Using Ryan White Case Management Standards to Support Status Neutral Service Delivery to PrEP Patients

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Andrew Wilson, MA – Project Connect Director

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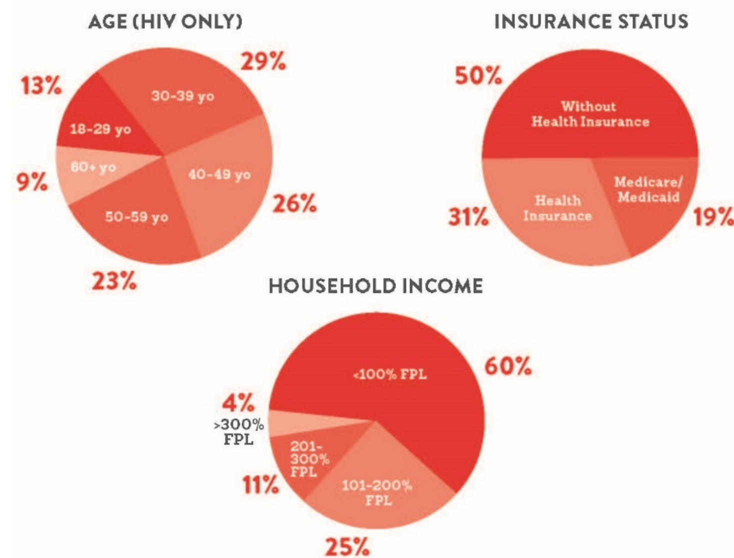
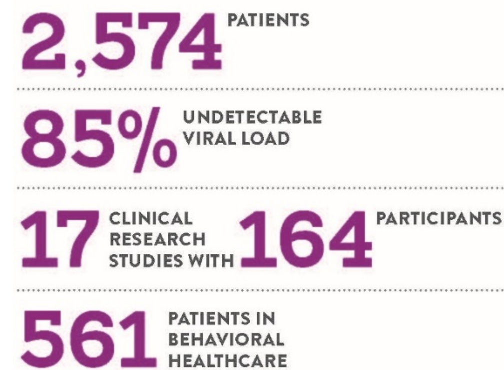
Prism Health North Texas by the Numbers

Patient Profile



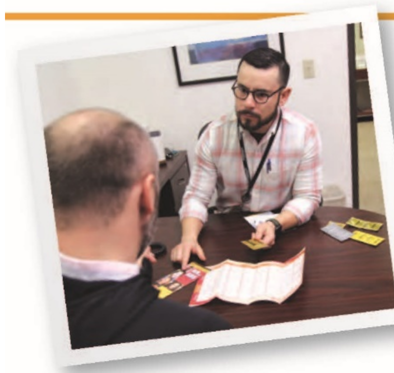
INSURANCE STATUS
50% Without Health Insurance
31% Health Insurance
19% Medicare/Medicaid

Personalized HIV Primary Care

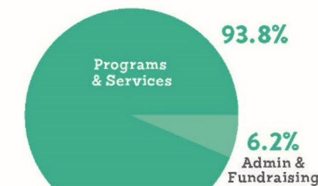


Unique Interventions

HIV Prevention



OPERATING EXPENSES



North Texas Locations

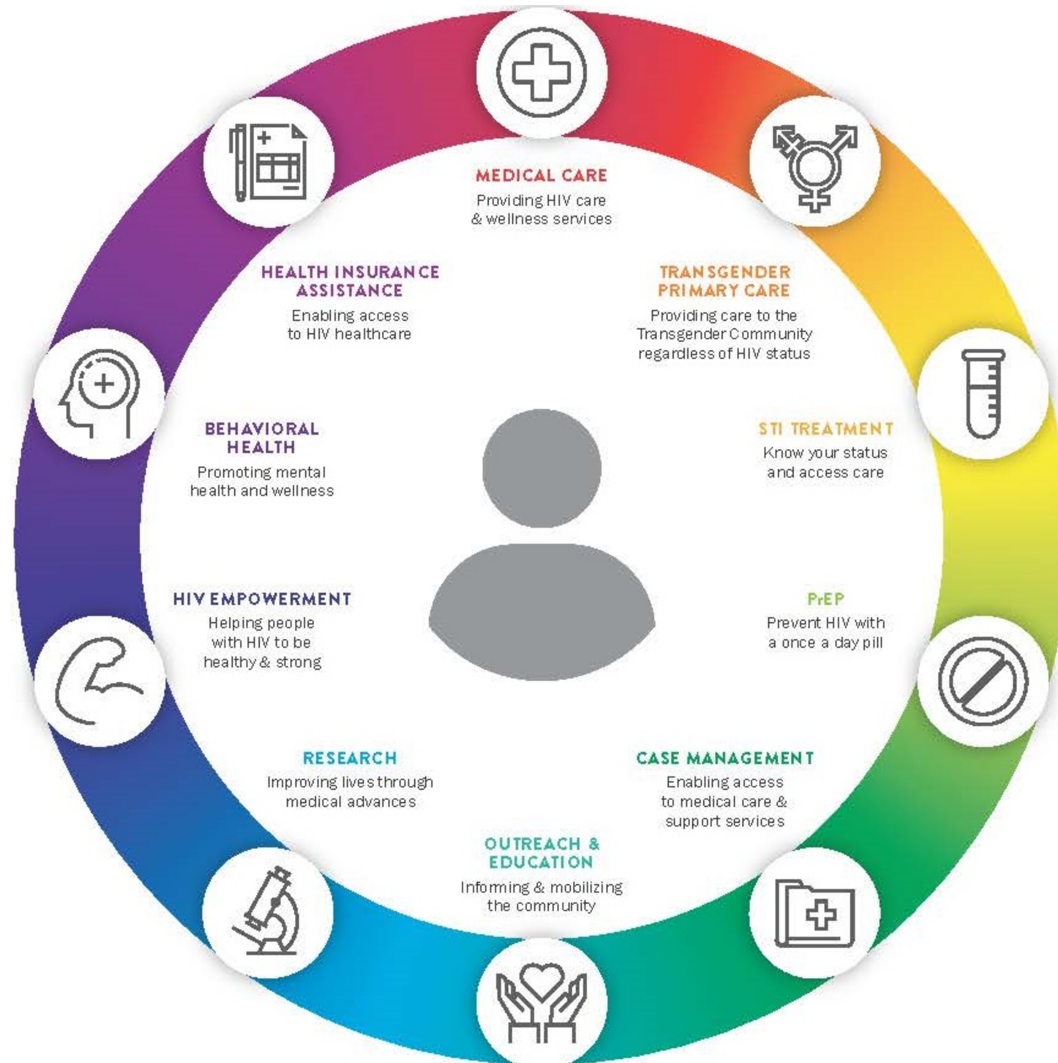
LOCATIONS THROUGHOUT NORTH TEXAS

GREENVILLE
HENDERSON
OAK LAWN
7
1
OLD EAST DALLAS
2
DESIGN DISTRICT
VICTORY PARK
DEEP ELLUM
3&4
Dallas
SOUTH DALLAS
KESSLER
BISHOP ARTS
5
6

1. Oak Lawn Center
2. East Dallas Empowerment Center
3. South Dallas Health Center
4. Prism Health North Texas Pharmacy
5. Oak Cliff Health Center
6. Community & Client Services, Administration
7. Dallas County Sexual Health Clinic - PHNTX

PrismHealth
NORTH TEXAS

Prism Health North Texas



Advancing the Health of North Texas through education, research, prevention, and personalized integrated HIV care.

Integrated Care and HIV Medical Home

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RECEIVE HIV TEST

HIV NEGATIVE

CONNECT

Orientation Session

Meet Your Medical Provider

Receive PrEP Services

LIVING WITH HIV

CONNECT

Welcome Visit
- Assessment & Screening
- Care Plan developed

Case Management
- Culturally sensitive support available
- Address barriers, provide referrals, link to additonal care as needed.

Medical Home

Empowered Community

PRIMARY CARE

DOCTOR

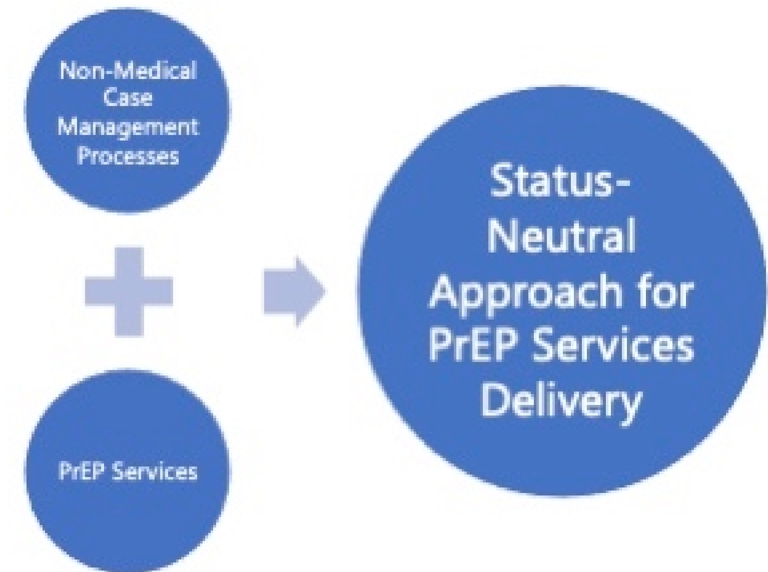
BEHAVIORAL HEALTH | DERMATOLOGY | PHARMACY
LATEST RESEARCH STUDIES | PRESCRIPTION ASSISTANCE | MEDICAL CASE MANAGEMENT
INSURANCE ASSISTANCE | PRIMARY CARE | STI TESTING

- All clinicians are experienced with latest in HIV treatment
- Extended hours
- Same day appointments for established patients
- Hormone therapy treatment provided to current patients
- Care provided inclusive for LGBTQ and ethnic minority populations

PROVIDING HIGHLY SPECIALIZED APPROACHES TO ADDRESSING UNIQUE NEEDS

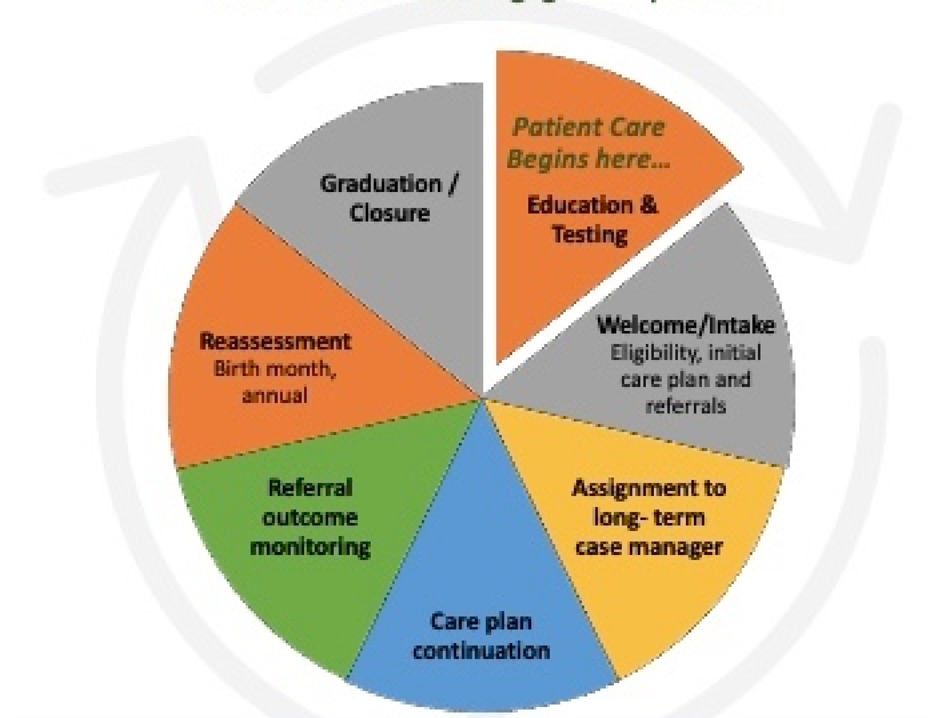
Learning Objectives

1. Apply Ryan White care standards to a patient-centered, integrated HIV prevention program.
2. Translate how relevant tools (acuity assessment, integrated care plans, encounter notes, risk assessment tools) originated to assist PLWH through HIV care to people at risk of acquiring HIV.
3. Introduce a comprehensive PrEP program into an existing integrated HIV care system that includes case management, behavioral health, housing, etc.



PHNTX Care Engagement Process

- 1986 – established a program to assist individuals living with HIV/AIDS with access to support services.
- 2005-Transitioned into an electronic health record system to manage program objectives.
- Program Structure: NMCM program aligns with TX Department of State Health Services standards of care to conduct the following key activities:
  - Initial assessment of service needs;
  - Development of a comprehensive, individualized care plan;
  - Coordination of services required to implement the plan;
  - Patient monitoring to assess the efficacy of the plan; and
  - Periodic re-evaluation and adaptation of the plan as necessary over the patient's enrollment in case management services.



Encounter Log Template Design (Time Allocation)

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- **Goal:** capture total encounter time N-MCM spends to assess a patient's needs to facilitate access to services.
- **Key template features**
  - Key assessment areas
  - Reportable, non-reportable data points
  - Holding an incomplete log
  - Signing a completed log
  - Appending a completed log with Supervisory approval
  - Emergency assistance / conditional eligibility

	Reportable Minutes	Non-Reportable Minutes
Eligibility Update		
Needs Assessment		
Linkage to HIV Medical Care		
Linkage to Referral/Resource		
Care Plan		
Crisis Intervention		
Travel Time		
Client Tracking/ Unsuccessful Contact		
Case Conferencing		
Case Documentation		
Other		

If Other, specify

Total Reportable Minutes: 0 Total Non-Reportable Minutes: 0

Total Encounter Duration: 0 Units:

Conditional Eligibility

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn)

Encounter Note Template (Contact Purpose and Acuity)

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- **Goal:** To capture case management session details to support encounter log (time)
- **Template Features**
  - Primary purpose of contact
  - NMCM required follow-up
  - Patient required follow-up
  - Acuity Assessment (used to assist in assessing case management need)

Encounter Content

Primary Purpose of Contact:

Staff Follow Up:

Client Follow Up:

Acuity Assessment: (●) yes ( ) no

System Acuity Scale

	1	2	3	4
Medical/Clinical:	●			
Basic Necessities/Life skills:		●		
Mental Health:		●		
Substance Abuse:			●	
Housing:		●		
Support System:	●			
Insurance Benefits:			●	
Transportation:				●
Legal:		●		
Cultural/Linguistic:			●	
Self-Efficacy:			●	
HIV Education/Prevention:	●			
Employment/Income:		●		
Medication Adherence:			●	

[Calculate Weighted Acuity] Weighted Acuity Score: 42

Acuity Level: 3

Encounter Note Template (Identified Needs)

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- Template Features
  - Additional assessment areas
  - N-MCM creates a care plan to address the identified needs on the encounter notes
  - N-MCM launches care plan from a needs assessment page

Needs Identified

- [ ] Financial/Employment
- [ ] Health Insurance
- [ ] Housing Services
- [ ] Mental Health Services
- [ ] Oral Health
- [ ] Outpatient/Ambulatory Medical Care
- [ ] Treatment Assistance
- [ ] Crisis Support
- [ ] Education
- [ ] Emergency Financial Assistance
- [ ] Family/Social Support
- [ ] Hospice
- [ ] End of Life Planning
- [ ] Legal/CJ History
- [ ] Nutrition
- [ ] Resource Navigation
- [ ] Risk Reduction: Sexual Behaviors
- [ ] Risk Reduction: Substance Use
- [ ] Substance Abuse
- [ ] Transportation
- [ ] Other/Miscellaneous

Create or Revise Care Plan | Care Plan Progress Note

Embedded N-MCM Assessments

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- Screening/assessment tools yields a positive or negative response
- Positive screening results allow N-MCM and the patient to decide on the next priority

System Acuity Measurement Scale	Substance Abuse and Mental Illness Symptoms Screening (SAMISS)	Behavioral Risk Assessment
• 14 needs assessment categories to identify unmet needs	• 16 questionnaire/ tool to screen for mental health and substance abuse conditions	• Identifies behaviors which increase HIV exposure risk to patients and persons with whom they engage in such behaviors

• Offer case management services to patient
• Assigns a N-MCM level (1-4) to each patient
	• **If negative** – intervention is not required
	• **If positive** – referral is offered
	  • Patient is already in program
	  • Patient declined referral
		• **If negative** – intervention is not required
		• **If positive** – referral is offered
		  • Patient is already in program
		  • Patient declined referral

System Acuity Measurement (SAM) Scale Acuity was developed by Washington State Department of Health

N-MCM Documentation Structure in the EHR

- Acuity Scale – Used to determine the level of case management need (Systems Acuity Measurement Scale)
  - Systematic approach – ensures standardized assessments across all case management teams
  - Calls the case manager's attention to the areas of unmet need
  - Provides a clear set of objectives to work towards to meet the patient's needs
  - Outlines guidance for frequency of contact, based on need

Medical / clinical
Basic necessities / life skills
Mental health / psychosocial
Substance use
Housing / living situation
Support system
Insurance benefits
Transportation
HIV-related legal
Cultural / linguistic
Self-efficacy
HIV education / prevention
Employment / income
Medication adherence

Care Planning Components (Case Management)

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- N-MCM work with patients to identify the following :
  - Problem statement/need
  - Goal(s)
  - Intervention (tasks, referrals, service delivery)
  - Responsible party for the activity
  - Timeframe for completion
  - Client acknowledgment

Identified Needs

Non - Medical Case Management

Target Date: 12/4/2020
Description: Client is seeking non - medical case management services to help client access support services.
Objectives: Welcome / Intake Specialist will assign client to a N-MCM within 72 hours to assist client access support services.
Current Measure: Client lacks support services.
Desired Measure: Client will successfully access non-medical case management / support services.

Client Action Items

PHNTX Non - Medical Case Management - CM will follow up with client upon client assignment

Problems

Z60.9 - Problem related to social environment, unspecified

Interventions

Create Referral (1 time per week for 1 week) Started on 06/05/2020
Non-Medical Case Management follow-up visit (1 time per week for 1 week) Started on 06/05/2020

Care Team

Addo, Akosua (Case Manager (Non- Medical))

Signatures

Test, Leo "Rafa"

Addo, Akosua

Project Connect PrEP Program

- Funded by the Texas Department of State Health Services (DSHS) to ensure HIV prevention services are provided to persons at greatest risk of acquiring and/or transmitting HIV infections.
- We serve core priority populations as identified by DSHS.
  - Black Men who have Sex with Men (MSM)
  - Black Women who have Sex with Men (WSM)
  - Hispanic MSM
  - Transgender Persons
  - White MSM

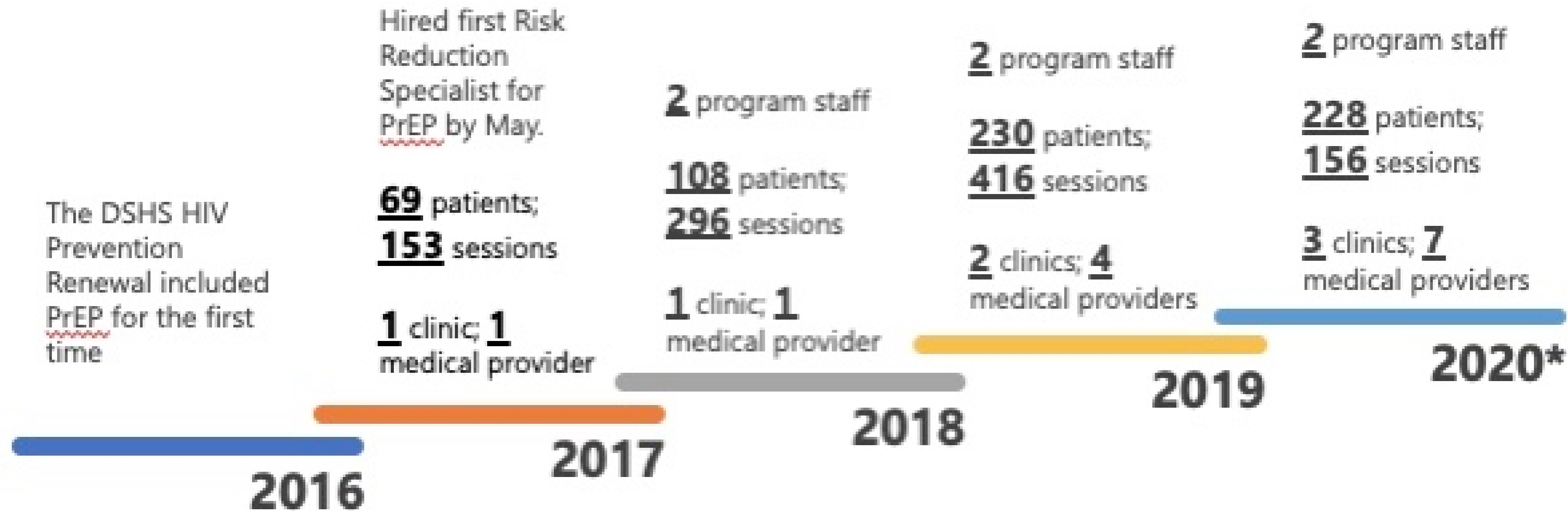
TEXAS
Health and Human Services

- Serve the Dallas Health Services Delivery Area
  - Collin, Dallas, Denton, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties

What makes Project Connect PrEP Unique?

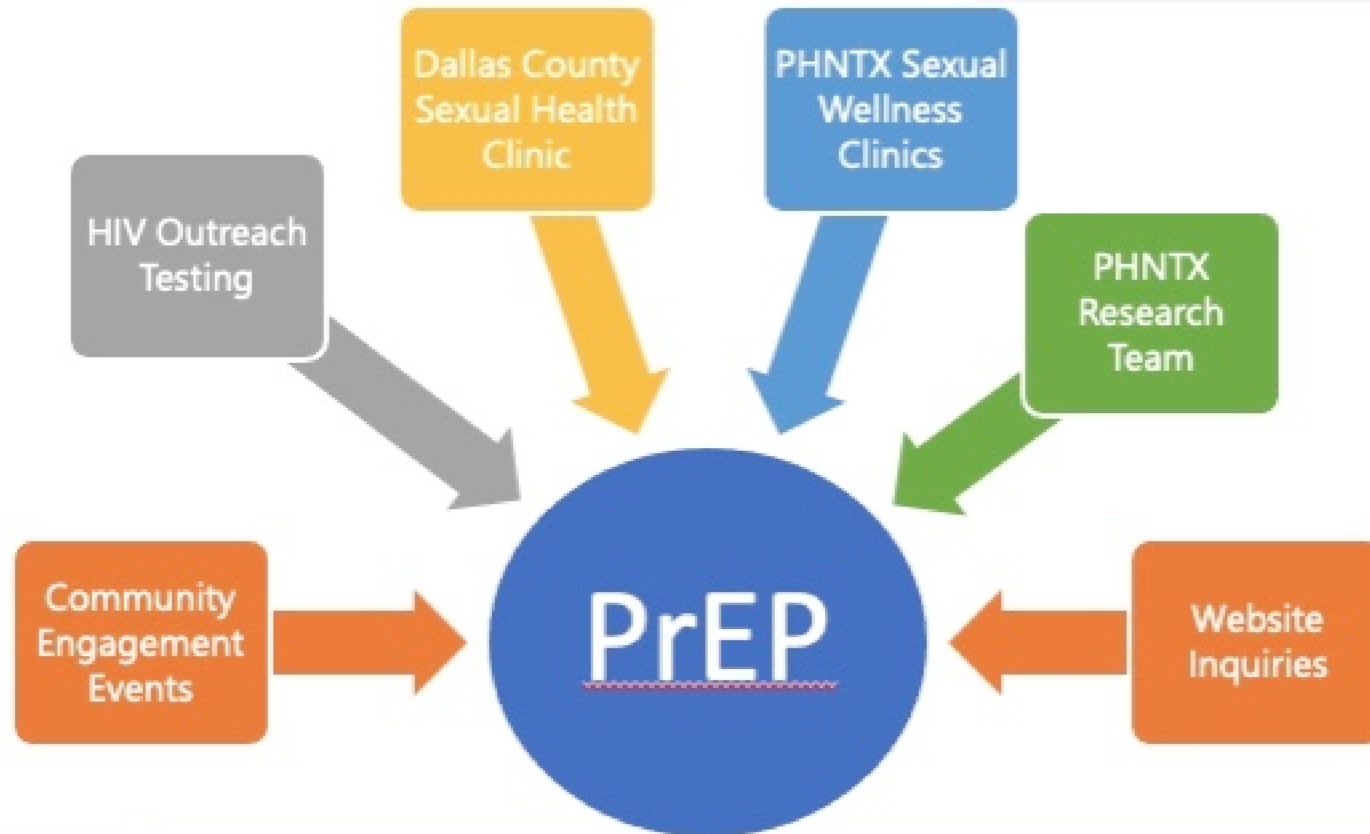
- Behavioral Intervention Specialists (BIS): structured follow-up to retain people into care and deliver at least three monthly sessions
- Risk Reduction Counseling: address behavior change coupled with medication via *Personalized Cognitive Counseling* (PCC) and *RESPECT HIV Prevention Counseling Model*
- Mobile staff: can meet the patients at and outside of the clinics
- Incorporating the Project Connect PrEP program in with the agency's electronic health record (EHR)

Program Growth

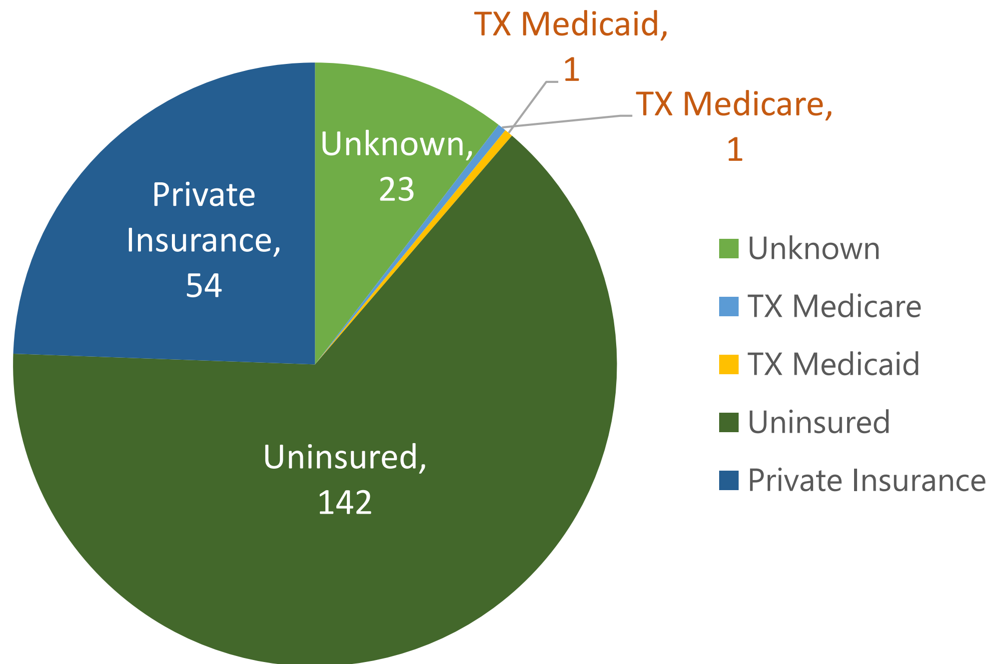


*Approximately at the halfway point of 2020

PrEP Referrals



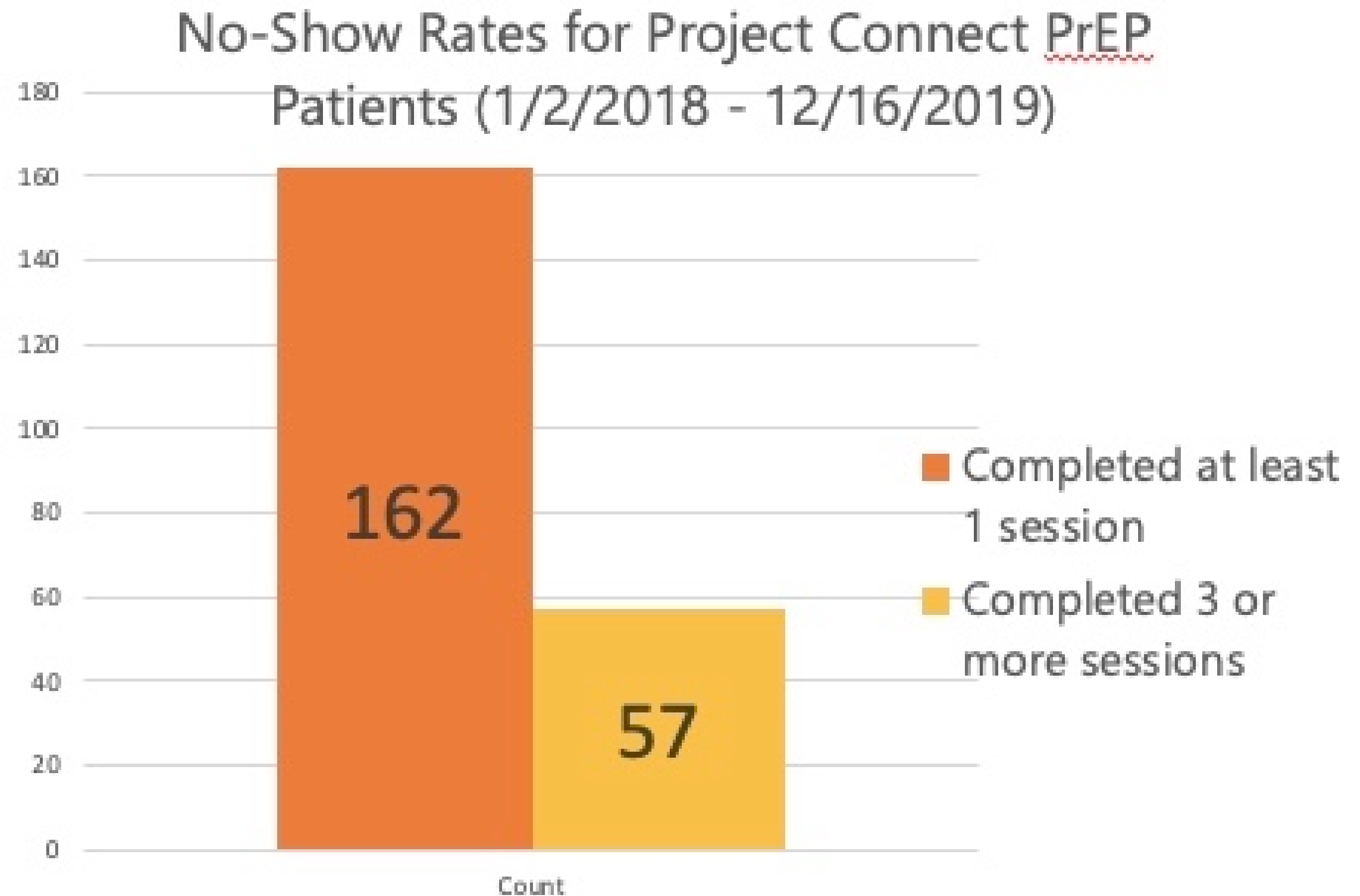
Insurance Status/PrEP Payment



- Most private and state Medicaid plans cover PrEP.
- Co-pay assistance is available for individuals with insurance.
- Patient assistance programs are available for individuals without insurance.

Increased no-show rates

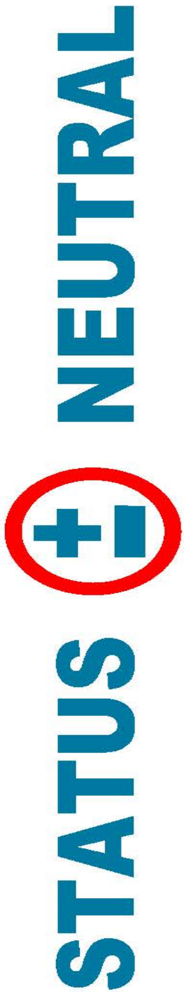
- Dramatic drop after fist session
- Inconsistency of counseling provided
- Patients are motivated to access medication, not receive risk-reduction counseling

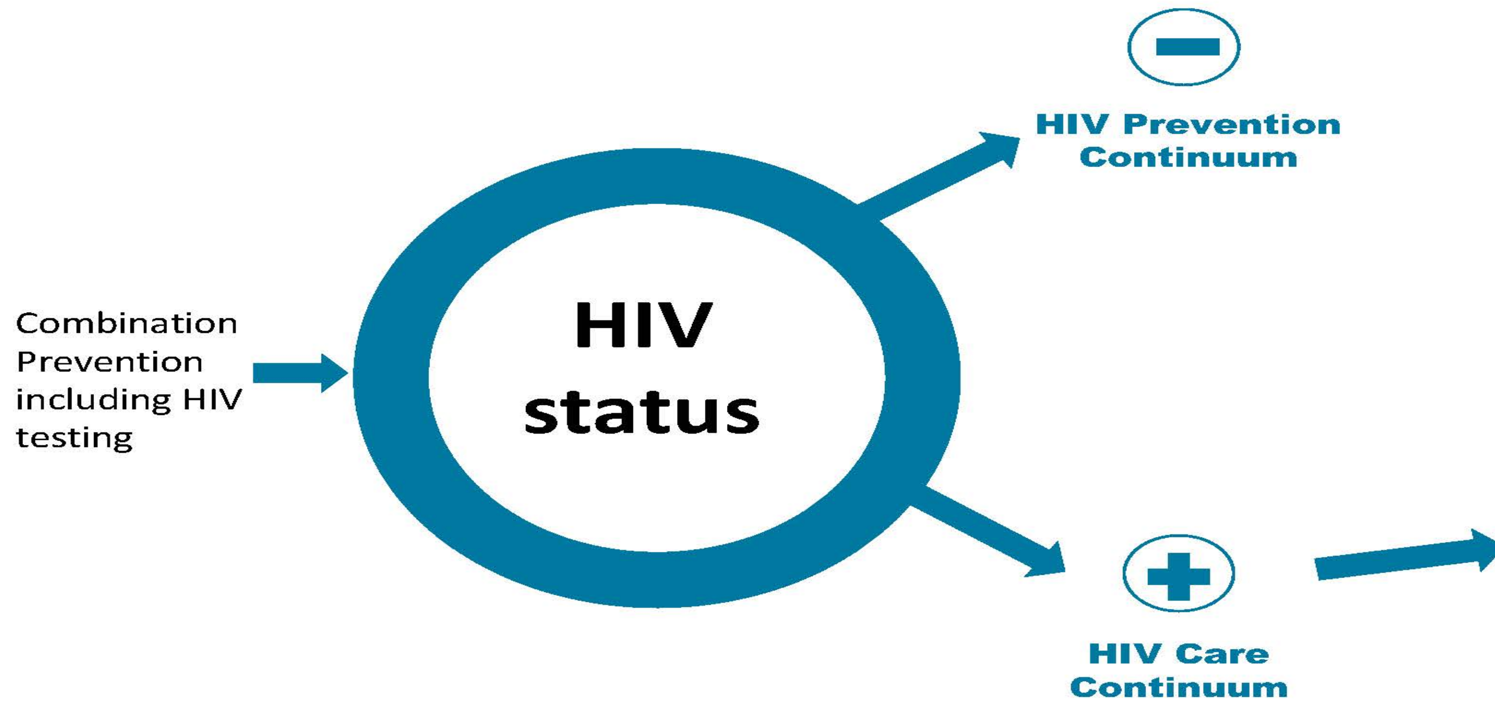


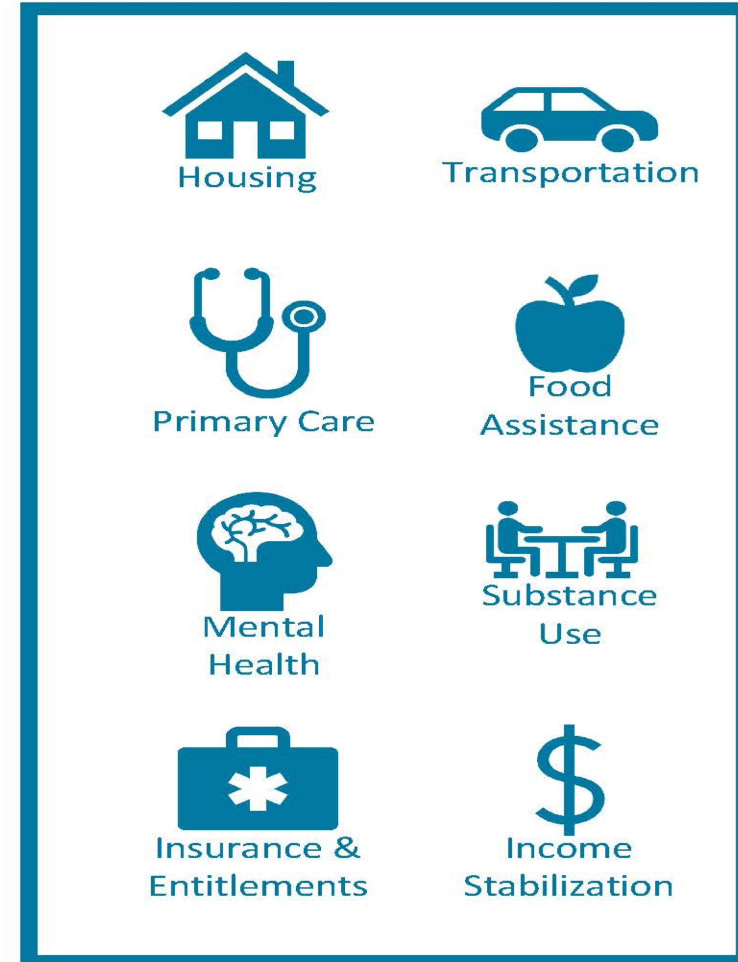
Reducing HIV Transmission & Acquisition

- Promote the Continuum of Prevention, Care, & Treatment
- Collaborate, Cooperate, & Coordinate Across Systems
- Address Mental Health, Substance Abuse, Housing, & Criminal Justice
- Provide Culturally-Affirming Prevention, Care, & Treatment

Status Neutral Systems







Status Neutral image was developed by Texas Department of State Health Services

Status Neutral Systems

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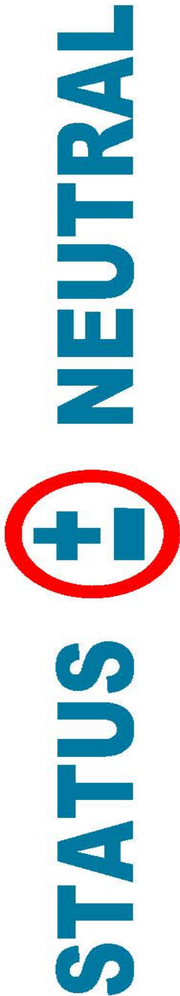
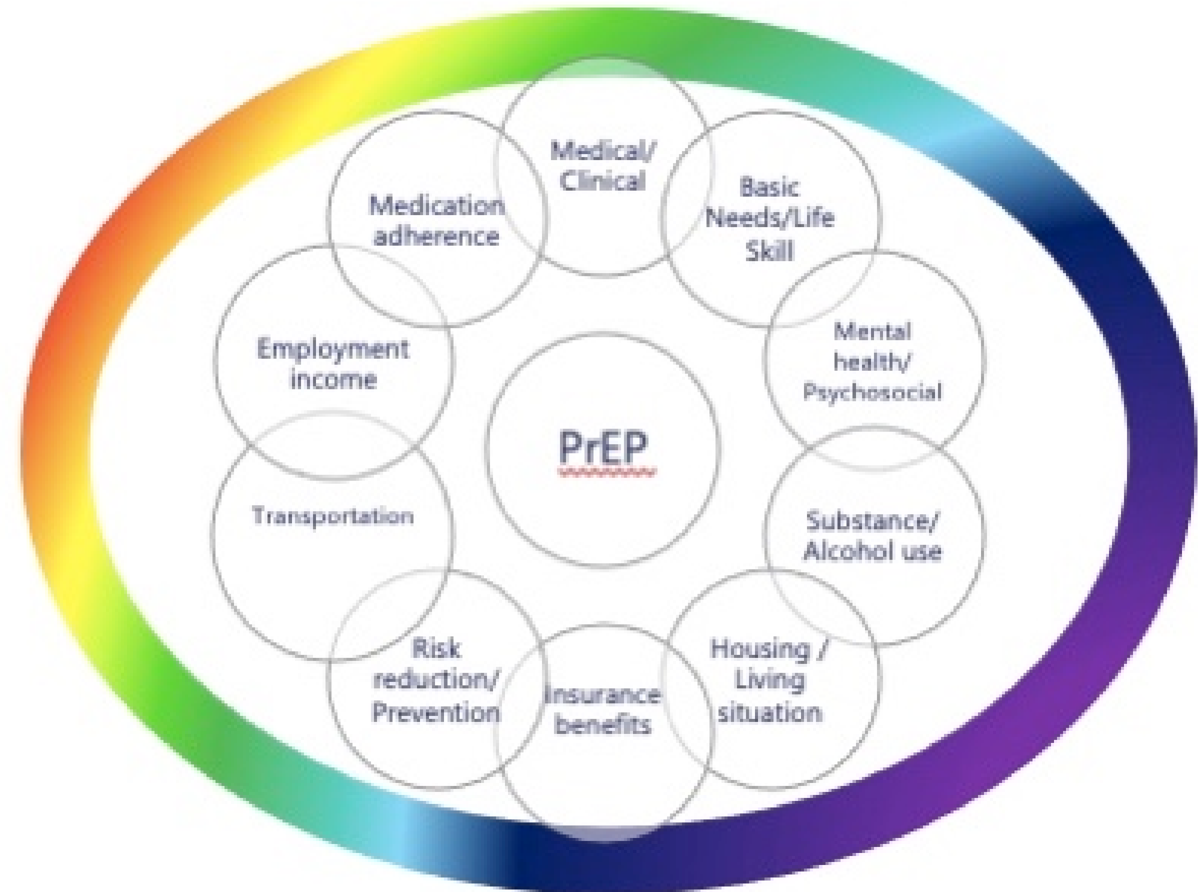
30 YEARS



Status Neutral image was developed by Texas Department of State Health Services

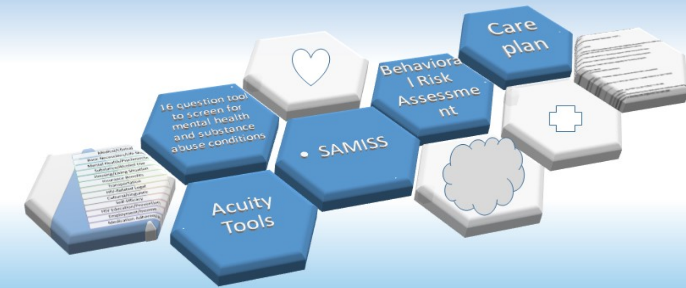
Modifying Case Management Tools

- People at risk of acquiring HIV still have many of the same needs as PLWH outside of HIV medical care.
- Referring patients to support services (transportation, housing, mental health, etc) can positively affect patient experience and health outcomes.

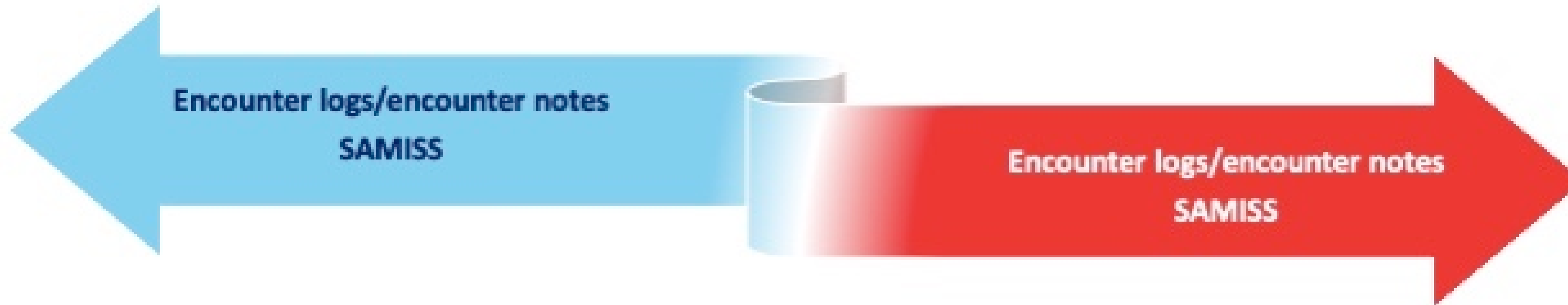


Modifying Case Management Tools

- Adapted case management tools to fit the needs of PrEP patients (modified as necessary):
  - Acuity Scale
  - Care Plans in EHR



Encounter Tools and SAMISS



- We were able to incorporate the Encounter logs and notes from the EHR without modification.
- The Substance Abuse Mental Illness Symptoms Screener (SAMISS) used to screen for behavioral health services fits both CM and PrEP.

PrEP Acuity Scale

- Modified SAM Acuity to assess needs of PrEP patients = PrEP Acuity

PrEP Acuity Scale

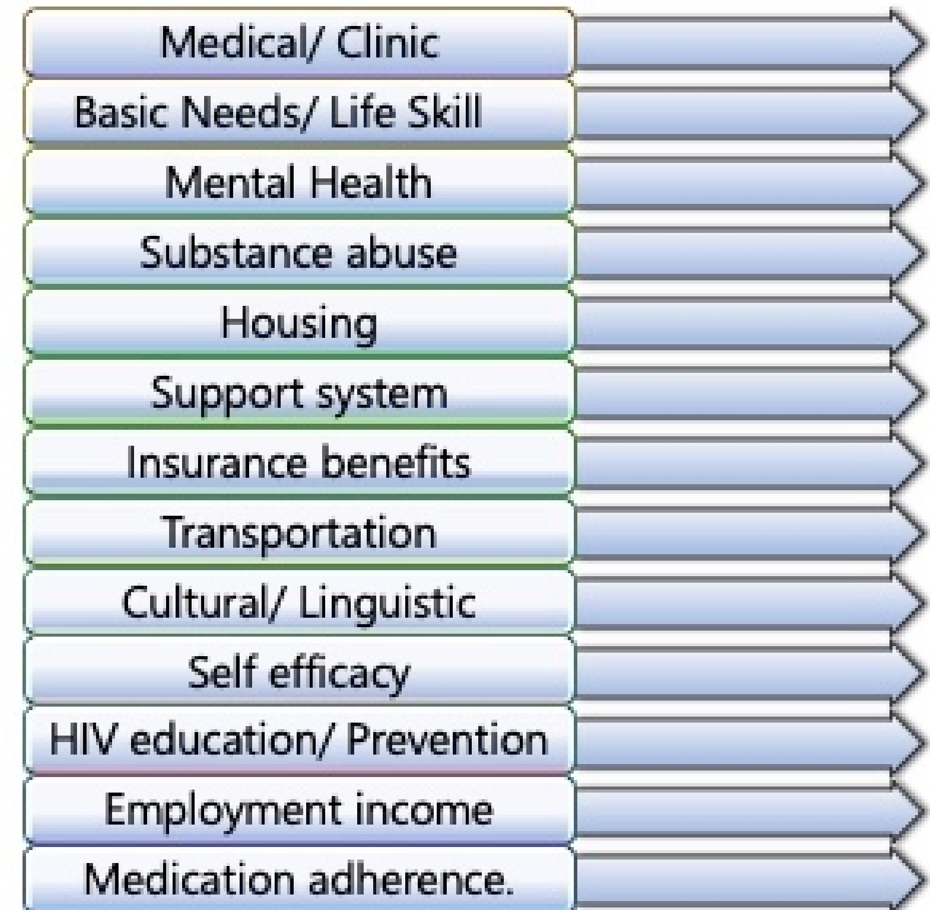
Check one box for each area. Add scores for all 14 areas for total acuity score.

Category	
Medical / Clinical	(●) Stable health status. Patient has stable, ongoing access to primary HIV medical care and treatment. Patient is fully empowered for self-care and can independently maintain medical care with information and very occasional referral. ( ) Patient's health is stable or may have moderate health problems. Patient needs active occasional assistance to access or maintain access to medical, clinical and/or oral health services. ( ) Patient is medically fragile but still able to maintain the activities of daily living. Patient requires regular assistance to access and maintain access to appropriate medical, clinical and/or oral health services. May require active coordination of multiple care providers. ( ) Patient has serious-to-sever medical issues; may be life threatening or one-time medical crisis as a result of multiple adverse health diagnoses or events. Patient may require complex coordination between multiple providers or agencies; may have end of life issues.
Basic Necessities / Life Skills	(●) Patient's basic needs being adequately met; patient has high level of skills, no evidence of inability to manage ADL. ( ) Patient has the ability to meet basic needs and manage ADL, but may need referral and information to identify available resources. ( ) Patient needs assistance to identify, obtain and maintain basic needs and manage ADL. Poor ADL management is noticeable and pronounced. ( ) Patient is unable to manage ADL without immediate, ongoing assistance; in acute need of caregiver services.
Mental Health / Psychosocial	( ) No known history or evidence of mental illness, high level of social functioning, appropriate behavior and coping skills. (●) History of mental illness with appropriate treatment, stabilized as a result of past treatment, ongoing compliance with outpatient counseling, emotional stability and coping skills are adequate to manage ADL, minimal difficulty in family or other significant relationships. ( ) Moderate emotional stress in significant relationships, ongoing diagnosis/treatment of chronic or major mental illness, limited access to mental health services, inability to maintain adherence to psychiatric medication, inappropriate social behaviors, mild to moderate impairment in ADL. ( ) Danger to self or others, highly depressed, suicidal, violent thoughts towards others, frequent or ongoing psychotic, violent or threatening behaviors, in crises, immediate psychiatric intervention needed.

What's measured on our PrEP Acuity Tool?

Modified SAM Acuity to assess needs of PrEP patients = PrEP Acuity Scale

- Methodical access – ensures patterned assessments for Behavioral Intervention Specialist PrEP
- Acknowledges fields of unmet needs
- Provides a clear set of goals that meet the patient's needs.
- Provides guidance for the regularity of communication, based on Patient needs



PrEP Care Plan

- BIS-PrEP work with patients to identify the following :
  - Problem statement/need
  - Goal(s)
  - Intervention (tasks, referrals, service delivery)
  - Responsible party for the activity
  - Timeframe for completion
  - Patient acknowledgment

Encounter Content

Entered By: Ismael Cruz Start Time: 12:00 PM End Time: 12:02 PM Total Time: 2
Care Plan: Expires 12/25/2020
Providers:
Cruz, Ismael (Behavioral Intervention Specialist - PrEP)

Risk Reduction
Target Date: 12/25/2020

Description: Patient reported having recurrent STI

Objectives: Patient will incorporate prevention strategies that fit their lifestyle, including:

Current Measure: Patient reported Risk behaviors

Desired Measure: Patient will incorporate prevention strategies that fit their lifestyle, including:

Client Action Items:
Condom during sex
Decrease condom-less receptive sex
Condom negotiation
Practice using condom skills

Problems:
Z60.9 - Problem related to social environment, unspecified

Interventions:
PrEP Follow-Up (1 time per week for 2 weeks) Started on 06/25/2020

Incorporating New Tools in Electronic Health Record

1. Modeled after case management structure in EHR
2. Created templates into a word document
3. Worked with IT to create forms in EHR
4. Conducted Beta test forms for about a month

Education, Support, and Implementation

Education: Modeled user N-MCM guide to support current standards

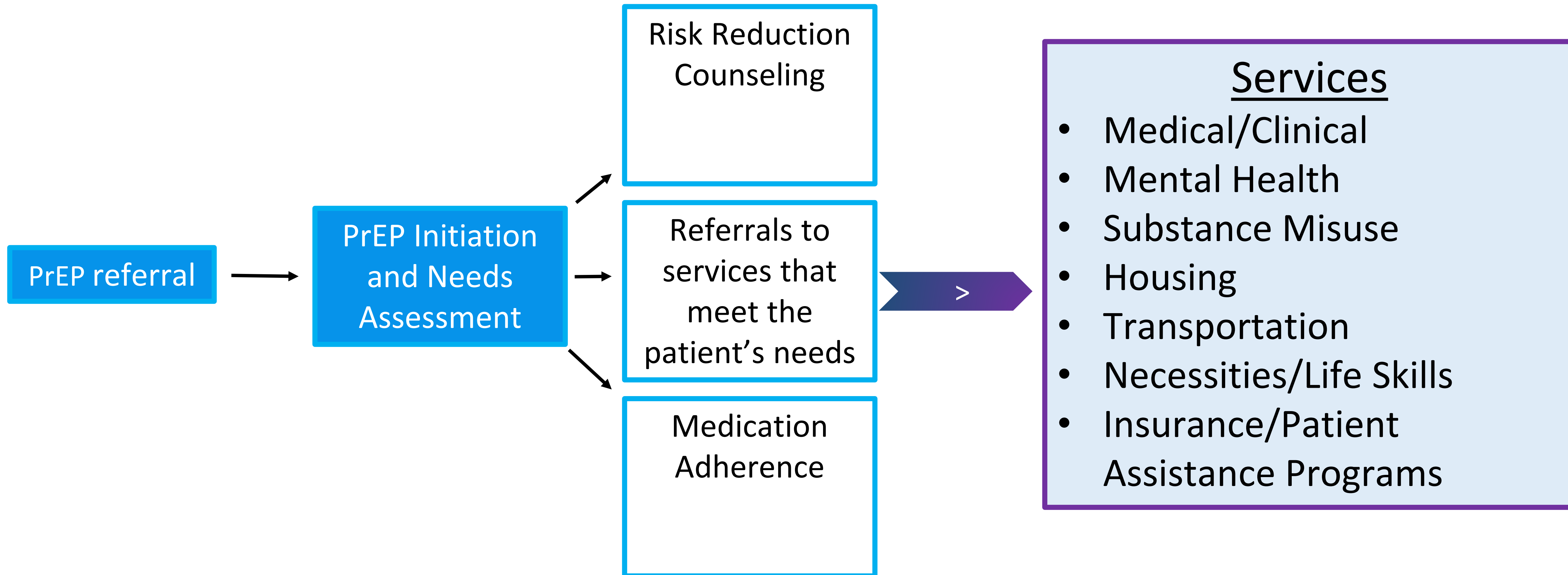
Support: Conducted Beta testing : Recurring one on one and group practice sessions to allow the staff practice on test patients

Implementation: Review feedback and troubleshoot concerns

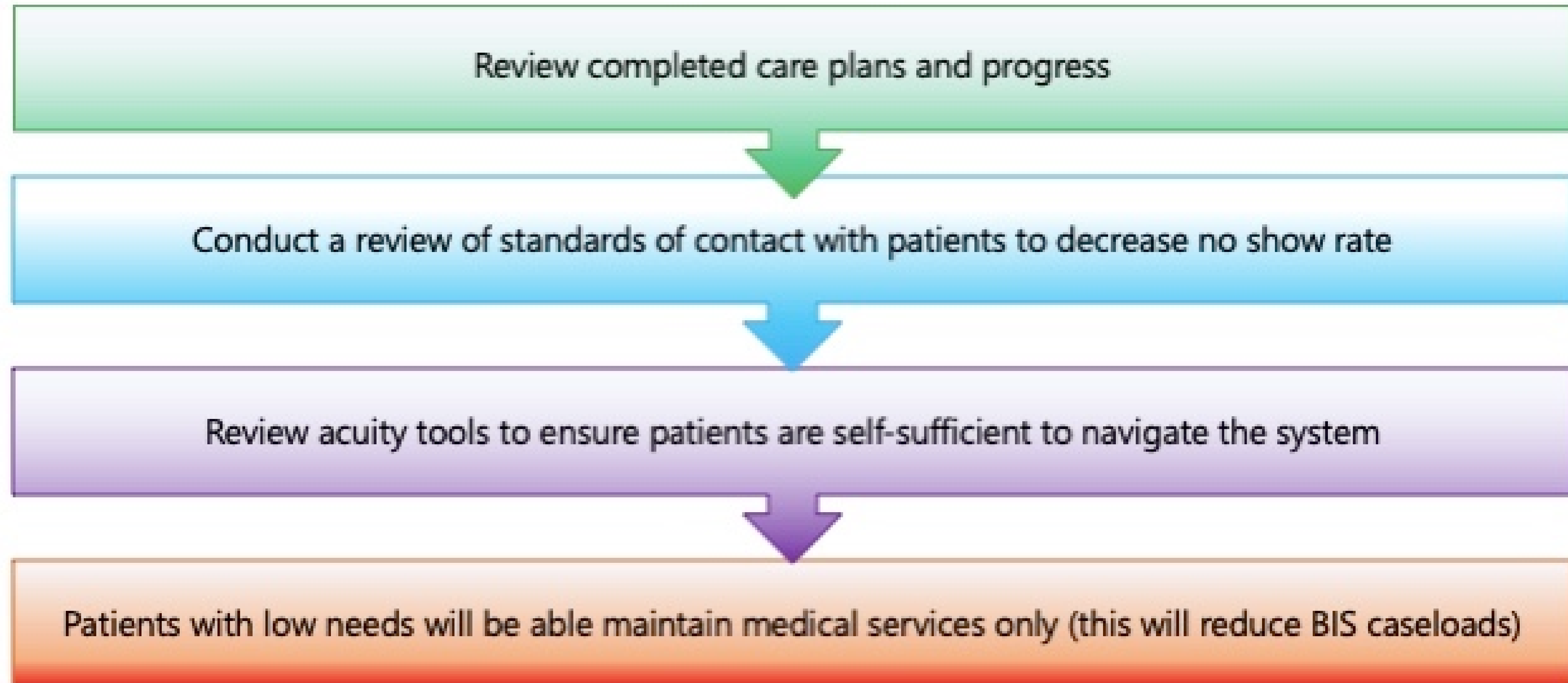
Decide on a date to Go Live for BIS- PrEP program

On demand /immediate on -site assistance

PrEP in the Larger System



Program Monitoring



Challenges

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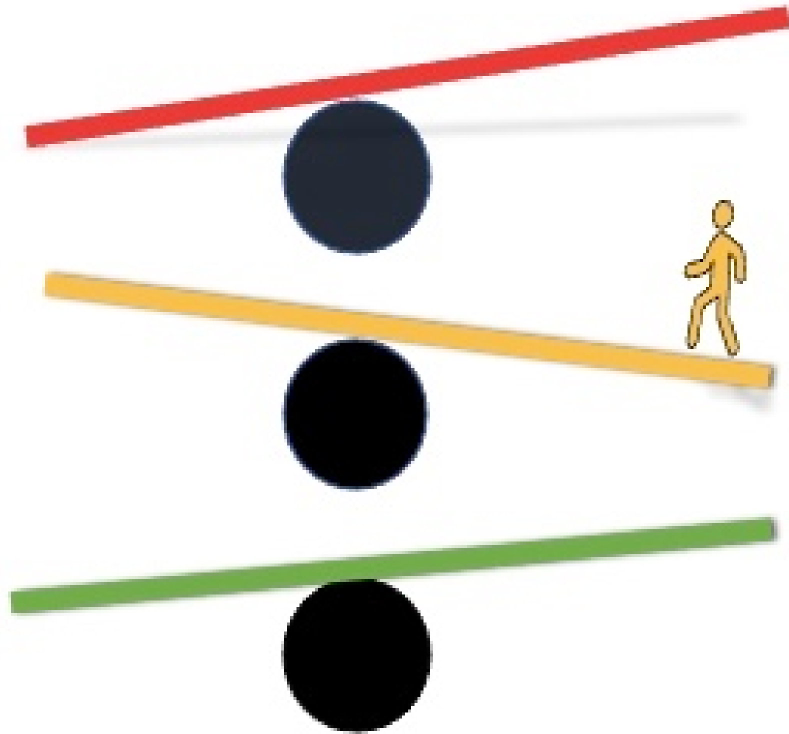
30 YEARS



- Lack of structured funding support for people who are at risk of acquiring HIV -> Ryan White system is not status neutral yet.

- COVID-19 altered service delivery as we started implementing these tools.

- Staff/Leadership turnover

Future Goals

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Strengthen collaborative relationships with CM.

Prioritize housing by utilizing Homelessness Management Information System (HMIS).

Utililze telehealth to increase patient convenience, decrease barriers to care, and incorporate COVID-19 precautions

Questions?