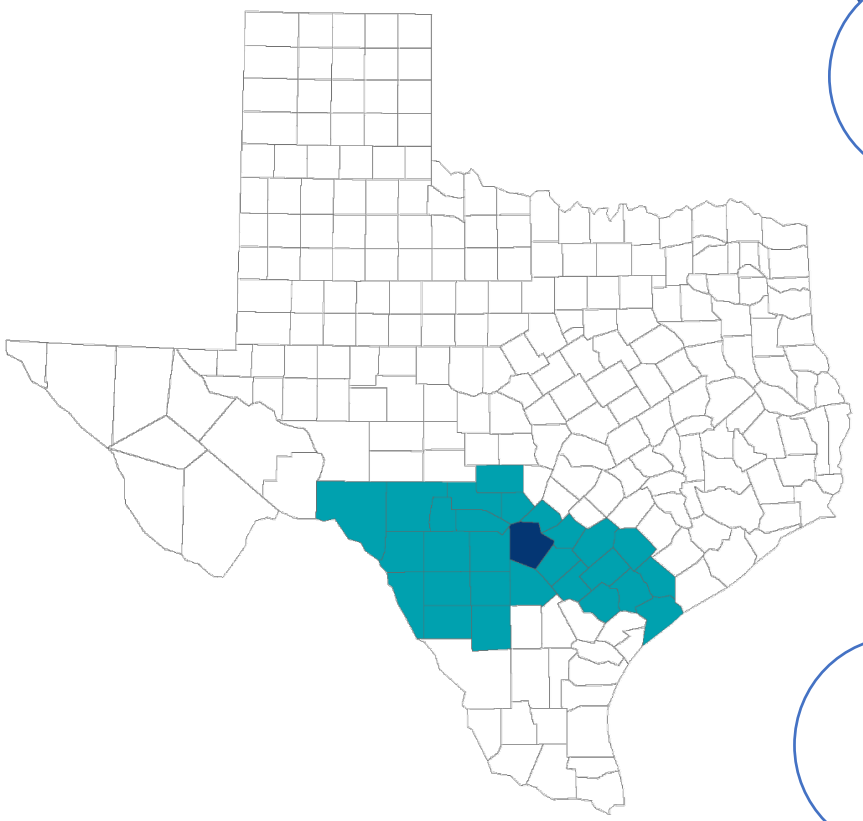


- University Hospital
- Ambulatory and urgent care locations
- Family Focused AIDS Clinical Treatment Services clinic (FFACTS)
  - Largest Provider of Specialty HIV services in South Texas



# Bexar County Hospital District dba University Health System





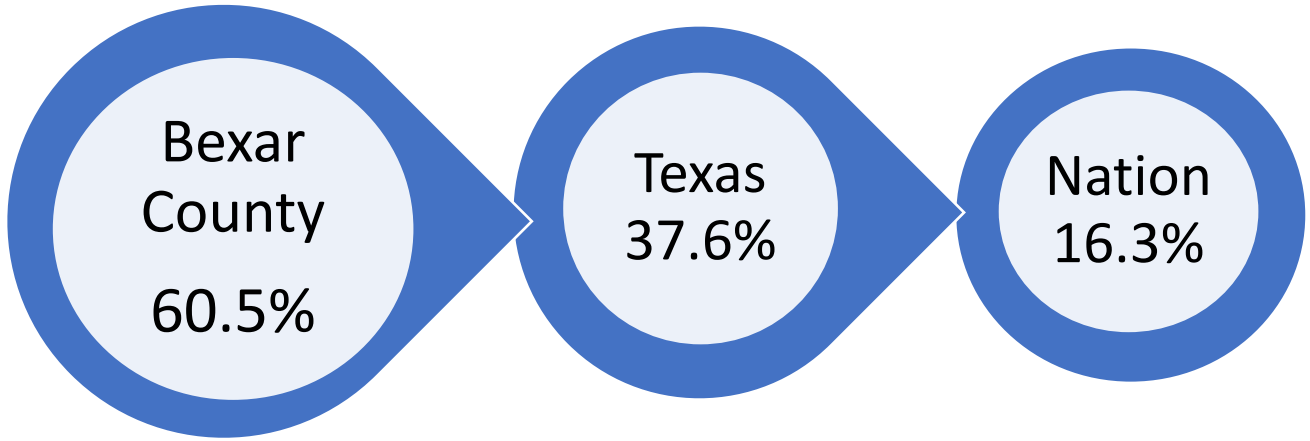
- Approximately 2.5 million people in 28 county service region
- Contains San Antonio, the 7th largest city in the United States
- Bexar County houses 94% of the region's people living with HIV (PWH)

Reference: Bureau of the U.S. Census. American FactFinder Results Bexar County. 2010; https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.

# Service Region



General Population % Hispanic



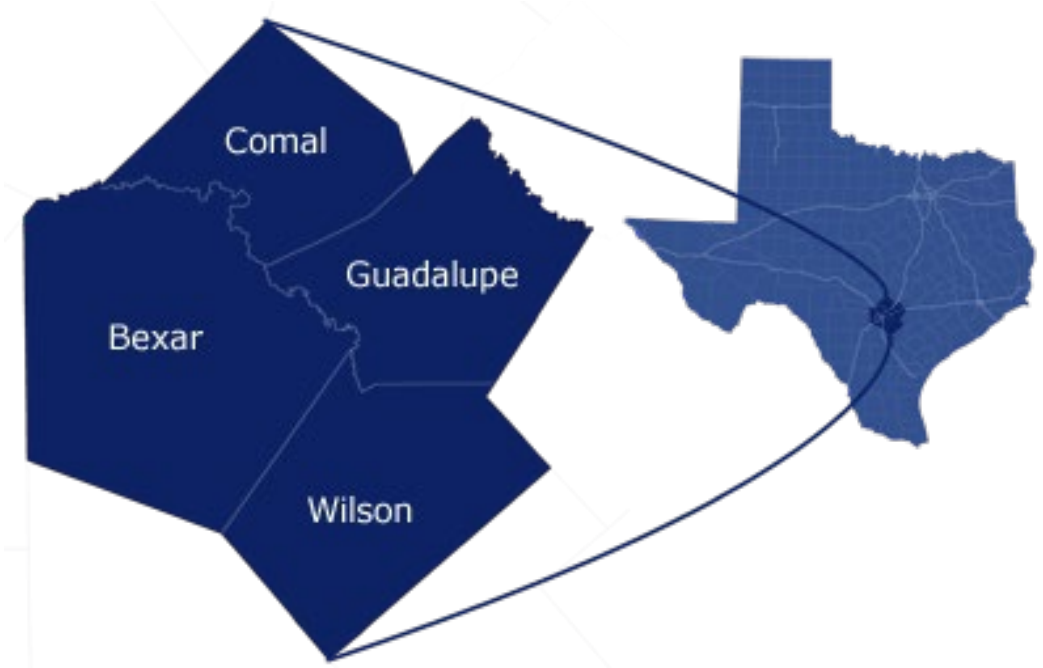

- Bexar County has a significantly larger proportion of Hispanics than Texas and the nation
- Many federally designated Medically Underserved Areas
- Majority of the SATGA's PWH live below the Federal Poverty Level (FPL) (61%)

Reference: Bureau of the U.S. Census. American FactFinder Results Bexar County. 2010; https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.

# Bexar County Hospital District dba University Health System



- Ryan White Administrative Agency for Parts A, B, D, and F (SPNS)
  - Serves over 6,000 low-income, uninsured and under-insured people
  - Primarily serves the San Antonio Transitional Grant Area (SATGA)
    - Bexar, Comal, Guadalupe, and Wilson Counties



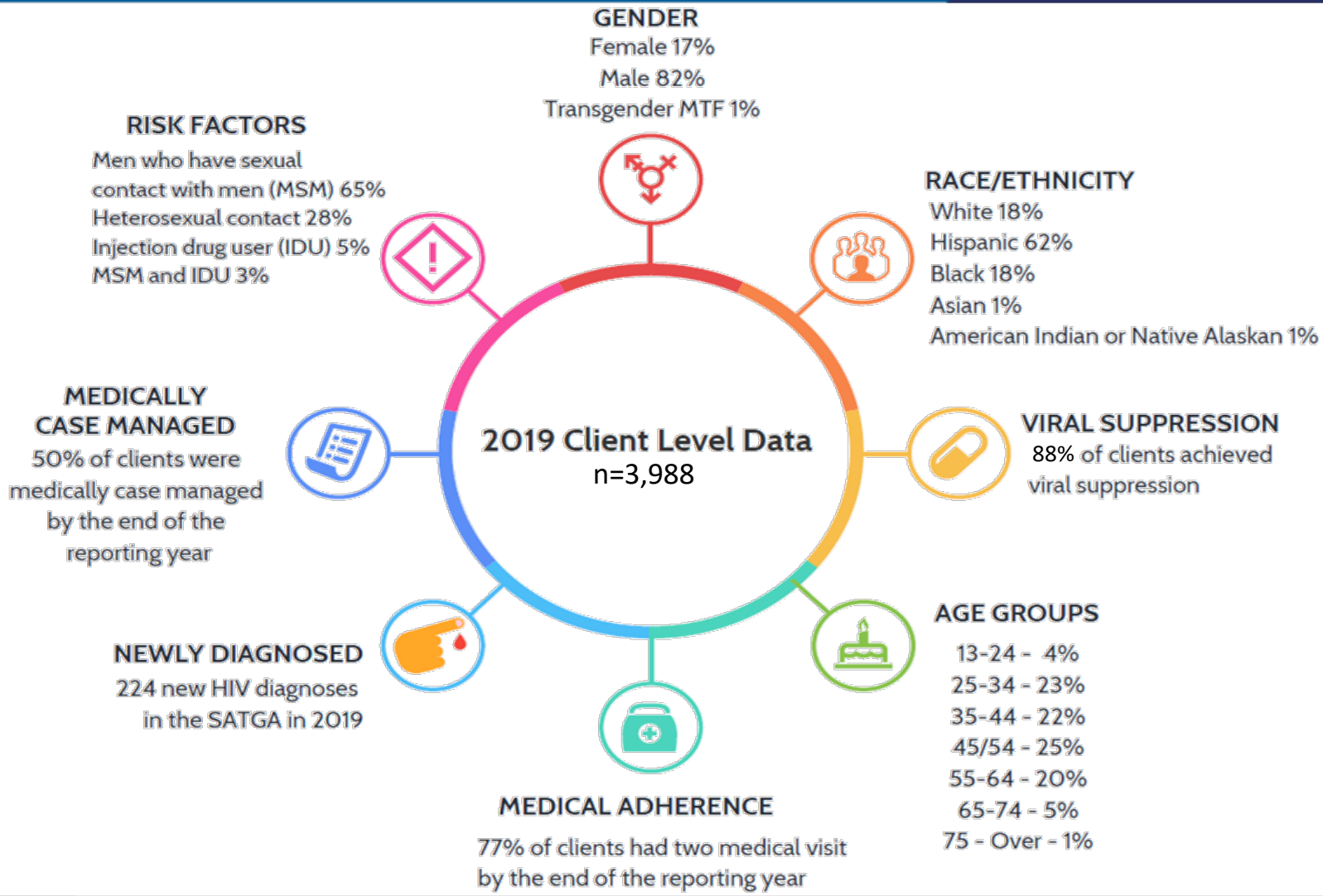
# Bexar County Hospital District dba University Health System



- Ryan White Administrative Agency for Parts A, B, D, and F (SPNS)
  - Serves the San Antonio Transitional Grant Area (SATGA) 4 county area – Bexar, Comal, Guadalupe, and Wilson
  - ~2.4 million people
- Partners with the SATGA's prominent HIV specialty community organizations

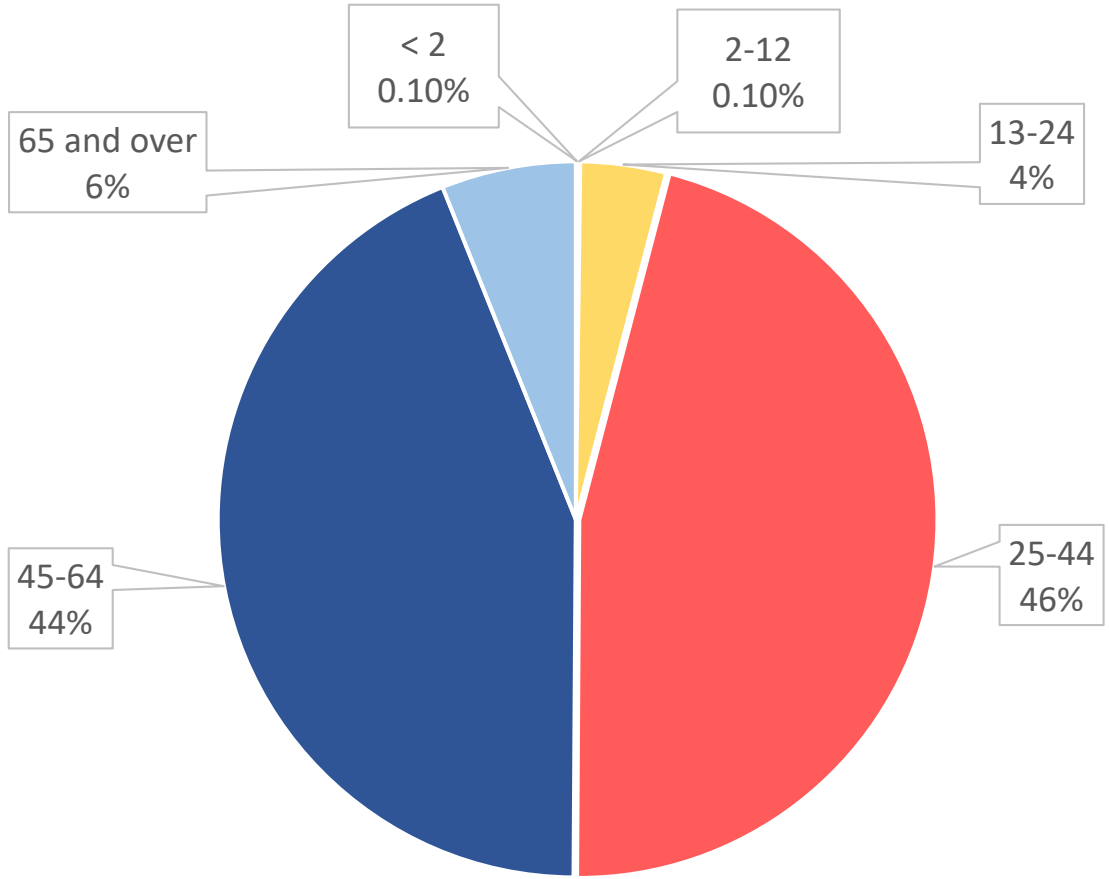
# 2019 SATGA Ryan White Clients





# SATGA PWH Population by Age (years) 2019

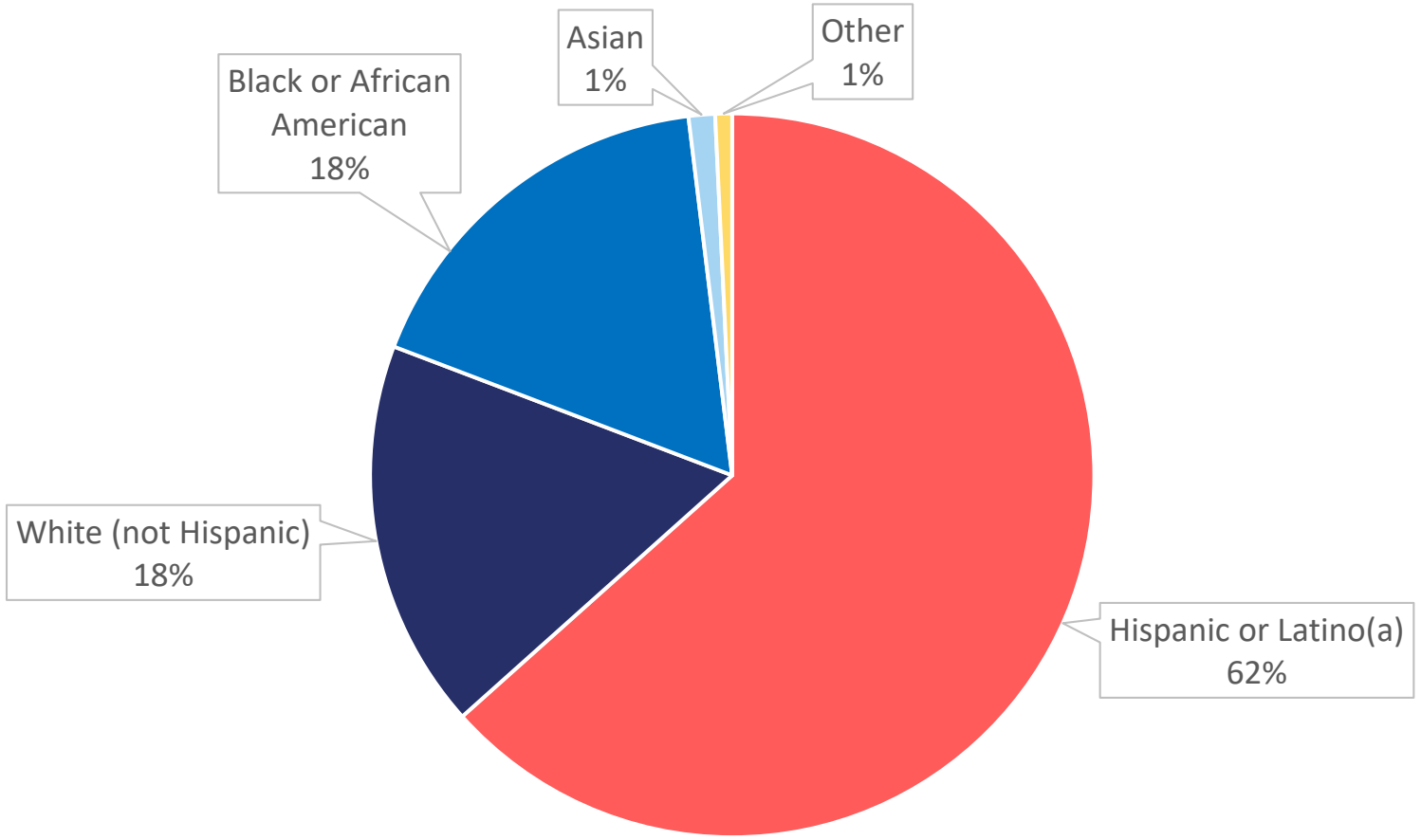
| Age Group | # Clients |
|---|---|
| < 2 | 4 |
| 2-12 | 4 |
| 13-24 | 154 |
| 25-44 | 1836 |
| 45-64 | 1748 |
| 65 and over | 242 |
| Grand Total | 3988 |




*ARIES Data Source

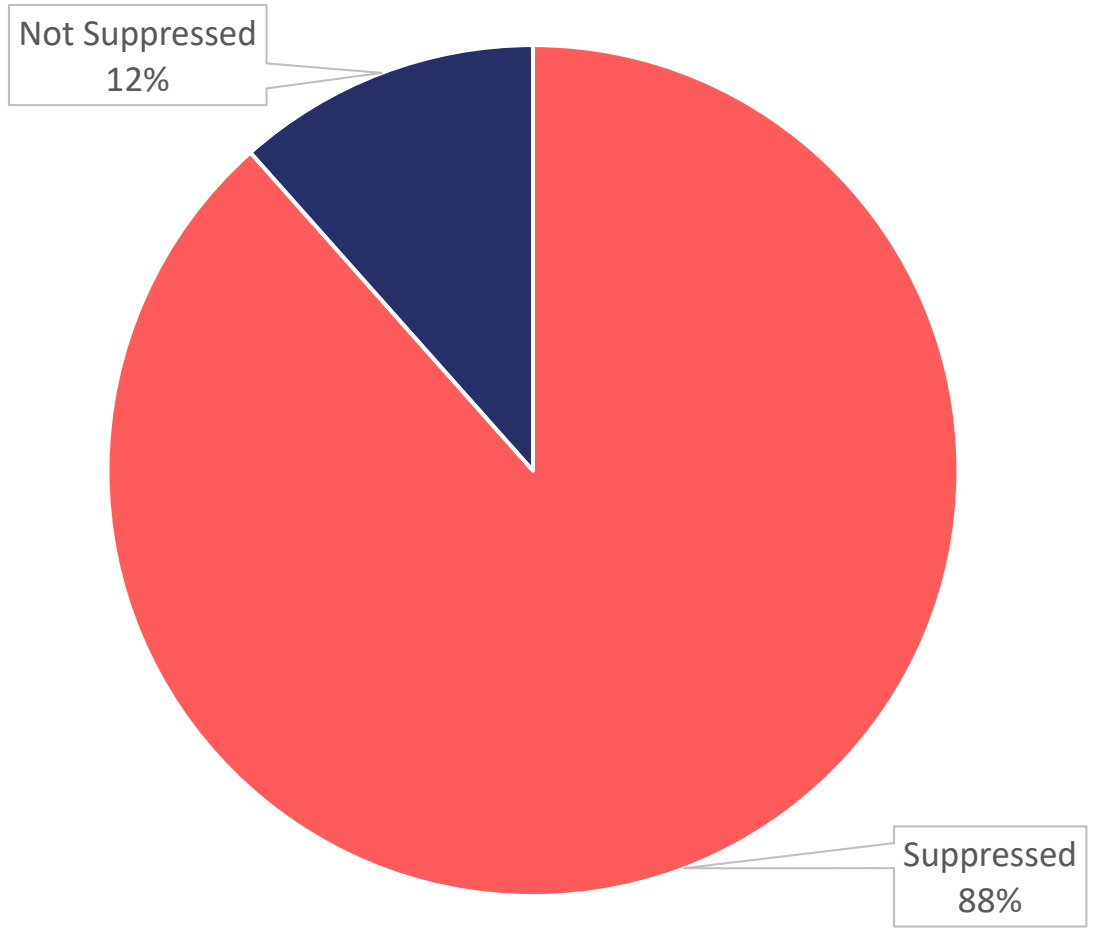
# SATGA PWH Population by Race/Ethnicity 2019

| Race/Ethnicity | # Clients |
|---|---|
| Hispanic or Latino(a) | 2528 |
| White (not Hispanic) | 694 |
| Black or African American | 689 |
| Asian | 47 |
| Other | 30 |
| Grand Total | 3988 |



# SATGA PWH Population Viral Suppression Rate 2019

| Virally Suppressed | # Clients |
|---|---|
| Suppressed | 3527 |
| Not Suppressed | 461 |



# RWPA Care Continuum Defined



**Prevention/ Education**

**Tested and Aware**

PWH who received at least one RWPA funded service

**Linkage to Care/ Started in Treatment**

PWH who received at least one medical visit funded by RWPA

**Retained in Treatment**

Clients who received at least two medical visits, 90 days apart and were prescribed ART

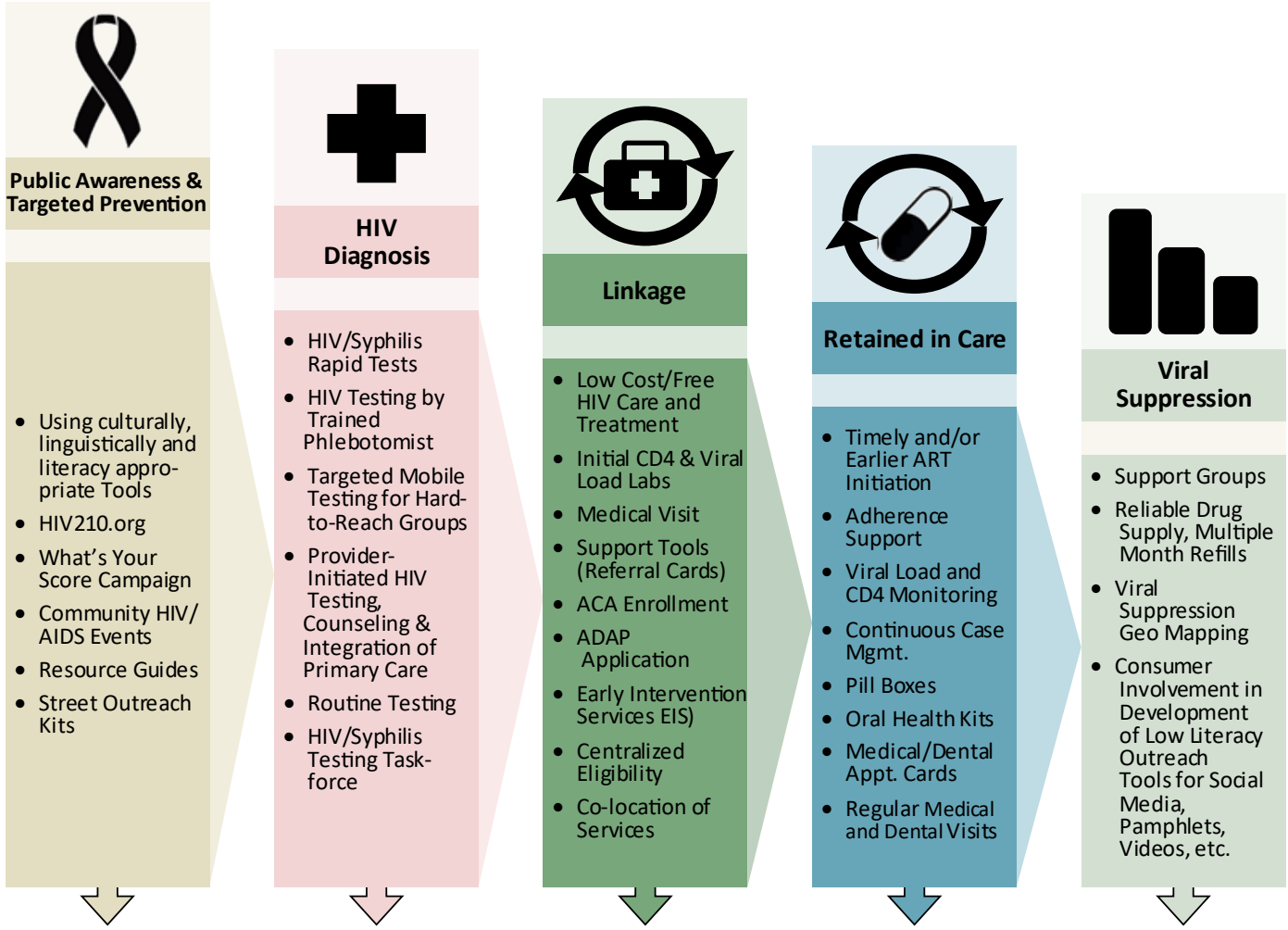
**Virally Suppressed**

PWH who have an HIV viral load less than 200 copies/ml at last viral load test

# HIV Services Care Continuum



- Nurse Care Coordinators support people with HIV (PWH) as they move through this Continuum of Care
- Designed to link PWH to care within 72 hours of diagnosis
- Focus on re-engaging clients



# Current State of the Health System HIV Care Continuum


**Legend**

**HIV Care Continuum**

**Prevention Focused Programs**

**Testing Focused Program**

**Linkage to Care/Retention Focused Programs**

**Programs Providing Treatment Services**

# Part A Needs Assessment

**Most Cited Reasons in Delaying Care**

Stigma
Unaware of Services
Denial
Comorbidities
No insurance

**Reported Barriers to Achieving Viral Suppression**

Out-of-care
Forget to take meds
Comorbidities
Lack of education about medication adherence
Homelessness

# Most Cited Service Needs by Non-Virally Suppressed PWH



- Seeing a HIV doctor
- Taking HIV medications
- Help with payments for HIV medications
- Case management
  - making appointments
  - developing a care plan
  - setting up medical appointments
- Nutrition support
- Navigation to assistive services
  - Medical
  - Social
  - Community
  - Legal
  - financial
- Help with bills
  - Rent
  - Food
  - Utility
  - Gas
  - Phone
  - Electric
  - water
- Dental care
- Counseling or support groups
  - Substance abuse
  - Mental health care
- Transportation to HIV related appointments

# Nurse Care Coordinators



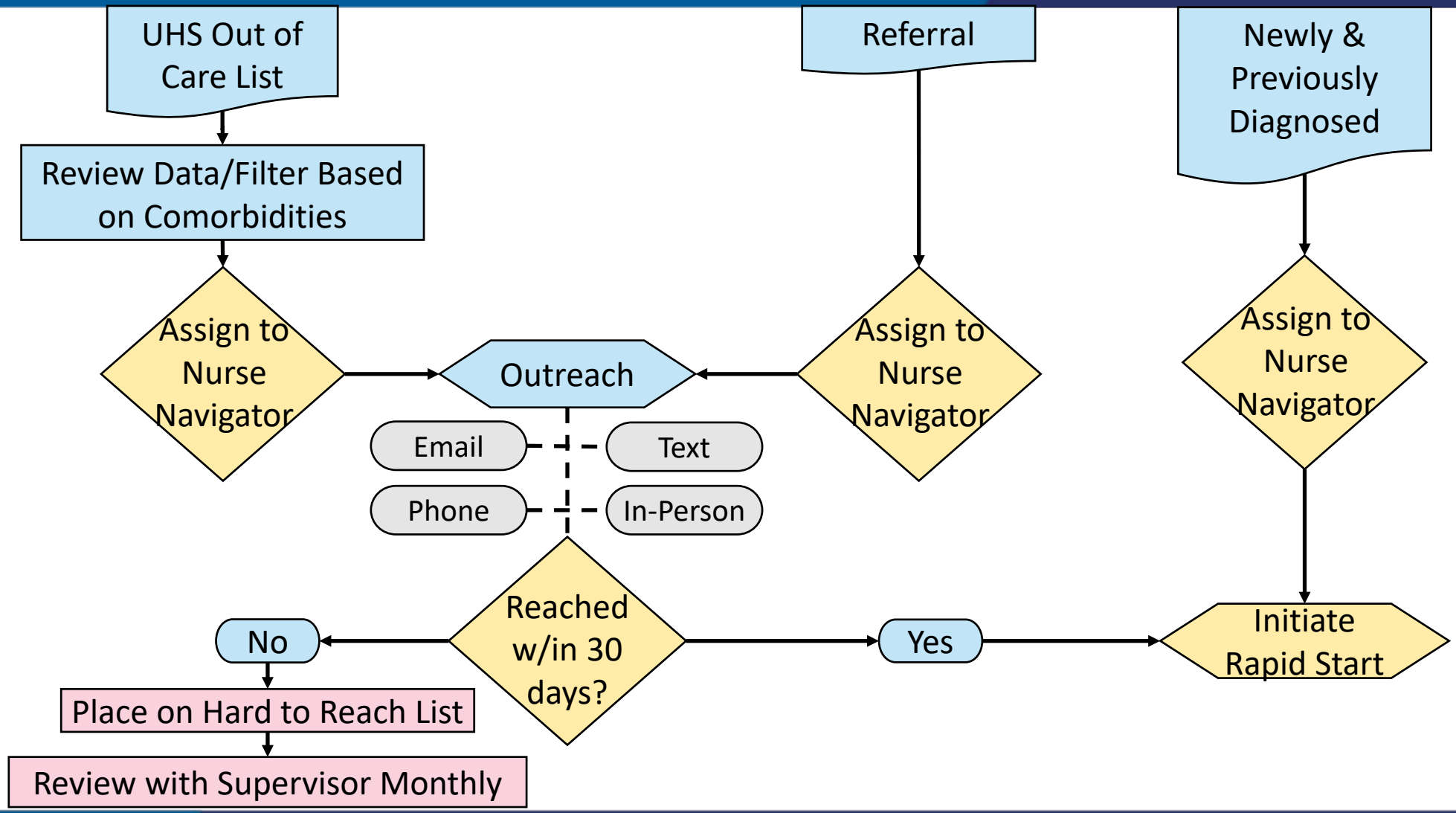
- In 2019, University Health System hired 3 Nurse Care Coordinators
  - 2 LVNs
  - 1 RN
- Purpose
  - Provide personalized assistance to clients and guide them through the care continuum
    - out of care
    - late to care
    - newly diagnosed
- Rely on cooperation from community partners to assist in the care of each client
  - Establishing working relationships with community partners
  - Build workflows for the intake of new clients

# Evidence-Based Practice



- Why care coordination/navigation?
  - Research has proven a positive impact of patient navigation on HIV retention in care and viral suppression
  - Effects of a nurse guide/nurse navigator on taking initial patient navigation further

# Navigation Workflow



# Identification of PWH



- Reports
  - UHS Emergency Room (opt-out testing) reports are run daily
  - Internal data team complies out-of-care reports
- Referrals
  - Self referrals
  - Community partner referrals
  - UHS ambulatory referrals
- Community outreach programs
  - Peer Navigators
  - SPNS Team
  - Support Groups

# Care Coordination



- Individuals are contacted by a member of the Care Coordination Team
- Available services are explained and offered to each client
- Upon agreement, a partnership in their care is established
- Clients are then assessed to determine their needs and goals

# Part A Activities

The 14 service categories funded by RWPA are:

- AIDS Pharmaceutical Assistance (Local) {LPAP}
- Early Intervention Services (EIS)
- Emergency Financial Assistance (EFA)
- Food Bank/Home Delivered Meals
- Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
- Medical Case Management (MCM)
- Medical Nutritional Therapy
- Medical Transportation
- Mental Health Services
- Non-Medical Case Management (NMCM)
- Oral Health Services
- Outpatient Ambulatory Health Services
- Referral for Health Care and Support Services
- Substance Abuse – Outpatient

# Peer Engagement Program



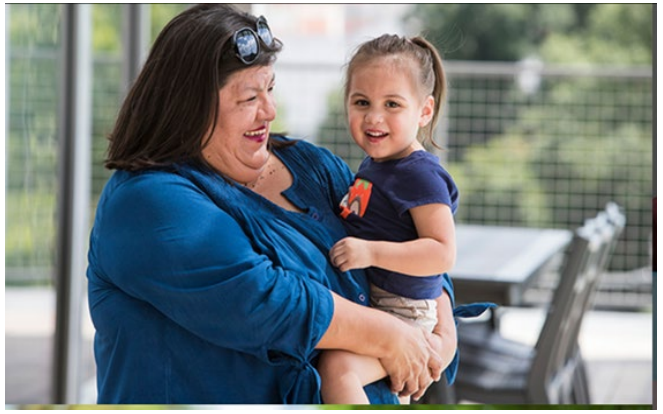
- Peer Engagement Specialists direct initiatives to improve linkage to care, reduce barriers and improve retention
  - Facilitate and plan support group activities
  - Provide direct client support in collaboration with Patient Navigators
  - Developed a peer mentor website with HIPAA compliant chat capabilities for PWH and their support systems

# Results



- Through implementation of navigation efforts we attempt to:
  - increased medication adherence
  - improved appointment attendance
  - improved retention and viral suppression

- Feedback from clients in the program
  - Feel supported
  - Show less fear of their diagnosis
  - View viral suppression as an attainable goal



# Case Example #1



- Married Hispanic Male presented to clinic feeling ill accompanied by wife
  - After assessment labs were drawn
  - Labs came back with confirmed HIV
- Clinic called Care Coordination team to offer assistance and guidance after diagnosis was presented to patient.
- After receiving results, provider gave warm hand off to Care Coordinators.
  - Care Coordinator spoke with patient
  - Coordinated rapid start appointment for the next day
  - Accompanied client to appointment.
- Client currently in care

# Case Example #2



- 30 year old female presented at clinic with husband who feels ill
  - After assessment and testing husband is identified as positive for HIV
- Patient Navigator is given referral/warm handoff
- Patient Navigator scheduled rapid testing for wife and accompanied to appointment.
  - Patient tested negative
- Navigator gave warm handoff to PREP Navigator who then scheduled appointment for assessment and PREP medication
  - Patient on PREP and is actively tested every 6 months

# Testimonials



- Changes in hope
  - Prior to working with our team, many clients report believing that their diagnosis "would be my death sentence"
- Better Communication
  - Many clients describe that their care coordinator was able to provide transparency from navigating the health system
  - Clients have also discussed, "learning what to expect" during their appointments with the doctor
- Support
  - Some clients have noted the availability of their care coordinator
    - "I was always able to reach her through a phone call or text. And I know that I could depend on her to help me"

# Barriers to Success



- For Clients:
  - Status changes at home or work
  - Emergencies
  - Comorbidities
  - Interactions with other providers or organizations
  - Entering into the denial phase of there diagnosis
  - Stigma

# Barriers to Success



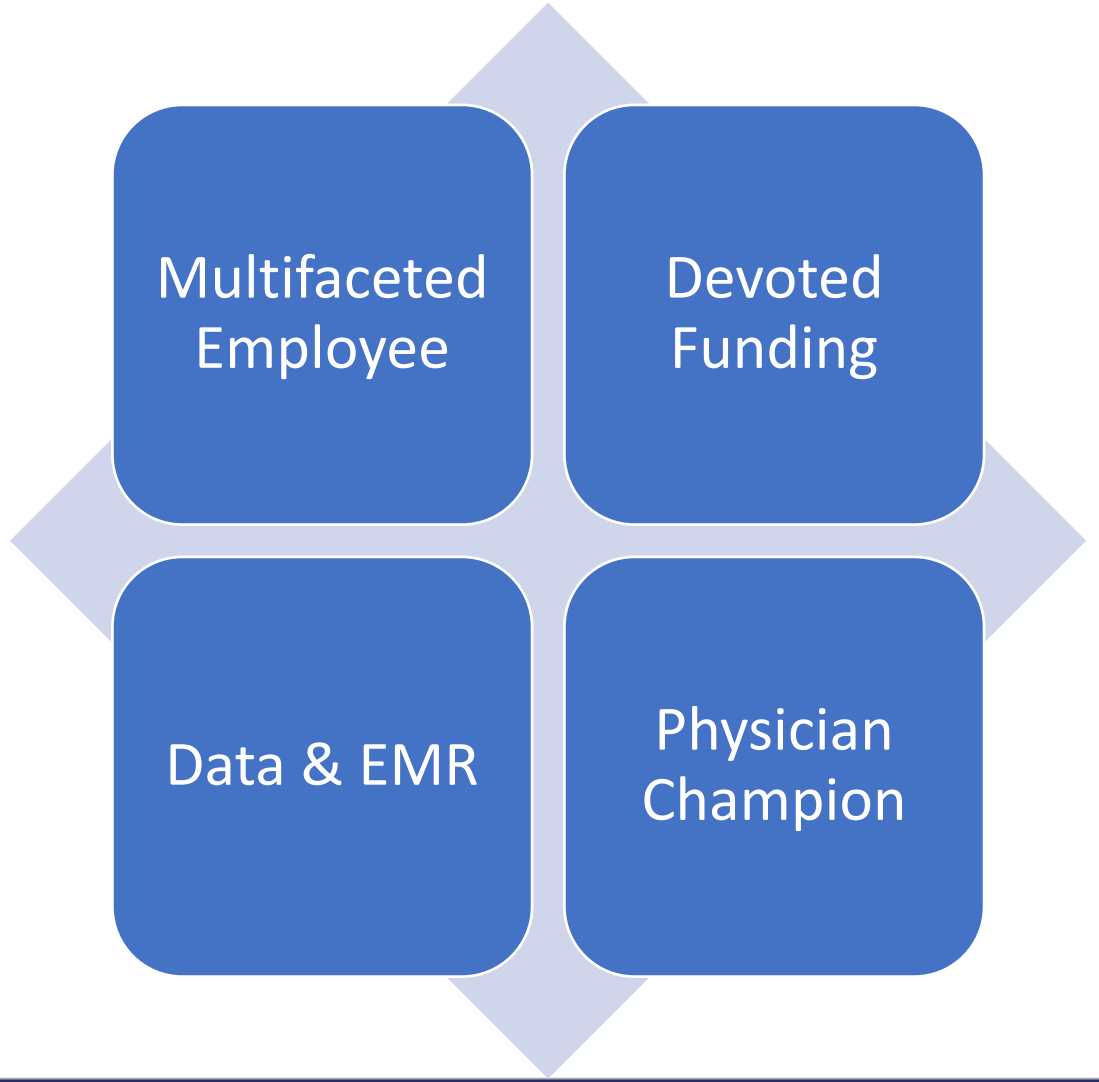
- For Care Coordination Team:
  - Loss of interest from clients
  - Inability to engage with clients
  - Changes in phone numbers or addresses
  - Incarceration
  - Siloes in departments and agencies

# Challenges

- Maintaining engagement has proven to be difficult
  - Need a central location where patients could easily access the navigation team
- Currently, clients are tracked in various reporting systems which makes charting very time consuming
  - Need a centralized charting system for clients

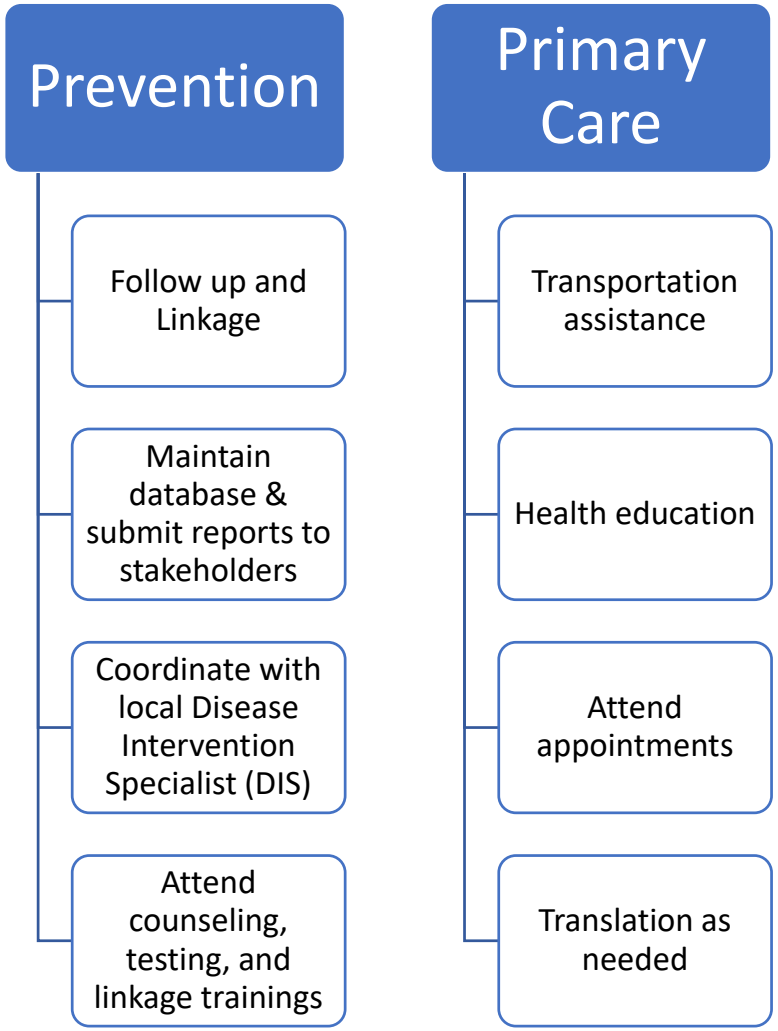
# Lessons Learned
# Key components for Success





# Lessons Learned
# Multifaceted Employees





# Lessons Learned – Continued



## Challenges

- On-call
- Meet clients same-day
- Maintain working relationships with all departments

## Benefits

- Intimate knowledge of all departments = better experience for clients
- Expedited linkage

# Q & A

Any Questions?