The Role of Primary Care in HIV Prevention: Primary Services for Positives

Bedford Stuyvesant Family Health Center

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Partnerships for Care Staff
Outline

1. Mission
2. Overview of BSFHC
3. P4C Team Composition
4. 3 Main Prevention Services for Positive Patients
5. Selection of Services
6. Internal Monitoring Processes
7. Suggestions for Integration
Mission

To provide the most professional, courteous and highest quality health care, with dignity, to those we serve, especially the underserved population, without regard for their ability to pay.
Demographics

Total Number of Patients by Age and Gender - 2014

Age Groups

- Under 12 years old
- Ages 12-17
- Ages 18-24
- Ages 25 - 34
- Ages 35 - 44
- Ages 45 - 54
- Ages 55 - 64
- Ages 65 - 74
- Age 75 and over

Total Number of Patients

- Female
- Male
Demographics

Newly Diagnosed HIV Patients by Age and Gender - 2014-2015

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Total Number of HIV Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 20-25</td>
<td>2</td>
</tr>
<tr>
<td>Ages 26-31</td>
<td>6</td>
</tr>
<tr>
<td>Ages 32-37</td>
<td>1.5</td>
</tr>
<tr>
<td>Ages 38-43</td>
<td>1.5</td>
</tr>
<tr>
<td>Ages 44-49</td>
<td>5</td>
</tr>
<tr>
<td>Age 50 and over</td>
<td>1.5</td>
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</tbody>
</table>

Legend:
- Female
- Male
Demographics

Newly Diagnosed HIV Patients by Race and Ethnicity - 2014-2015

- Black: 86%
- White: 4%
- Native Hawaiian: 7%
- Unreported/Refused to Report: 3%

Legend:
- Red: Black
- Brown: White
- Beige: Native Hawaiian
- Light Blue: Unreported/Refused to Report
P4C Team Composition

- 2 HIV Specialists
- Adherence/Care Manager & Medical Assistant
- Chief Medical Officer
- Data Analyst
- Outreach/Health Education Specialist
- Psychiatrist
- Program Manager
- Social Worker
- Critical Staff (Not funded) – CEO, Clinical Coordinator, Finance Control, Billing, Patients Relations Officer
3 MAIN PREVENTION SERVICES

1. INTEGRATED CARE
2. PATIENT INVOLVEMENT
3. H.E.A.R.T APPROACH
I. Integrated Care

1. All patients with a medical visit also see the behavioral health visit:
   a) The “warm-hand off” allows for thorough review and integrates well with the team:

B. Engagement with social worker:
   b) Looks broadly at socio-economic determinants of health
   c) Adjustment to new diagnosis
   d) Facilitate re-engagement to care

C. Involvement of psychiatrist:
   a) Deeper levels of depression
   b) Additional medical intervention (i.e. psychototropic medication)
I. Integrated Care

2. Referral to Dental and other Specialties

3. Medical Case Worker Assigned:
   a) Assist with insurance application, housing, rehab needs, other referral

4. Patient tracking:
   a) Closely looking at what services patients are accessing
   b) Where on the continuum of access to service delivery they are?

5. Case conference integrated care team approach
   a) Highlight patient needs
### Patient Tracking Form - P4C Patient Services Tracking Form

<table>
<thead>
<tr>
<th>Patient ID #</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
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<tr>
<td>P4C Care Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred (YES/NO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred by</td>
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</tr>
</tbody>
</table>

### Psychotherapeutic & Support Services

<table>
<thead>
<tr>
<th>Case Consultation</th>
<th>Services Began On</th>
<th>Patient Seen On</th>
<th>Case Review Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling: individual/married/family</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health Education</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adherence Risk Assessment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adherence intervention</td>
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<tr>
<td>Psychological Assessment</td>
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II. Patient Involvement

1. Surveying patients for feedback on overall intervention effectiveness (e.g. interviews, focus groups)
   - Since October we have been administering a patient survey

2. Conduct projects such as healthcare stories, developing a word cloud – we have started asking patients for one word that describe “what quality healthcare means to them”

3. Convene Community Advisory Board
II. Patient Involvement

4. Building a uniquely patient-focus workshop intervention
   a) Utilizing the health educator to engage with patient (broaden current role from outreach/recruitment)
   b) Address topics that looks at the overall wellness, discordant couples, basic HIV facts, internal stigma, relationships, and living with dignity (feedback from a recent patient survey):
      a) Individual and workshops will be rolled out – patients have supported this direction
      b) Will hire a part-time peer navigator - HIV+ MSM of color to support the intervention implementation
Showing Concern
Acceptance
Human Compassion
X-tra-Mile
Care
Good Information
Treatment
advice
Confidentiality
Counseling
Follow-up
Warmth
Support
Patience
Respect

Patient Activity - Quality Care
2012 HIV Care Continuum for New York City

Largest gap: Linkage → Retention

- Estimated HIV-infected: 133,635 (100%)
- Ever HIV-diagnosed: 114,926 (86% of infected)
- Ever linked to HIV care: 97,940 (73% of infected, 85% of diagnosed)
- Retained in HIV care in 2012: 72,918 (55% of infected, 74% of linked to care)
- Presumed ever started on ART: 67,624 (51% of infected, 93% of retained in care)
- Suppressed viral load (≤200 copies/mL) in 2012: 55,453 (41% of infected, 82% of started on ART)

As reported to the NYC DOHMH by June 30, 2013.
III. H.E.A.R.T APPROACH

1. Helping Enhance Anti-Retroviral Therapy (H.E.A.R.T)
   a) Evidence based Adherence intervention drawing on 3 models
      • Self-determination model,
      • Problem solving model, and
      • Social support model

2. HEART is most effective with patients who are treatment naïve and/or transitioning to other ART therapies.
   a) Has a retention record (adherence levels) of 73% within a 3 month period and 70% within a 6 month period.
III. H.E.A.R.T APPROACH

Implementation – what we do:

1. We conduct 5 sessions over a period of 6 months - phone call follow up in between sessions.

2. The aid of a patient – a support partner is identified - should attend at least 2 sessions.

3. Initial sessions (2) take place before the therapy is initiated or transitioned.

4. Initial sessions allows for identification of barriers and concerns through motivational interviewing, and patients self-awareness.

5. Also allows for enhanced HIV and health education.
III. H.E.A.R.T APPROACH

Progress – what we see

1. We have seen results only after 3 months of using the intervention

2. Patients have been receptive to follow up calls, follow up sessions, and problem solving cooperatively to identify barriers and concerns

3. Achieve viral suppression and address social concerns such as housing, employment, and overall health – this elevates HIV care as a priority
How Did We Select These Services

1. NYC HIV Continuum of Care introduced early into our work - training workshops
2. We wanted to track our patients services - “what, where, with whom & status”
3. Foster openness among the Care team:
   a) Integrate patient tracking into our case management meetings – assessing appropriateness, additional needs, actual status –Include patient voices in quality care –
4. Quality Improvement
   a) We wanted to include our patients in the story –
   b) Awareness about areas for involvement
How Did We Select These Services

5. We opted to do workshops:
   a) Low rates of attendance
   b) Developing patients skill-sets as oppose to giving information

6. Prior to utilizing HEART, we created a list of questions that we thought would help determine risk adherence.
   a) The list of questions were developed in March/April as part of the adherence staff work plan – including intervals, sequencing and type of communication.
   b) Towards end Yr.1, as our patient based started to grow – the need for our approach to be evidenced based became more pronounced.
   c) Search CDC’s DEBIs, listened to various webinars and reviewed manuals – in search of something that worked
How Do You Know Whether The Services You Are Providing Are Working Well For Your Patients?

1. Providing quality – Process focus
2. Dedicated medical providers
3. Care manager/medical assistant – to follow up with patients regularly – has access to labs and consults with physicians.
4. Team oriented – allows for providers to support each other to ensure patients receive what they need.
5. Case conferences – utilized around specific patients to share and exchange updates – key meeting for strategizing on engagement in care.
How Do You Know Whether The Services You Are Providing Are Working Well For Your Patients?

6. Measuring quality, reviewing data – quantitative focus
   a) Viral load is key for evaluation prevention for positives
   b) CD4 count
   c) New infections such as other STIs or abnormal labs
   d) Appointments/Retentions
   e) Other indicators that provide broad understanding and forewarning

7. Patient feedback
   • Routinely surveying patients
   • Cold calls - checking-in with patients
   • Workshop assessments
Suggestions for Integration

1. Identify a clinic-focused provider who links all providers together (MA, Nurse, Caseworker, etc.).

2. Establish/Use working policies, procedures, workflow – how things will work – practice will inform further directions.

3. Interventions can be homegrown, cutting-edge, pre-packed or whatever works for your setting.

    Important point: is to incorporate some type of measuring of the intervention.