Improving Reengagement in Care using a Community Health Worker Model: Evidence from New Orleans

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A division of the New Orleans Health Department

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NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Daniel Murdock has no relevant financial interests to disclose.

Vatsana Chanthala has no relevant financial interests to disclose.

Fran Lawless has no relevant financial interests to disclose.

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Identify opportunities and challenges to using community health workers to improve retention and reengagement in care
2. Discuss common barriers to care facing clients who have fallen out of care and how community health workers can help address them
3. Discuss how community health workers can play a role in quality improvement work and help to prevent clients from falling out of care

What is a Community Health Worker?

- A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has a close understanding of the community served[1]

- CHWs reduce the burden and stress of large caseloads and strengthen traditional Ryan White HIV/AIDS Program care teams

How CHWs Strengthen the Health Care Workforce

- CHWs facilitate access to services and improve the quality and cultural competence of service delivery[1]
- CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through outreach, community education, informal counseling, etc.[1]
- CHWs can help address COVID-related challenges to HIV care
  - Enhance workforce capacity
  - Help clients overcome COVID-related barriers to care

Development of a CHW Intervention in New Orleans

Background

- Identification of the CHW intervention was derived from the Learning Collaborative, a quality improvement initiative collaboration with UCSF.
- Design meeting April 2020
- Purpose: Identify opportunities and challenges to using telehealth services to improve engagement and retention in care for PLWH who are out of care and/or lost to follow-up in New Orleans in the context of the COVID-19 pandemic
- Stakeholders: Part A funded agencies (medical and social services), State, community members

Group Breakout Session Results

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- making access to providers (medical, behavioral health) more accessible (same day)..making services available when clients are ready
- have more tele health options
- location/access to essential places...grocery stores
- home monitoring devices to clients (diabetic clients)
- triage client system based on needs and barriers
- Access to electronic devices
- people released from jail and not have phones or mechanism to access services
- lack Of human to human contact/support/ emotional support
- unidirectional service (client has to get to the service) versus bi-directional where services can get to clients)
- reduce structural, institutional, environmental barriers
- Structural: hours, building, client access to cell phone, internet access
- Institutional: facility operating care, don't have expanded hours, weekend hours,
- Environmental: housing, transportation, financial...things that would prevent clients from getting from point A to B
- need providers to be informed and trained in mental health first aid, trauma-informed intervention
- Gov't issued phones are not smart phones
- client knowledge of change in policy adjusted for COVID

Items identified during the group breakouts recategorized

- Access
- Transportation
- Health system literacy
- Supportive services visits (case mgmt. social work, psych, navigation)
- Incentives
- Availability/flexibility Of services
- Pharmacy issues /access to medications
- Provide services at home (food, PPE, CM)
-
- Stigma
- Empowerment
- Collaborative decision-making — goal setting
- Welcoming "friendly" clinics
- Medical mistrust
-
- Clinic Factors/Service Delivery
- Scheduling
- Staff knowledge and preparation
- Handoffs
- EMR alerts
- Home Visit to follow up With those out Of touch
- Shared decision-making
- COVID policies (supplies, spacing, triage, visitors, childcare, essential v non-essential visits)
- Change policy for requiring labs before refill
- Multi-month dispensing
- Tracking systems
- Assessing capacity of patient to take meds/attend services
- Special efforts with prisoner and
- Contact information Of patient
- Promotion of adherence
- Emphasize benefit of VLS
- Limited educational programs in community

IMPROVING RETENTION IN CARE FOR PLWH IN NOLA DURING THE COVID-19 PANDEMIC 1

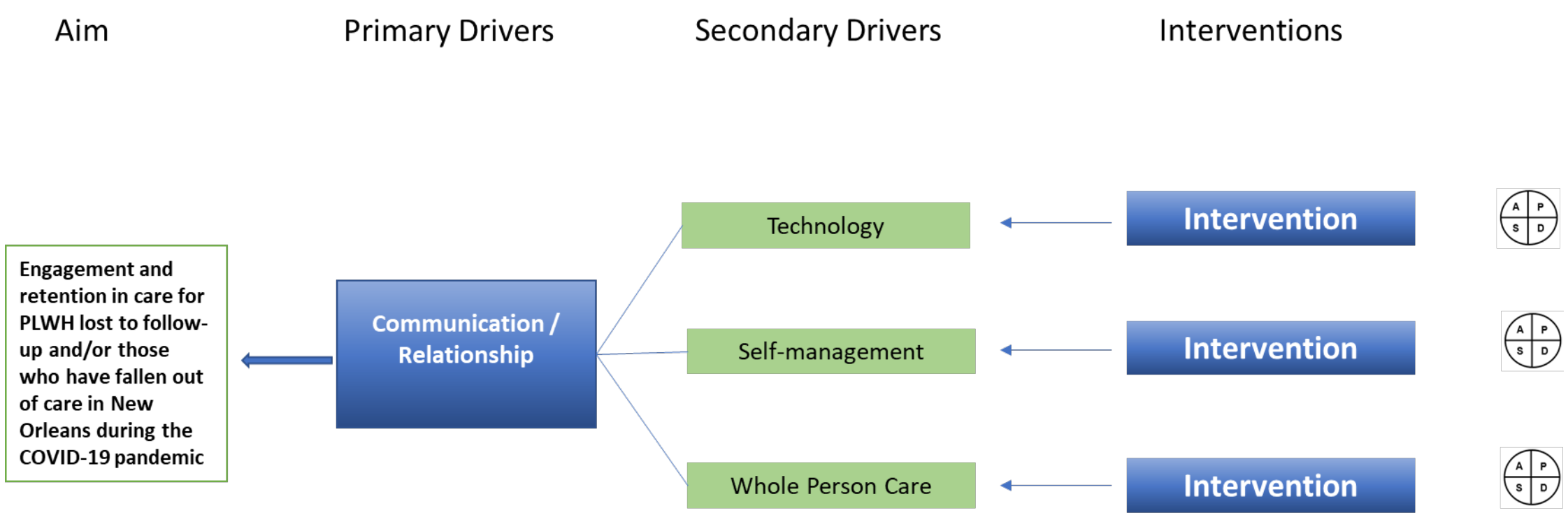
Aim

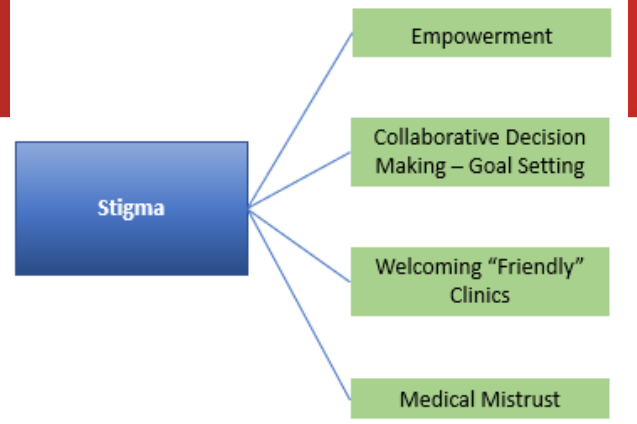
Engagement and retention in care for PLWH lost to follow-up and/or those who have fallen out of care in New Orleans during the COVID-19 pandemic

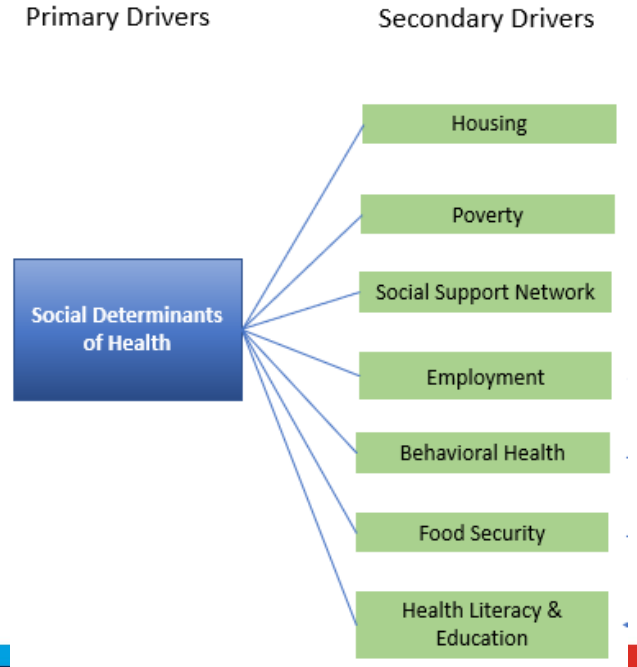
Primary Drivers

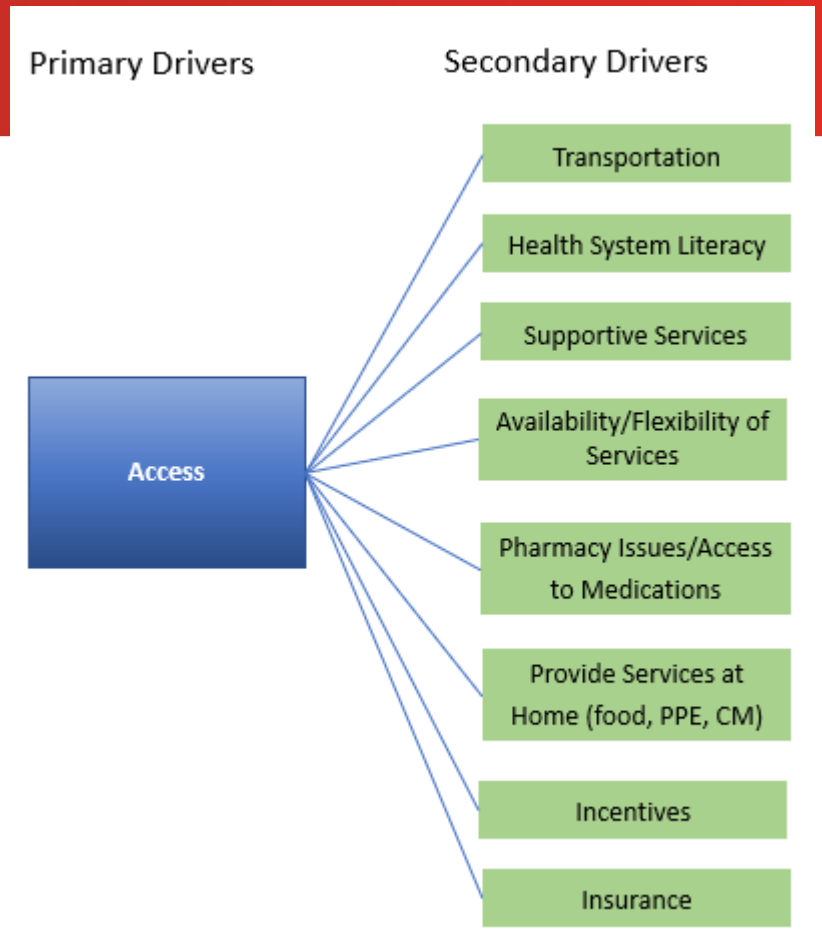
- Communication Relationship
- Stigma
- Social Determinants of Health
- Access
- Clinical Factors/Service Delivery

IMPROVING RETENTION IN CARE FOR PLWH IN NOLA DURING THE COVID-19 PANDEMIC 2




Primary Drivers
Secondary Drivers
Stigma
Empowerment
Collaborative Decision Making – Goal Setting
Welcoming "Friendly" Clinics
Medical Mistrust


Primary Drivers
Secondary Drivers
Social Determinants of Health
Housing
Poverty
Social Support Network
Employment
Behavioral Health
Food Security
Health Literacy & Education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Access
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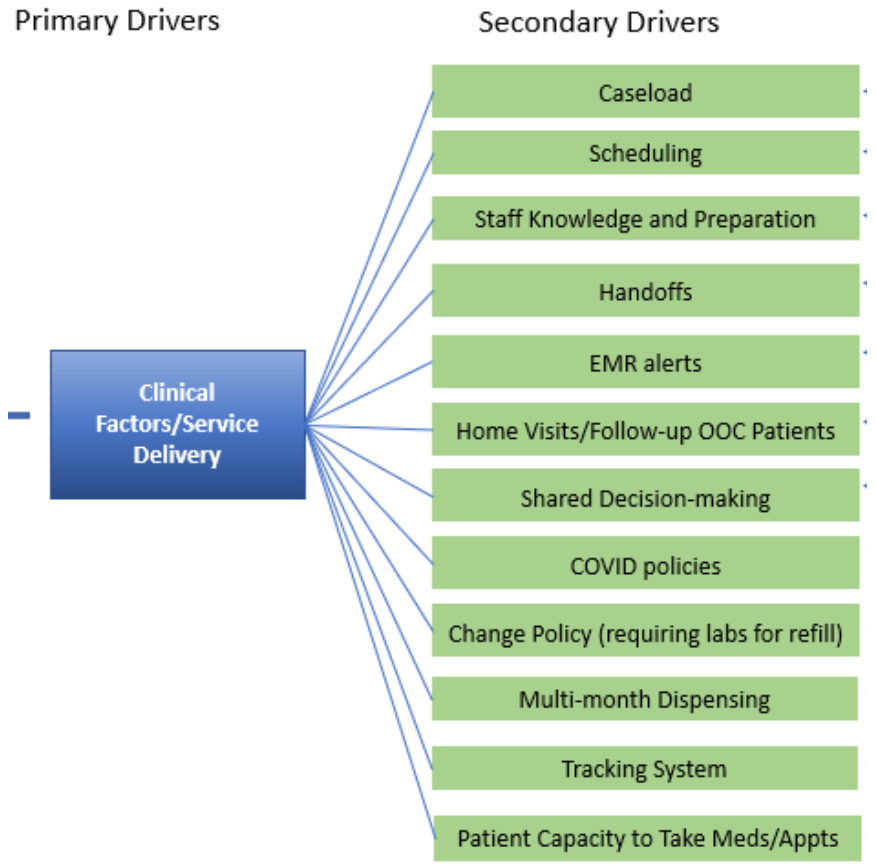
Health System Literacy
Supportive Services
Availability/Flexibility of Services
Pharmacy Issues/Access to Medications
Provide Services at Home (food, PPE, CM)
Incentives
Insurance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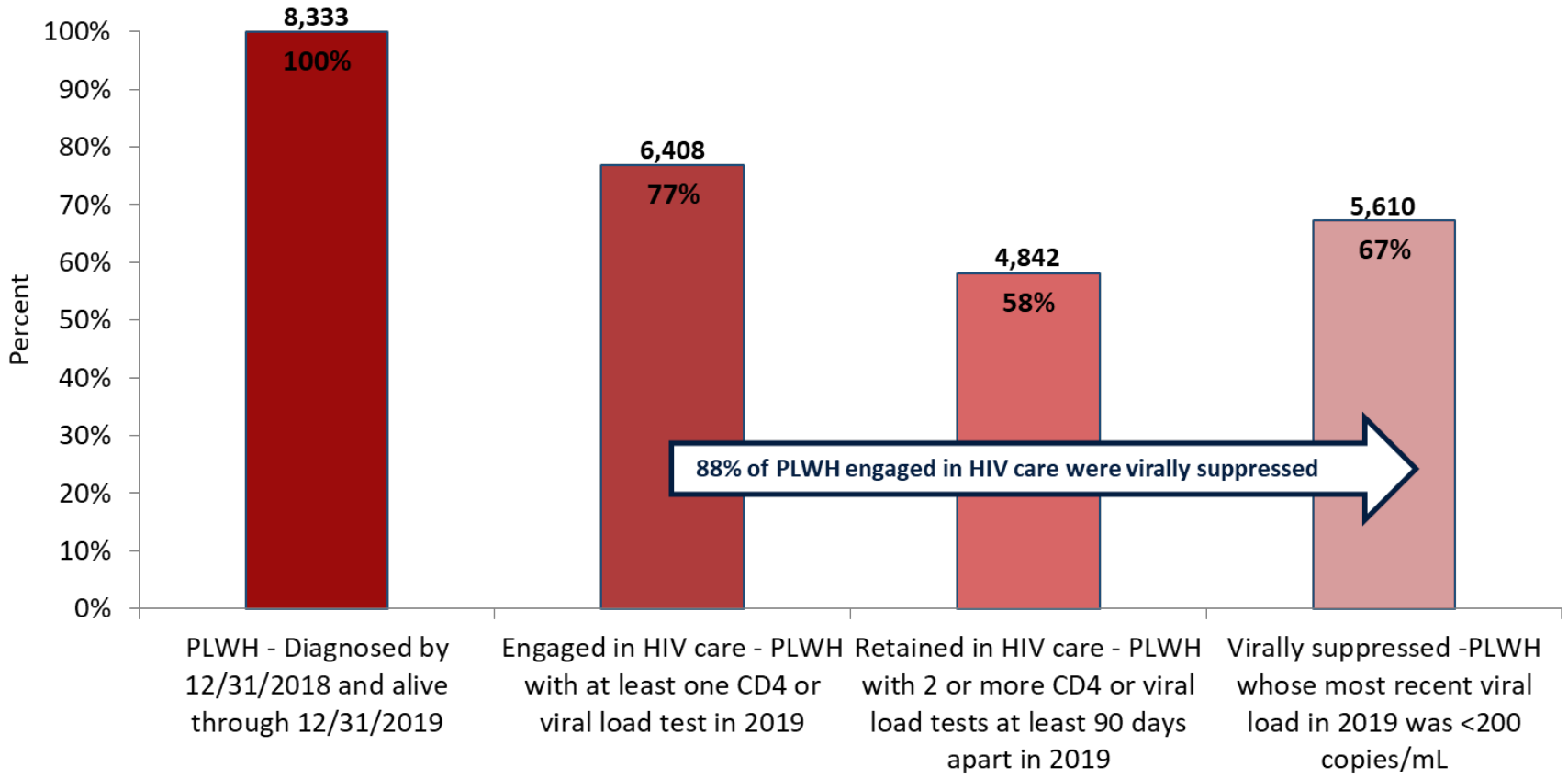
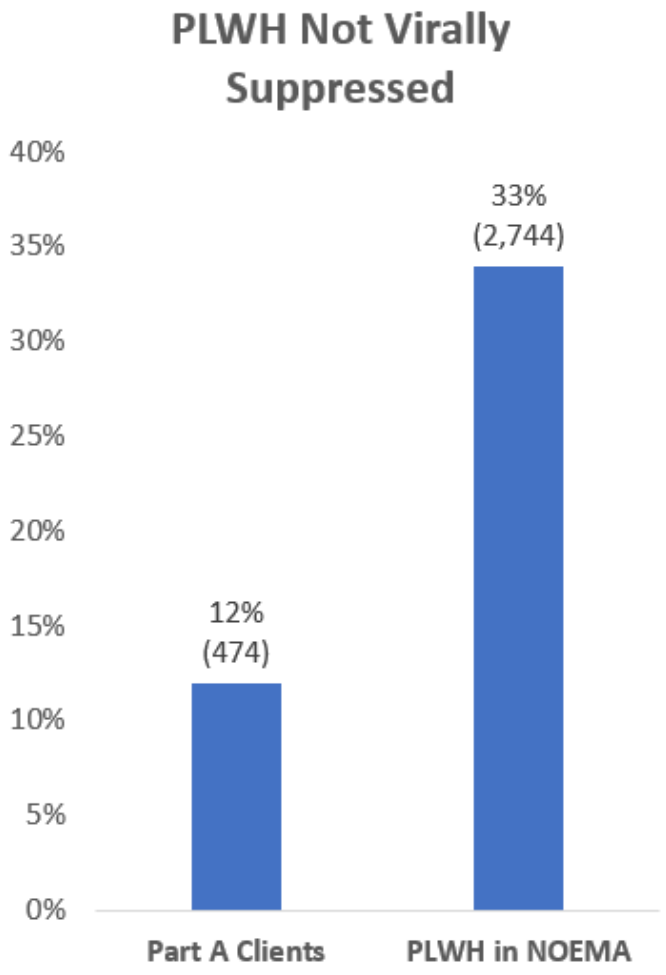
COVID policies
Change Policy (requiring labs for refill)
Multi-month Dispensing
Tracking System
Patient Capacity to Take Meds/Appts

HIV Care Continuum
New Orleans EMA, 2019

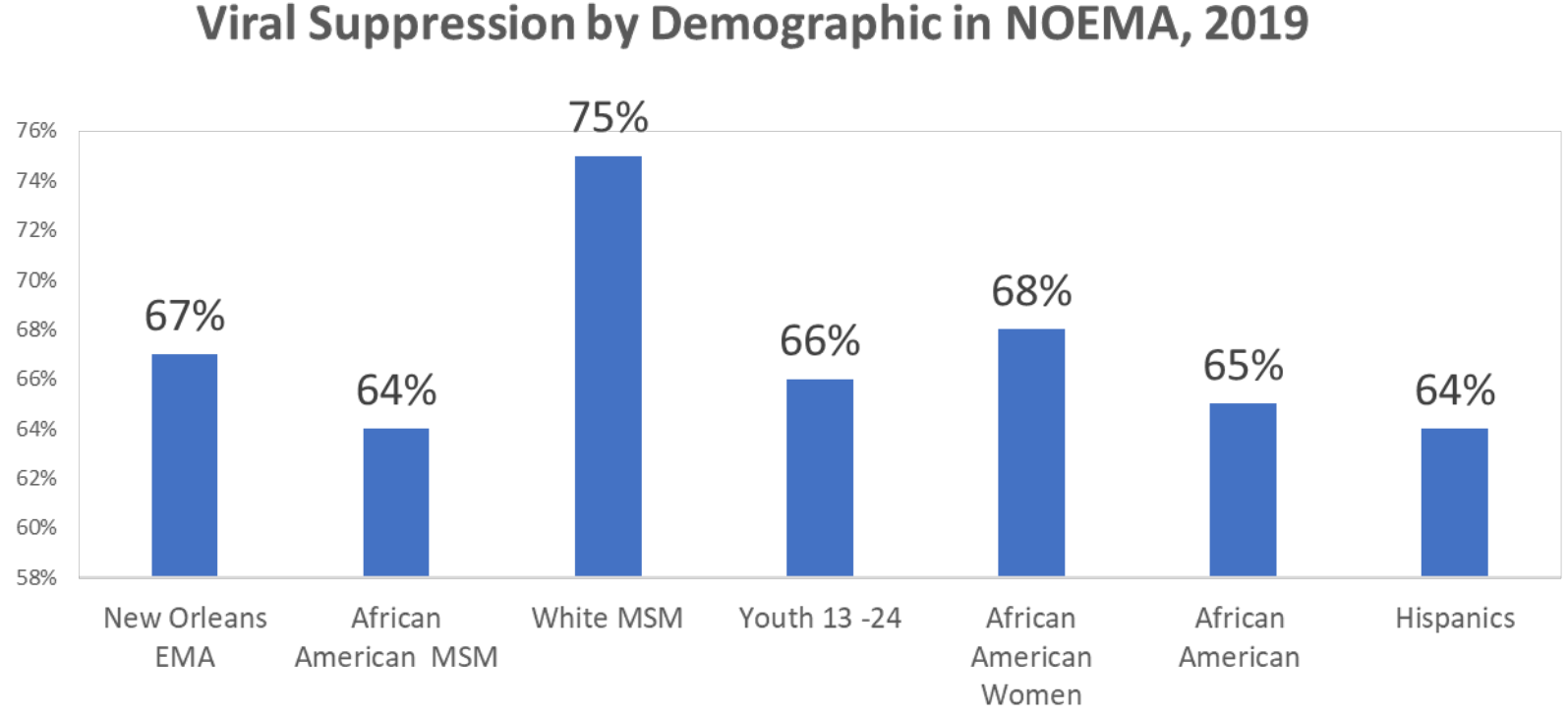


Viral Suppression & Out of Care

Part A clients: FY2019
NOEMA: Calendar Year 2019



Gap in Care Measure for Part A clients:
11% or 392



CHW Intervention

- Leveraged EHE funds to hire 5 CWHs in February 2021
- Each was assigned to Ryan White Part A Agencies
- Each agency identified their own process to integrate a CHW into their reengagement in care efforts
- CHWs receive out of care lists from their assigned agency and work to reengage clients into care
- CHWs also conduct HIV testing and prevention focused community outreach

EHE Pillars

- **Pillar 1: Diagnose** - Conduct HIV and other integrated screening
- **Pillar 2: Treat** - Re-engage PLWH who have fallen out of care
- **Pillar 3: Prevent** – Conduct outreach, provide condoms, education and referrals to SSPs and PrEP services
- **Pillar 4: Respond** - Assist agencies in responding to outbreaks

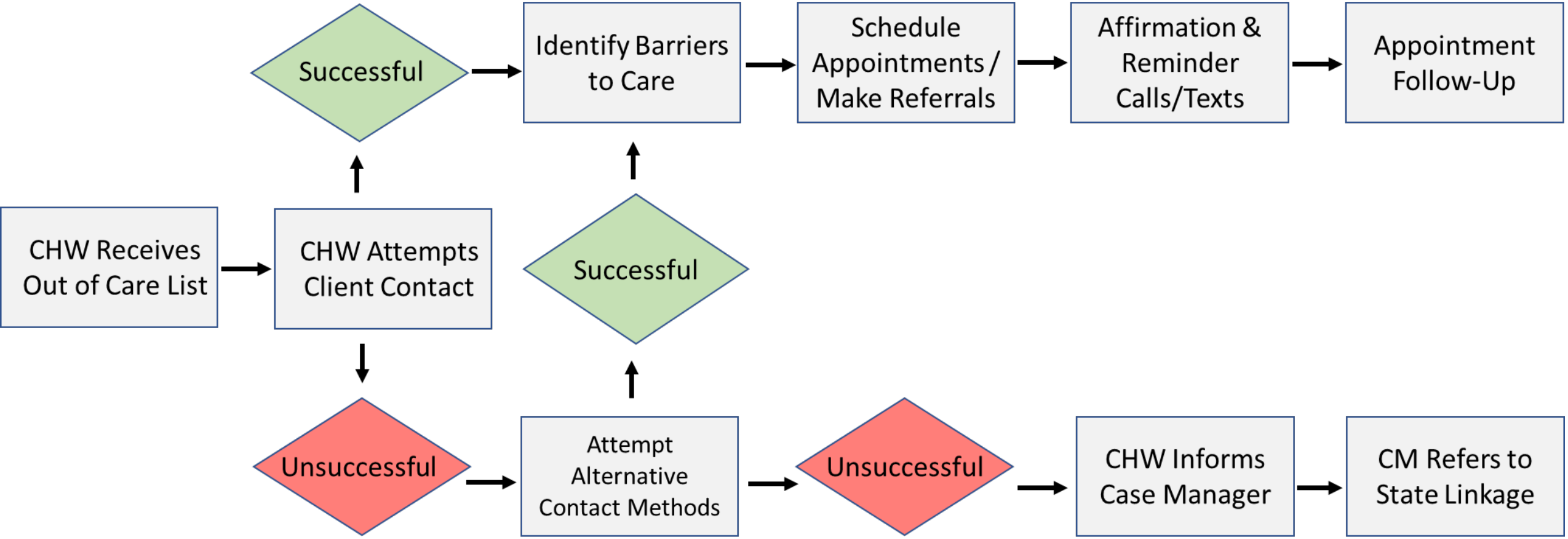
Reengagement in Care

Reengagement Process

- Each agency sets their own criteria for identifying an out of care list that is assigned to a CHW
  - Hardest to reach clients
  - Specific target populations (e.g., AA women)
  - Clients with identified barriers to care

- CHWs contact clients, identify barriers to care, help clients to develop a reengagement plan, make appointments, and make referrals to supportive services to address barriers to care

Typical CHW Workflow



Common Barriers to Care

Barrier to Care	CHW Interventions
Lack of transportation	Provide transportation vouchers, transportation assistance, and/or arrange telehealth appointment(s)
Employment/housing instability	Refer to workforce/employment training services and/or housing services
Mental health and substance use	Refer to mental health, psychosocial support, substance use counseling, and/or harm reduction services
Schedule conflicts	Work with agency staff to identify accommodating appointment times, arrange telehealth appointment(s), and/or refer to childcare services
Stigma and fear of status disclosure	Identify opportunities to attend appointments without disclosing status to family, friends, etc.

Reengagement Successes

- Impact between February 2021 and April 2022:
  - CHWs have attempted contact to 1,215 clients who were out of care
  - CHWs made primary care appointments for 455 clients
  - 207 clients have attended an appointment and re-entered care

Reengagement Challenges

- Locating clients is often difficult
  - Non-working numbers / contact information
  - Incarceration
  - Use social networks
- Clinic hours are a common barrier to care
  - Telehealth can be a useful tool, but labs still require in-person visits
- Many clients have dual diagnoses that pose barriers to care (mental health, substance use, chronic conditions, etc.)
  - CHWs must develop reengagement plans that emphasize holistic health care

Agency Responses to CHW Intervention

- “From day one, she has fit in with our staff with ease and has been a great asset to our department. She has participated in community events, is able to effectively communicate with both our staff and our clients, and often provides fresh and new ideas to help us move forward and be productive.”
- “They have been very helpful in creating one on one relationships with our patients to encourage and actually get them to attend their appointments”

Retention in Care

Patient Experience Questionnaires

- CHWs support retention in care efforts in multiple client engagement opportunities, including administration of patient experience questionnaires after appointments

- The questionnaires ask:
  - Was information explained clearly?
  - Was the clinic/agency welcoming?
  - Was the patient treated with respect?
  - Were privacy and confidentiality observed?
  - Was the patient involved in health care decision making?
  - Did the provider spend enough time with the patient?

Patient Experience Questionnaires continued

- CHWs can identify client concerns in real time, bring them to the attention of agency staff, and work to resolve problems
- These steps can help improve care quality and prevent clients from falling out of care
- Clients often report that they feel more comfortable discussing their experiences with a CHW than with a provider or agency staff member
- Examples of concerns raised in questionnaires:
  - Client said they felt unheard when raising concerns about their blood pressure meds
  - Client said staff made them state personal information in front of other people, which made them feel uncomfortable
  - Client said they felt “left in the dark” regarding their treatment/care options

Emergency Preparedness

- CHWs administered an emergency preparedness survey to Part A clients in April 2022
- Survey asked clients about experiences accessing HIV care and medications after Hurricane Ida
- Collected responses from 194 clients
- Gathered vital information to inform EMA-wide efforts to help clients remain engaged in care during future emergencies

Access to Care After Hurricane Ida

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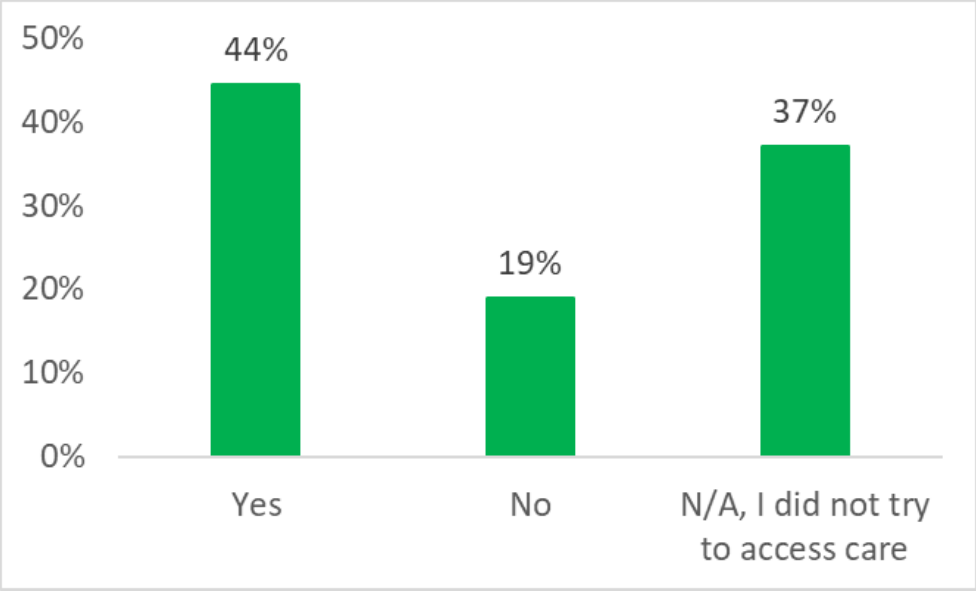
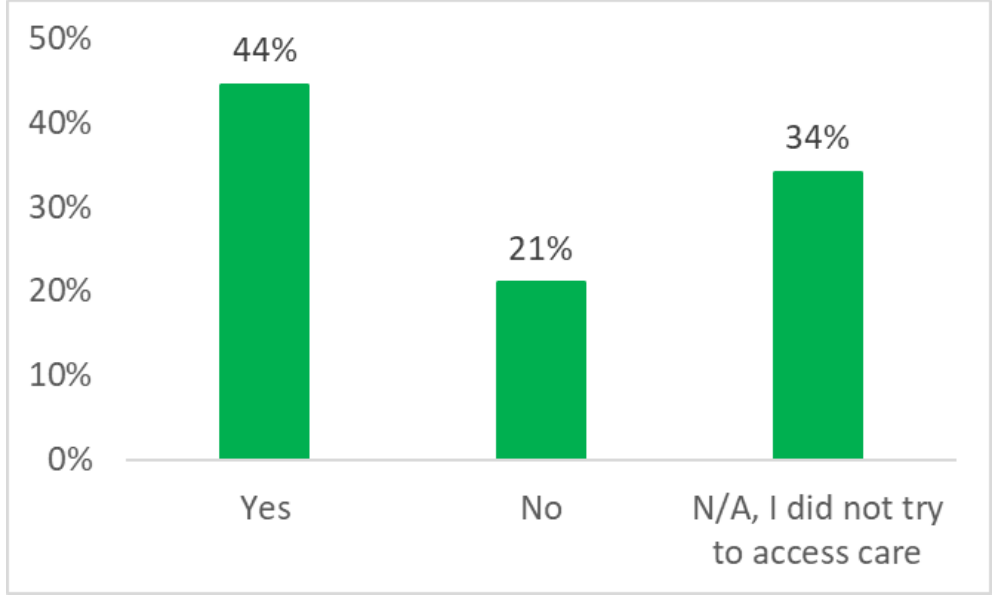
Clients who Evacuated



Of those who tried to access care, 30% were unable to access care.

Clients who Stayed



Of those who tried to access care, 32% were unable to access care.

Access to Medications After Hurricane Ida

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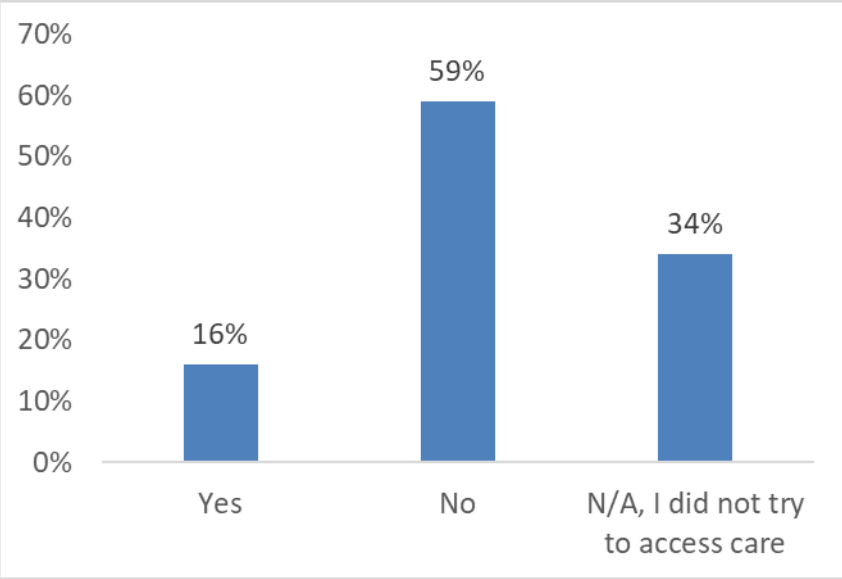
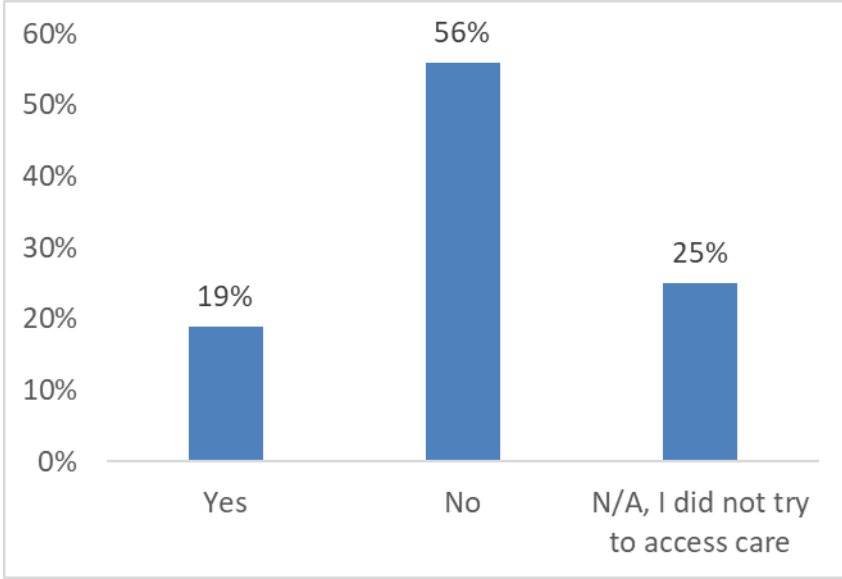
Clients who Evacuated



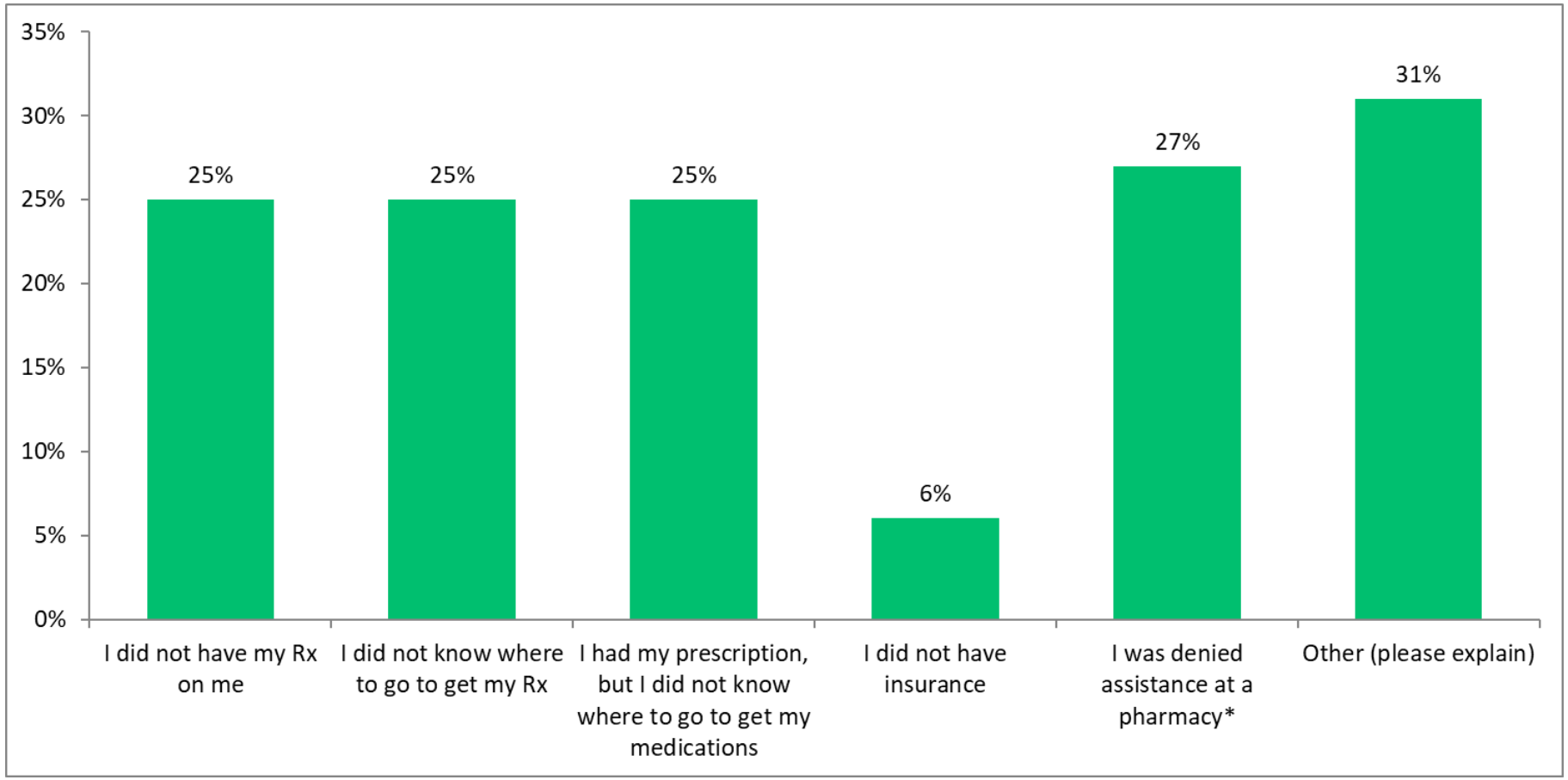
Of those who tried to access medications, 21% had problems.

Clients who Stayed



Of those who tried to access medications, 25% had problems.

Problems Accessing Medications: Clients who Evacuated

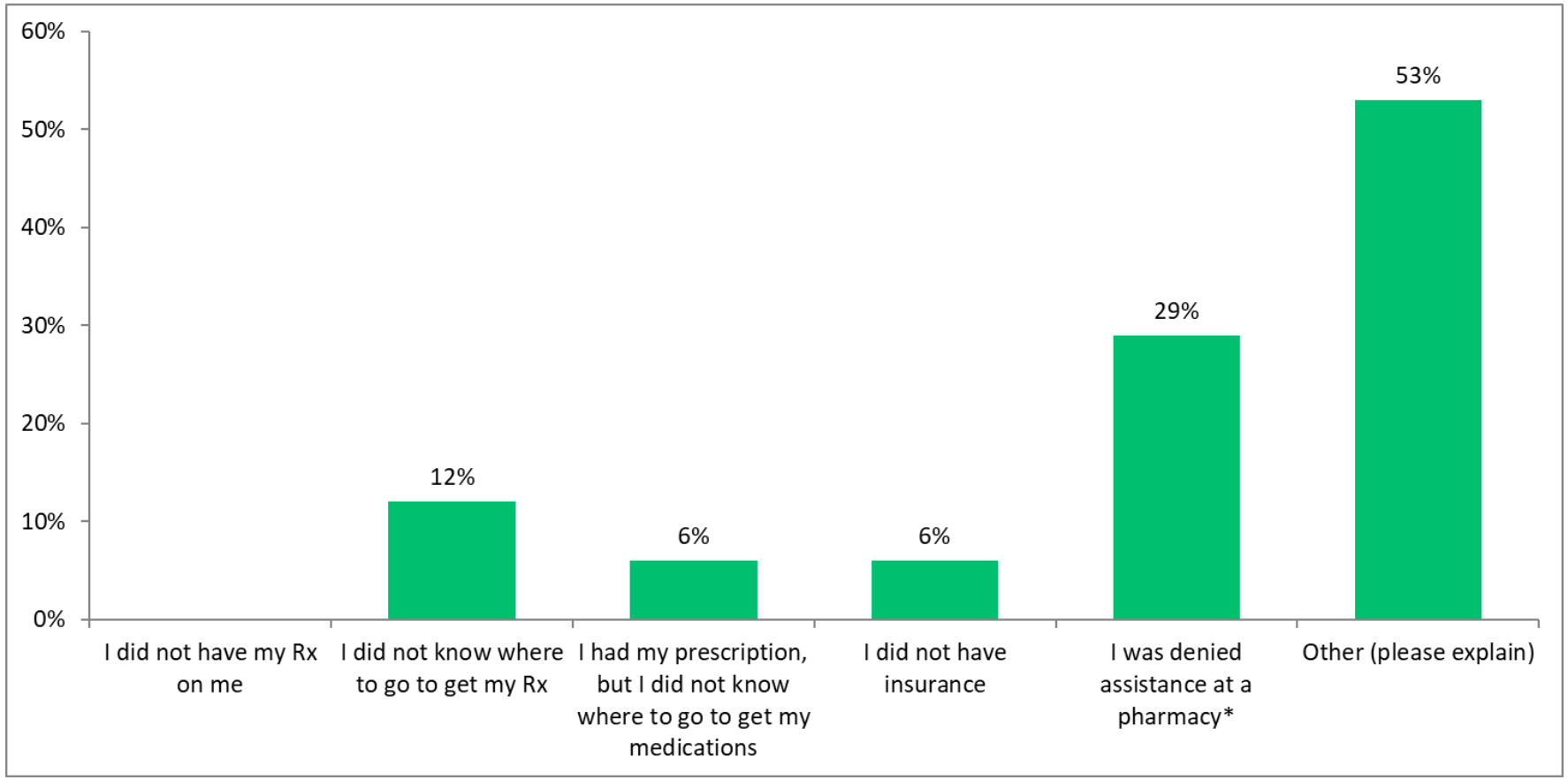


*pharmacy did not accept insurance, pharmacy would not fill, pharmacy did not have medications, pharmacy did not have my prescription, etc.

Other Meds Access Problems

- "I had to order it and it took 9 days to go through to get my medications."
- "I needed a doctor and wasn't able to get a referral or care anywhere I had gone to."
- "Facility was responsible for my medication."
- "My family doesn't know my status."

Problems Accessing Medications: Clients who Stayed

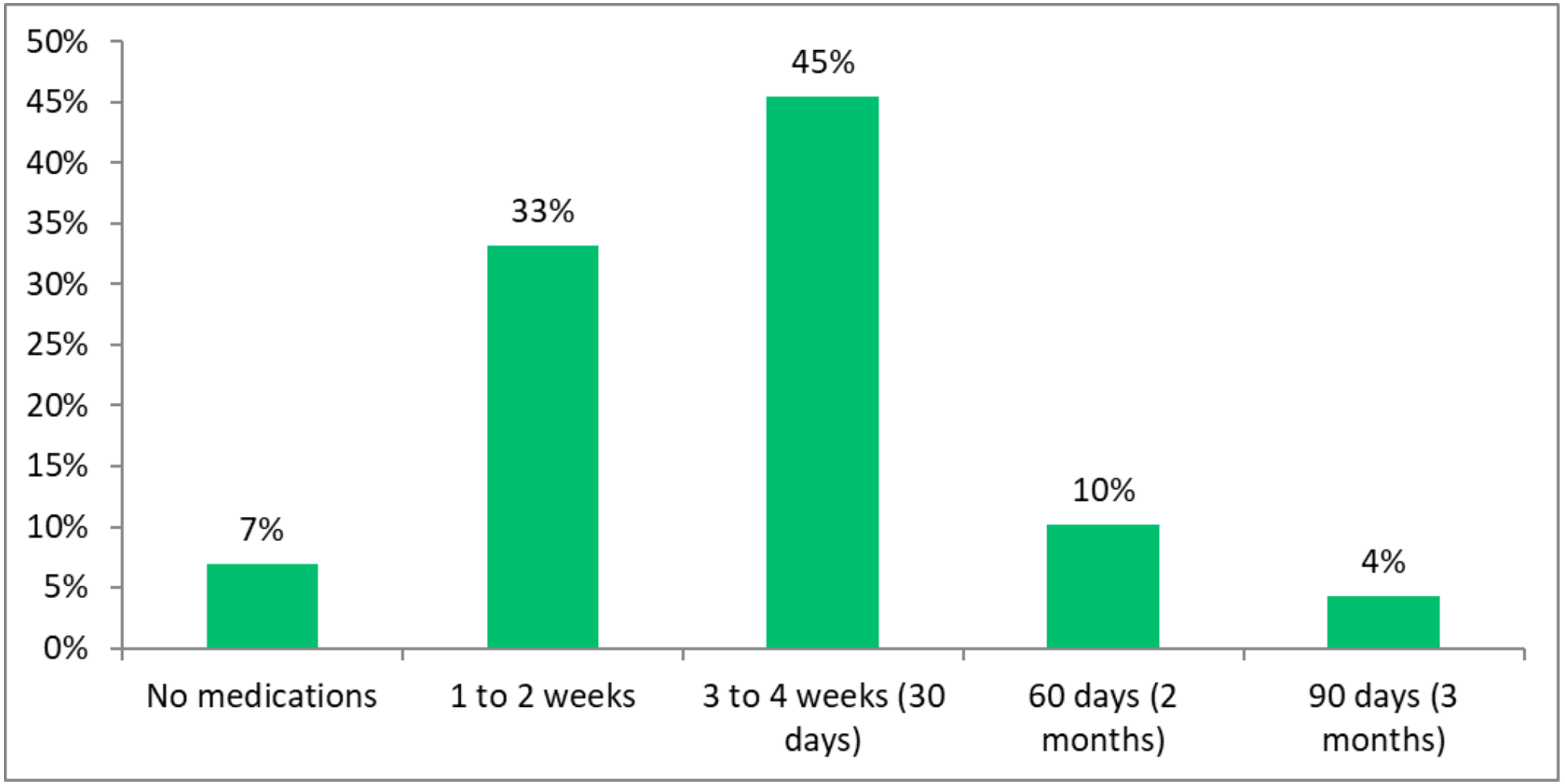


*pharmacy did not accept insurance, pharmacy would not fill, pharmacy did not have medications, pharmacy did not have my prescription, etc.

Other Meds Access Problems

- Pharmacy was closed
- Could not find pharmacy with medications in stock
- "I was out of night meds and depression meds."
- "Very long wait at pharmacy and they did not have some medications in stock. They were not open regular hours."

Medication on Hand During Hurricane Ida



How Survey Results Informed Emergency Planning

- Identified expanding access to 90-day prescriptions as a priority
- Agencies updated emergency protocols
  - Protocols in the event of a power outage
  - Protocols to inform clients how to access medications and health information following a natural disaster
- Identified need to better coordinate with surrounding states and agencies within Louisiana
- Developed plans for improved inter-agency communication and an emergency public information hub

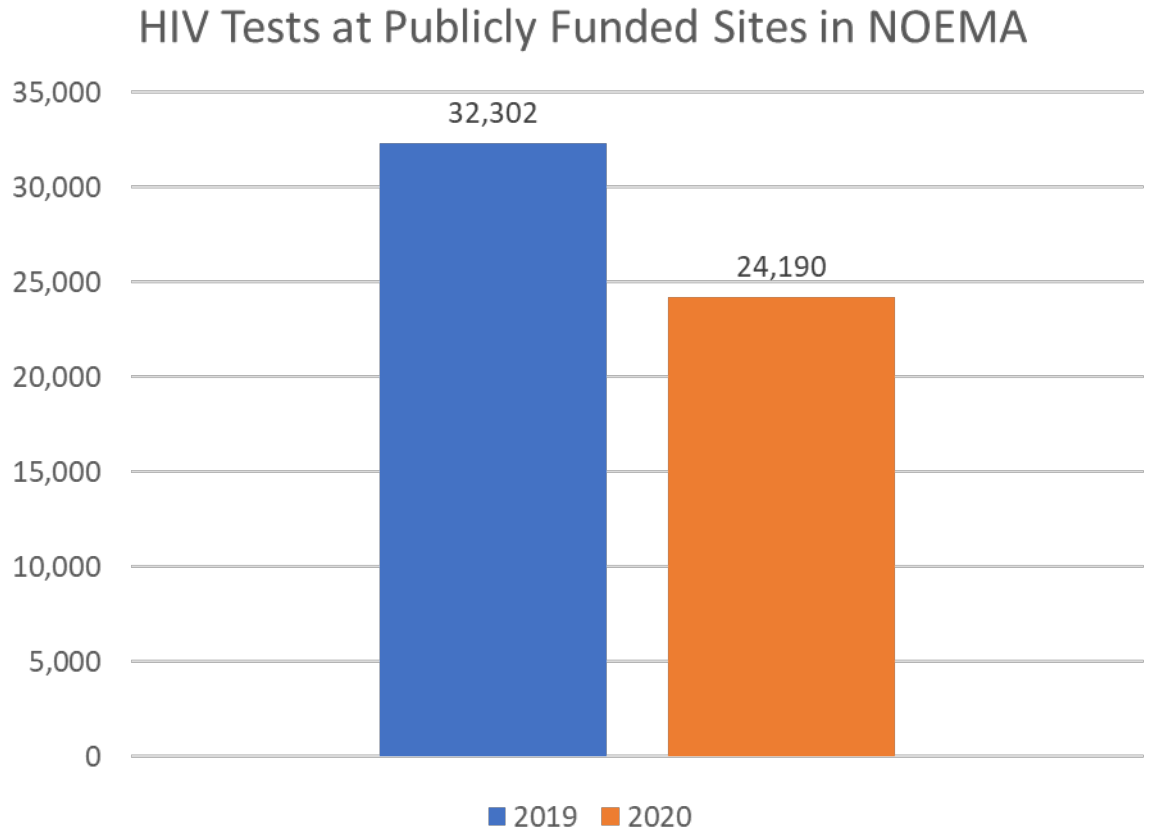
Retention Lessons Learned

- CHWs are in a uniquely effective position to gather quality improvement data
- Clients often express greater comfort sharing information with a CHW
- CHWs' ability to identify and address client concerns quickly can help prevent clients from falling out of care

CHWs as At-Home Testing Navigators

COVID Impact on HIV Testing

- HIV testing significantly declined in 2020
- Testing sites paused operations
- Clients were hesitant to access in-person testing



Text to Test

- NOEMA launched a “Text to Test” initiative in June 2021
- Residents can request an at-home HIV test kit by texting TEST to an automated text messaging number
  - Text exchange collects client contact information and asks for consent to contact
- Each request is assigned to a CHW
  - CHWs contact clients to set up a test drop off time and a virtual testing appointment
- CHWs serve as testing navigators
  - Walk clients through the testing process
  - Engage clients in a discussion about risk reduction
  - Help clients interpret results
  - Make referrals as necessary

Testing Lessons Learned

- Marketing strategy is key
  - Low demand without targeted marketing campaign
- Collect demographic info during first phone contact
- Schedule testing appointment within 24 hours of test drop off
- Be aware of 20-minute wait time for test results
- Establish procedures to visibly verify test result
- Have linkage to care systems in place
- Incentives may reduce loss to follow-up

Outreach & Prevention

Outreach Activities

- CHWs regularly conduct venue-based and event-based outreach
- CHWs distribute prevention information and safer sex resources, conduct on-site testing, and make referrals to PrEP, nPEP, and SSPs
- Outreach events promote U=U and engage community members in stigma reduction activities (e.g., filling out “stop HIV stigma” pledge cards)
- Community outreach increases the visibility and social standing of the CHW team and helps to destigmatize CHW interactions by providing status neutral services

Key Lessons Learned

Lessons Learned

- Adaptability is key
  - Part A agencies were able to integrate a CHW into their unique workflow and address agency-specific needs
- Community outreach is essential
  - Outreach events help to build trust/visibility and reinforce insider status
- CHWs can play an important role in quality improvement
  - Insider status helps CHWs identify concerns that may get overlooked
- Establish strong communication & reporting systems
  - Helps to prevent duplication of efforts and loss to follow-up
- CHW turnover
  - CHWs transitioned to working at agencies permanently or in other programs

CHWs Can Help Address COVID-Related Challenges

- CHWs distributed COVID home test kits to promote re-engagement in care
- CHWs distributed HIV home test kits to address testing site closures
- CHWs helped schedule telehealth appointments
- CHWs arranged for transportation assistance
- CHWs made referrals for mental health and other supportive services

References

[1] American Public Health Association. n.d. Community Health Workers. Available at: https://www.apha.org/apha-communities/member-sections/community-health-workers

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Text Description for Slide 18

Typical CHW Workflow

1. CHW Receives Out of Care List and Attempts client contact
    a. If successful, go to number 2.
    b. If not successful
        i. Attempt alternative contact methods
            1. If successful, go to number 2.
            2. If not successful, then CHW informs case manager and CM refers to state linkage.
2. Identify Barriers to Care
3. Schedule appointments/referrals
4. Affirmation and reminder calls and texts
5. Appointment follow-up