Kern County Health Officer's Clinic

Rapid Start Site Profile

RapidART
Dissemination Assistance Provider

A Project of CAI

Table of Contents

The Kern County Health Officer's Clinic At-A-Glance

The Kern County Public Health Services Department operates out of Bakersfield, California, providing services to people in this rural, primarily agricultural county. The Kern County Health Officer's Clinic (HOC) provides immunizations and is a comprehensive sexual health and family planning clinic, offering testing for HIV and other STIs, Rapid Start, PrEP and PEP services. With funding and technical support from the California Department of Public Health Office of AIDS Branch, the Kern County HOC began providing their Rapid Start services in 2019.

The Kern County HOC identifies people who are newly diagnosed through onsite testing, surveillance data, and referrals from local hospital emergency departments (EDs). The Kern County HOC provides Rapid Start services and then refers clients to other community clinics for ongoing care.

Key Rapid Start Service Characteristics

Year of Implementation 2019
Urban-Rural Classification Rural
Care Setting Local health department
RHWAP Funding Part B
Population Size Approximately 100 people newly diagnosed with HIV per year
Clients Served Newly diagnosed and re-engaging in care

Priority Population Early intervention services for people newly diagnosed with HIV
Medicaid Expansion State (Yes/No) Yes
Starter Packs Available (Yes/No) Yes
Onsite Pharmacy (Yes/No) Yes
Onsite Lab Draws (Yes/No) Yes
Onsite HIV Testing (Yes/No) Yes

Unique Features of Kern County HOC's Rapid Start Program

Kern County HOC, part of the California Department of Public Health, plays a critical role in providing ART rapidly to clients and then **linking them to ongoing HIV primary care,** without being their ongoing source of care.

Kern County HOC has a **partnership with a local emergency department (ED)** that provides opt-out HIV testing and, together, they have developed a streamlined process to link people to care, and address gaps in HIV care continuum outcomes.

Kern County HOC utilizes a small **disease intervention specialist (DIS)-led staffing model,** in partnership with Nurse Practitioners, which is effective in linking people to Rapid Start services, ongoing HIV primary care, supportive services, and in following up with clients once linked to ongoing care to support efforts to retain clients in care.

Kern County HOC receives **ongoing support from the California Department of Public Health,** including support in Rapid Start protocol development and ongoing clinical consultation, which has been essential to establishing and maintaining Rapid Start services in Kern County.

Client Outcomes (January 2021 – December 2021)

76 Clients

(both re-engaged and newly diagnosed) received care in 2021.

The average number of days for clients to be linked to care and provided with ART medication was

2.06 days

$ Cost Estimate per Client

Additional $2,308 per client during sustained implementation **(see page 17 for details)**

Intervention Characteristics

This section describes the core components of the Kern County HOC Rapid Start service delivery model, specifically: staff roles and structure, Rapid Start workflow, clinical appointment availability, same-day medication, and health education and client communication.

Staff Roles & Structure

The Kern County HOC has a small but effective group of staff that provide Rapid Start services. Key staff roles and responsibilities are described below, along with staff that fulfill these responsibilities.

- **Linkage Coordination:**
  - **Disease intervention specialists (DIS)** (also known as communicable disease investigators) oversee the referral process and connect clients to clinical care, case management, and benefit enrollment support. The client sees the DIS along with the nurse practitioner during the Rapid Start visit.

"The [DIS] are really a big part of this process. They really do a lot of the initial part, bringing them to the clinic, following up with the referrals, following up with the patients. They are the main people who really make this program work for me. If they're not there, it's just going to be hard."

– Kern County HOC Clinician

- **Clinical Services:**
  - **Nurse practitioners** conduct a physical exam, order labs, prescribe ART, and ensure that Rapid Start prescription does not interfere with other comorbidities. They also review HIV information with the client and provide education to the client on the diagnosis and treatment. Community-based providers render ongoing HIV primary care.
  - The onsite **pharmacy** can dispense ART medication.

- **Patient Care Support Services:**
  - **DIS** link clients to support services such as housing, transportation, and food vouchers. Community providers provide ongoing case management and social services support.

"They've always told me that if I need a ride, they would help me. They've told me of all the supports they provide so I keep going to the doctor and taking my medication."

– Kern County HOC Clinic Client

- **Benefits Enrollment:**
  - **DIS** assess client insurance status, assist with the Ryan White HIV/AIDS Program ADAP application, and refer clients to other county employees for Medi-Cal (i.e., Medicaid) enrollment, if needed. Community providers also provide enrollment support, especially into Ryan White HIV/AIDS Program (RWHAP).

Rapid Start Workflow

The Kern County HOC aims to link newly diagnosed clients to a clinician and ART prescription the same day as HIV diagnosis. The general process for the Rapid Start visit includes the following components:

- **HIV Testing**
  In addition to providing onsite walk-in HIV testing, the Kern County HOC participates in the FOCUS program, an initiative that provides opt-out HIV testing within two local hospital EDs and links clients from the ED to care. Clients who have not already been prescribed ART in the hospital ED will be connected to care in the Kern County HOC before being referred to a community provider. HOC has memorandums of understanding (MOUs) with the hospitals, so they can exchange health information. Once a client tests HIV positive at the ED, a DIS will be alerted via phone or via electronic health record (EHR). DIS also identify people who are newly diagnosed through surveillance data shared by the state and by checking a daily list generated by the hospitals.

- **Linkage to Care**
  DIS assist with the linkage process from the hospital ED. DIS receive lab values from the ED, contact the clinician who requested the lab for additional information, and identify any other risk factors that may impact the client's care. They reach out to the client and relay test results and inform them of their treatment options, either meeting them at the hospital or speaking with them on the phone to schedule a clinician exam in the Kern County HOC, ideally the same day as diagnosis.

- **Intake and Insurance Enrollment**
  Then, the DIS escorts the client to the Kern County HOC, or waits to greet them at the clinic if they spoke over the phone. If a client tests positive from walk-in HIV testing, the DIS is alerted via EHR and meets the client at the Kern County HOC. The DIS also reviews lab results that are submitted into a surveillance database by the California Department of Public Health daily and contacts the newly diagnosed clients using the information recorded in the database to connect them to care. Once at the clinic, the DIS helps the client enroll into Ryan White HIV/AIDS Program ADAP and/or starts the process for Medi-Cal enrollment, which is typically completed by the clinic that provides ongoing HIV primary care. With Ryan White HIV/AIDS Program ADAP's flexible COVID policies, the DIS can apply without the required documents and the client can pick up the prescription with coverage for 30 days as the enrollment worker collects the documents. RWHAP enrollment is typically conducted by the community provider once the client has been referred for ongoing HIV primary care.

- **Clinician Exam and ART Rx**
  The DIS then escorts the client to the clinician exam, which has already been coordinated by the DIS. The nurse practitioner conducts a physical exam, orders labs, and prescribes ART.

- **Medication Dispensing**
  The nurse practitioner typically dispenses two seven-day ART starter packs during the clinician exam, and provides it to the client, in addition to a three-month prescription for ART to be filled by a preferred pharmacy. Clients may even take the first dose before they leave the office.

- **Baseline Labs**
  The DIS then escorts the client to complete their blood draw for baseline labs.

- **Support Services**
  Next, the DIS connects the client with any support services that are needed after they receive medication and complete their blood draw. Kern County HOC's case management program connects clients to an array of services to support retention in care including substance use disorder services and to meet the needs of people who are unstably housed or homeless. Kern County HOC's partner community provider can place homeless clients in a hotel room for 30 days while case managers assist with permanent housing. The Kern County HOC provides $10 food gift cards and hygiene kits including deodorant, mouthwash, and toothpaste. The clinic also provides a fee waiver to obtain a California ID and transportation to appointments through a County-owned vehicle or bus service.

- **Ongoing HIV Primary Care**
  At the end of the Rapid Start visit, the DIS connects clients to a community provider for ongoing HIV primary care. Five days after the HOC Rapid Start visit, the DIS checks-in with the client and assesses medication tolerance and side effects. They ask the client to come back two weeks after the Rapid Start visit to review labs, only if the client has not been established in ongoing HIV primary care. The DIS continues to follow up with the client until they attend their first follow up visit with the HIV primary care community provider. If the client is unable to see a community provider for ongoing HIV primary care right away, the Kern County HOC can provide medication refills.

Re-Engaged Clients

The process is generally the same for those who are re-engaging in care and those who are newly diagnosed. However, the clinic only dispenses one type of medication in a starter pack; if re-engaged clients were not previously on this medication, they receive a prescription for the appropriate medication to be filled by a pharmacy instead. The DIS receives a Data to Care list from the California Department of Public Health that includes those who have not had labs in over a year for outreach and linkage.

Clinical Appointment Availability

The Kern County HOC has found that scheduling appointments as soon as possible positively impacts client retention, so staff prioritize Rapid Start clients. The clinic also has slots built into its appointment schedule, 8:00am-1:00pm, to accommodate walk-in services.

Same-Day Medication Prescription & Provision

Kern County HOC has partnered with a drug manufacturer to provide seven-day ART starter packs. The nurse practitioner dispenses the medication during the clinician exam. Clients typically leave the clinic with two starter packs (i.e., 14-day supply) in addition to a three-month prescription to be filled by a preferred pharmacy. While Kern County HOC does not serve as the ongoing care provider, the nurse practitioner still refills medication if the client has not established care with another provider after three months.

DIS generally submit Ryan White HIV/AIDS Program ADAP applications right after the Rapid Start visit so that uninsured clients can pick up their prescription on the same day of the Rapid Start visit.

Health Education & Client Communication

The nurse practitioners and DIS play a crucial role in providing education and supporting the client after HIV diagnosis or reengagement in care. DIS discuss their role in anonymously informing partners of a client's HIV status and how treatment typically works the subsequent several months, including how many times the client should meet with a clinician after diagnosis. The nurse practitioner reviews all clinical information with the client, such as any confounding health issues and Undetectable = Untransmittable (U=U) transmission. The Kern County HOC has distributed materials such as palm cards to clients and community partners on U=U transmission as well.

The DIS aim to be supportive of the client and present treatment options using a neutral tone. Many clients have other competing priorities that may prevent them from coming to the clinic, so the DIS recommend the best options for them without pushing clients towards a decision.

"We'll go into the hospital and speak with them, or we'll catch them on the phone and bring them in here afterwards. But we make contact with them, discuss how they're feeling, answer any questions that we can, [and] assess what's going on with them. Because a lot of [people] have a lot of barriers [that keep them from] getting into care. So, it's kind of a long process of just listening and just holding space and being there and finding out what's going on in their life before you even start doing, doing the actual linkage work."

– Kern County HOC Clinic DIS

Organizational Culture

This section describes the facilitators that support implementation of the Rapid Start service delivery model at Kern County HOC including: leadership, staff knowledge and beliefs, and communication strategies among the healthcare team.

Leadership

Leadership at Kern County HOC is very supportive of the clinic's Rapid Start service provision. Senior County health officers prescribe Rapid Start themselves, monitor client progress through a shared database, and have participated in presentations about the success of the Rapid Start services.

> "It was taking an extensive amount of time to link somebody who is positive to HIV care… upwards of a month or even possibly longer than that. So we thought if there was a way for us to introduce this (Rapid Start services) as another piece (standard of care) to our clinic, that we could get people on treatment sooner and avoid these long delays of getting them to a provider."
>
> **– Kern County HOC Leadership**

Staff Knowledge & Beliefs

Kern County HOC leadership has expressed enthusiasm for Rapid Start service provision since the start. However, some clinicians were initially overwhelmed with the change in process and hesitant to administer Rapid Start. One nurse practitioner only had experience administering PrEP and PEP. To address this, the clinic worked with a consulting physician who trained the nurse practitioner on HIV disease progression and Rapid Start administration.

The nurse practitioner attributes her comfortability with prescribing Rapid Start to the consulting physician; together, they were able to create the clinic protocol based on their experience working together.

Communication Strategies

The DIS and nurse practitioner typically have one-on-one meetings after the Rapid Start visit to debrief the client's appointment and exchange any important information related to follow up. For example, they discuss serious medical issues the client may have and expedite the referral process to the community provider if needed.

The clinic uses a shared Excel database accessible through Microsoft Teams to track client progress. It incorporates data on newly treated clients, such as the client's medication and appointment status. The nurse practitioner inputs the lab results, client demographic information, and detailed notes from the Rapid Start visit into the tracker. The DIS uses the tracker to follow-up with clients after their visit.

External Influences

This section describes external factors that informed the design and implementation of the Rapid Start service delivery model at Kern County HOC including: jurisdiction supports and policy landscape, payment for Rapid Start, collaboration with other providers, and client needs and perceptions.

Jurisdiction Supports & Policy Landscape

The California Department of Public Health, Office of AIDS Branch played a crucial role in supporting the Kern County HOC's Rapid Start service provision. In 2019, the agency awarded four providers funding for Rapid Start, including the Kern County HOC. Through the grant, the Kern County HOC had access to a consulting physician who supported protocol development and client treatment. Although the grant is over, she still regularly advises on client care.

The grant also covered staff time to develop the Rapid Start protocol, print materials to share with clients and partners, some of the nurse practitioner's time, hygiene kits, food cards, and temporary housing for clients.

"We were very fortunate that [physician consultant] really wanted to stay available to…our providers as they were still getting comfortable with prescribing Rapid Start. So even to this day, even after we no longer have a grant, she's still available to our providers around Rapid Start consults."

– Kern County HOC Leadership

The state has ample insurance options to cover ongoing treatment for people with HIV. California is a Medicaid expansion state with three managed care plans available to Kern County residents. The state has also expedited enrollment into Ryan White HIV/AIDS Program ADAP.

With the removal of some requirements due to the COVID-19 pandemic, enrollment may "take just 10 minutes" according to Kern County HOC leadership. Ryan White HIV/AIDS Program ADAP covers the cost of health insurance premiums, and through immediate Ryan White HIV/AIDS Program ADAP enrollment, aspects of the clinician exam, including labs, are covered by insurance.

When requirements are reinstated, individuals will still be immediately enrolled in Ryan White HIV/AIDS Program ADAP, but need to submit substantiating documents within 30 days. Kern County HOC staff foresee that this change may place a barrier to access if individuals do not submit the documents.

The California Department of Public Health also makes available surveillance lab values through a shared database. The Kern County HOC DIS, who plays a crucial role in Rapid Start linkage to care, checks the database every day for new diagnoses. He estimates that about 70-80% of new diagnosis appear in that database.

Kern County HOC appreciated the state's flexibility in how grant funding was used. With leftover funds, the clinic was able to work with the state to identify other supports to cover with the grant, such as food cards, hygiene supplies, and temporary housing, which "really mean a lot to people."

Payment for Rapid Start

The Kern County HOC has a partnership with a pharmaceutical manufacturer to provide clients with free ART starter packs. Typically, clients receive two sets of seven-day packs, but may receive more if they are uninsured and need time to connect to insurance coverage. Insurance, including Medicaid and Ryan White HIV/AIDS Program ADAP-sponsored insurance, serve as an important funding source for clinical aspects of Rapid Start, ongoing care at partner clinics, and ongoing prescriptions.

"If [the client's] insurance is good, they can get medication right away. We are trying to balance [that] out because we don't have [the] luxury of having a lot of samples to give to patients. After that, the medical investigator makes sure that they get their prescription filled. They help them process ADAP or Medi-Cal (California Medicaid program)."

– Kern County HOC Clinician

Collaboration with Other Providers

The Kern County HOC works in partnership with multiple providers in the area, including local hospitals that refer clients newly diagnosed in their EDs and clinics that provide ongoing outpatient care.

The Kern County Public Health Services Department serves as a coordinating entity throughout the county. Staff look forward to expanding testing partnerships to additional hospitals and a large Federally Qualified Health Center (FQCH) network. As part of the state grant, the Kern County HOC also participated in a handful of meetings with the other grant recipients, but programs mostly "acted independently."

Client Needs & Perceptions

The DIS indicates that about half of his clients who are newly diagnosed are "goal oriented" and eager to start treatment. The other half need some time to process the diagnosis. Regardless, once the Rapid Start service provision is presented to them, the vast majority are ready to schedule the clinician exam for treatment. Two clients interviewed for this project reported that they were ready to start treatment, especially because staff provided education on the importance of medication to stay healthy and offered supports, such as transportation.

The DIS indicates that clients rarely say "no"; instead, they agree to the appointment but no-show due to competing priorities. The Kern County HOC clinician indicated that people experiencing homelessness are often hard to contact for follow up after a no-show.

"They'll say 'yes' and then they never make it to their appointment. And then you call them back and reschedule, they don't make it back. Whatever else is going on in their life might be preventing them from coming in ... whether they have work, or they might be a substance user. I've never had anyone tell me 'no.' "

– Kern County HOC DIS

Kern County HOC DIS conduct home visits and pick clients up for appointment in the county van, important tools to encourage engagement in care.

Process

This section explores the approach and process of implementing and evaluating Rapid Start services at Kern County HOC, including: planning, champions, and data monitoring and evaluation. The section ends with a discussion about costs associated with planning, implementing and sustaining Rapid Start services at Kern County HOC.

Planning for Rapid Start Implementation

In 2019, Fresno hospitals initiated opt-out HIV, syphilis, and hepatitis C testing in their EDs in partnership with Kern County HOC and Gilead's FOCUS Program. Concurrently, the Kern County HOC began working more actively in prevention of HIV and STIs, in part through PrEP and PEP programs. Rapid Start was a natural extension of these activities, especially because staff were concerned that clients were typically linked to care 30 days or more after diagnosis, according to an analysis of surveillance data. A grant opportunity from the California Department of Public Health provided the funding and technical support needed to officially launch the initiative.

About ten years ago, Kern County HOC established a process to bill third-party payors for medical care and medications, supporting the eventual adoption of Rapid Start given the high cost of treatment.

Under the grant, recipients were required to develop a protocol, a process that was initially delayed due to COVID-19 and a prolonged contracts process. However, with the support of the physician consultant, the Kern County HOC began implementing aspects of Rapid Start. Eventually, she took the lead in documenting and formalizing the process by developing the protocol.

Staff Champions

See Leadership section for details.

Data Monitoring & Evaluation

As part of the state grant, the Kern County HOC began using an Excel spreadsheet that tracks referral source, date of diagnosis, date of ART prescription, and date of follow up medical appointment. While the Excel spreadsheet facilitates calculation of performance measures, it is primarily used for client care coordination and follow up.

As described by leadership, it is a great way for staff to identify and "follow up on clients who have not gotten into long-term medical care." The Kern County HOC also uses an EHR for day-to-day clinical care, but the system is not used to track outcomes for ART clients, because staff "have to go digging around" for information. The Kern County HOC hopes to implement a case conferencing process soon for even more accountability and follow up on the process and client care.

"We want to implement a case conferencing process so that we can get together [and look at that tracker and see] what's there. I think it's different to talk about individual cases in a case conference setting [for] another layer of that quality assurance."

– Kern County HOC Leadership

The following tables provide an overview of key outcomes for 75 clients, who were either newly diagnosed or reengaged in care, that received Rapid Start services from January through December 2021 at Kern County HOC as part of their Rapid Start services.

Clients Newly Diagnosed with HIV

MEASURE	OUTCOMES ACHIEVED
Number of newly diagnosed clients	
Average number of days newly diagnosed clients were linked into care and received ART medication	

Clients Re-engaged in Care

MEASURE	OUTCOMES ACHIEVED
Number of re-engaged clients	
Average number of days re-engaged clients were linked into care and received ART medication	

Cost for Rapid Start Implementation & Sustainment

Kern County HOC did not provide ART services prior to Rapid Start implementation. Therefore, we estimated planning costs during the year prior to implementation (pre-implementation), and the costs of planning, implementation, and management of Rapid Start during the first year of implementation (initial implementation) and during the most recent year of implementation (sustained implementation).

- In the pre-implementation year, Kern County HOC spent $ $64,064 on planning for Rapid Start. Planning costs declined to $21,829 during the initial implementation year and remained steady at $21,649 during the year of sustained implementation.
- The total costs to plan, implement, and manage Rapid Start were $1,931 per client in the initial implementation year, and declined substantially to $2,308 per client during sustained implementation.

Kern County HOC provided Rapid Start services to 66 clients in the initial implementation year and 76 clients in the sustained implementation year. The same number of staff provided Rapid Start services across the two years, and while the time per-client spent on oversight and management remained steady, the time that medical service providers committed to providing Rapid Start services during the sustained year more than doubled.

Notably, the initial implementation year was impacted by the COVID pandemic, and clinical visits were kept short. During sustained implementation, time spent on linkage to care became more efficient, and medical service providers were able to spend more time with clients, thus increasing per-client costs in the sustained year.