From Vision to Practice:

Best Practices from the Ground

2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Overview

- Introductions
- South Carolina Ryan White Part B Program Ending the HIV Epidemic with Rapid Treatment
  - AID Upstate
  - Piedmont Care
- Missouri Ending the HIV Epidemic - Community Engagement and Communication Planning
- Questions

South Carolina Ending the HIV Epidemic with Rapid Treatment

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Medical Director

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2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Learning Objectives

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

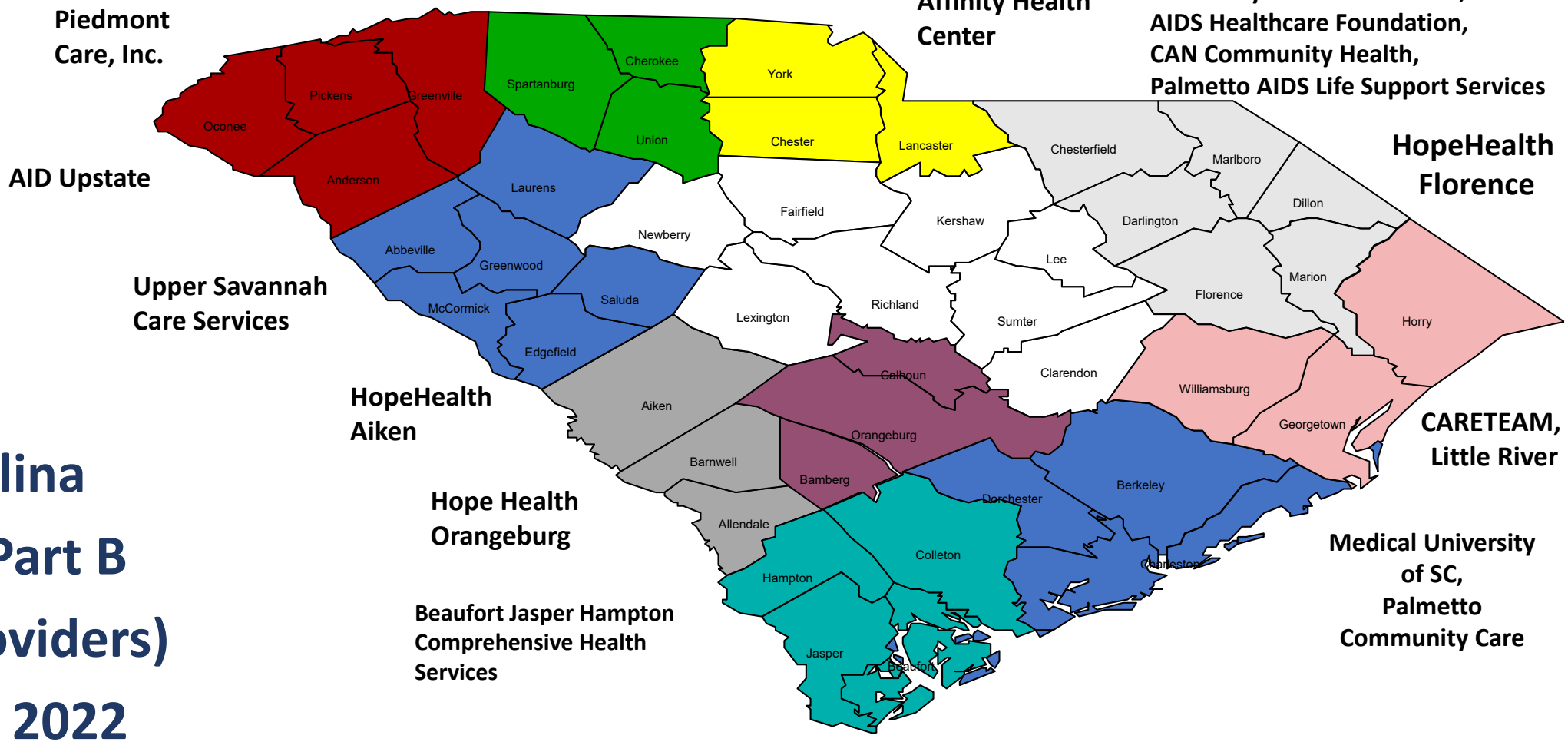
1. Understand how rapid treatment has been implemented with EHE funds in South Carolina.
2. Learn of the successes and challenges from two Ryan White Part B EHE funded providers implementing Rapid ART.

South Carolina
Ryan White Part B Program

RWB Program Overview

- South Carolina AIDS Drug Assistance Program (ADAP)
  - Administered by SC Department of Health and Environmental Control (DHEC)
- Ryan White Part B Core and Support Services
  - Provided through a network of DHEC contracted subrecipients

South Carolina
Ryan White Part B Program 2



South Carolina
Ryan White Part B
(16 Service Providers)
As of April 1, 2022

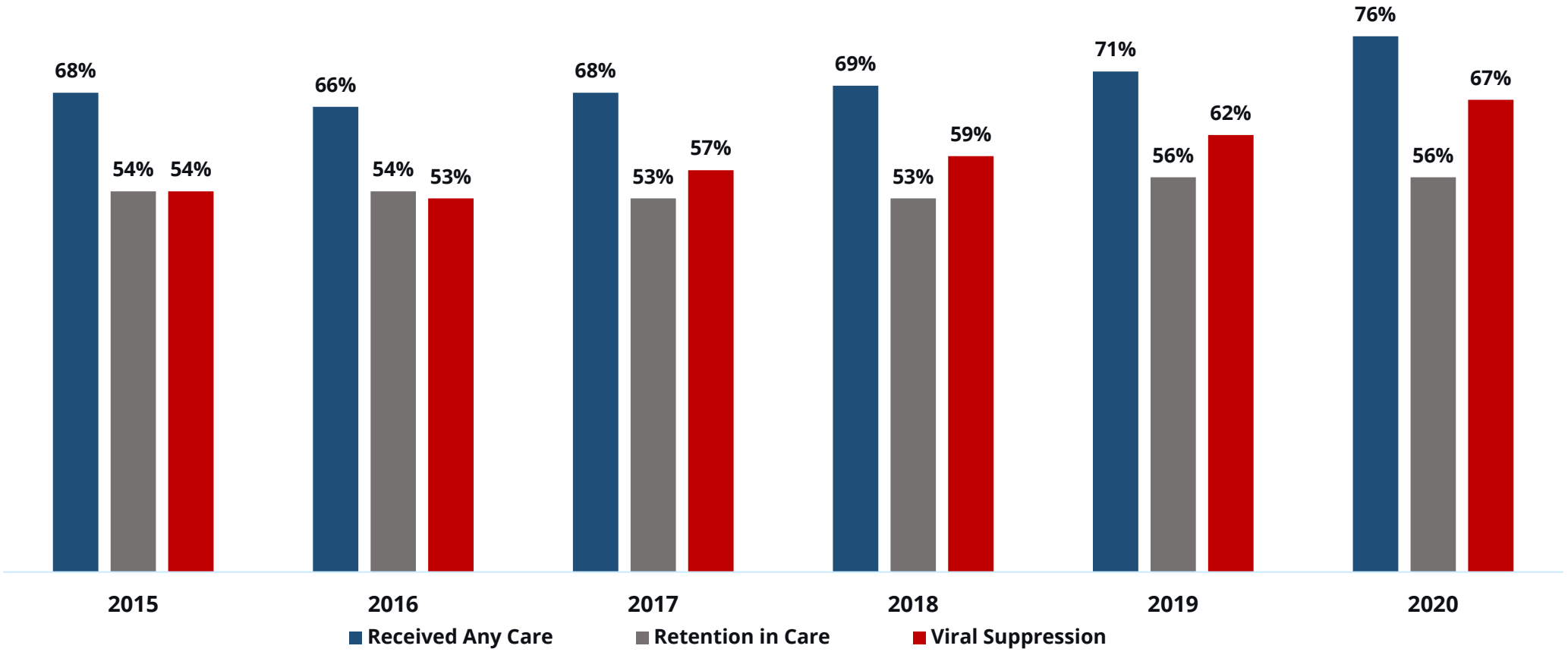
South Carolina
Ryan White Part B Program 3

Population	2012	2013	2014	2015	2016	2017	2018	2019	2020
People with HIV (PWH)	15,305	15,695	16,222	18,340	18,998	19,749	20,166	20,334	19,437
Served by Ryan White Part B (RWB - Care)	8,112	8,475	8,760	8,816	9,089	9,393	10,347	11,583	11,428
Percent of Prevalence Served by RWB - Care	53%	54%	54%	48%	48%	48%	51%	57%	59%
PWH Out of Care [1]	36%	37%	34%	32%	37%	32%	31%	29%	24%
Uninsured in ADAP	76%	75%	74%	65%	55%	53%	54%	56%	53%

Data Source: *SC Epi Profiles*

1. PLWHA Out of Care is based on absence of HIV tests at intervals within the calendar year.

South Carolina Care Continuum Yearly Comparison



Data Source: *2020 SC Epi Profiles*

2019 – RWB EHE NOFO

SC planned to implement a Statewide Rapid Continuum of Care Program to rapidly link and reengage PLWH who are newly diagnosed or returning to care and provide rapid treatment through the AIDS Drug Assistance Program (ADAP).

The overarching goal is to engage PWH into care (newly diagnosed or returning to care) and expedite HIV ART within 7 days of a new HIV diagnosis or re-engagement into care.

The Statewide Rapid Continuum of Care process will include:

(1) Rapid Linkage and reengagement to HIV Care;

(2) Accelerated eligibility and access to care services;

(3) Accelerated AIDS Drug Assistance Program (ADAP) approval;

(4) Sustained follow-up to provide support, including medication adherence; and

(5) Rapid cluster response.

Ryan White Part B EHE Funded Services

- A Request for Grant Applications for Ryan White Part B Ending the HIV Epidemic funds was released in Spring 2021.
  - To be eligible to receive funds, subrecipients were required to develop and implement or expand Rapid Access to Care and ART Initiation.
  - Goals of the program include (1) linkage to care no more than 2-3 days after diagnosis or returning to care, with a strong preference for day of linkage to care, and (2) initiation of ART at the first medical visit.
- DHEC awarded RWB EHE funding to 7 subrecipients to implement/enhance the rapid care and treatment initiative.

AID Upstate
RWHAP Part B AIDS Service Organization
Greenville, SC

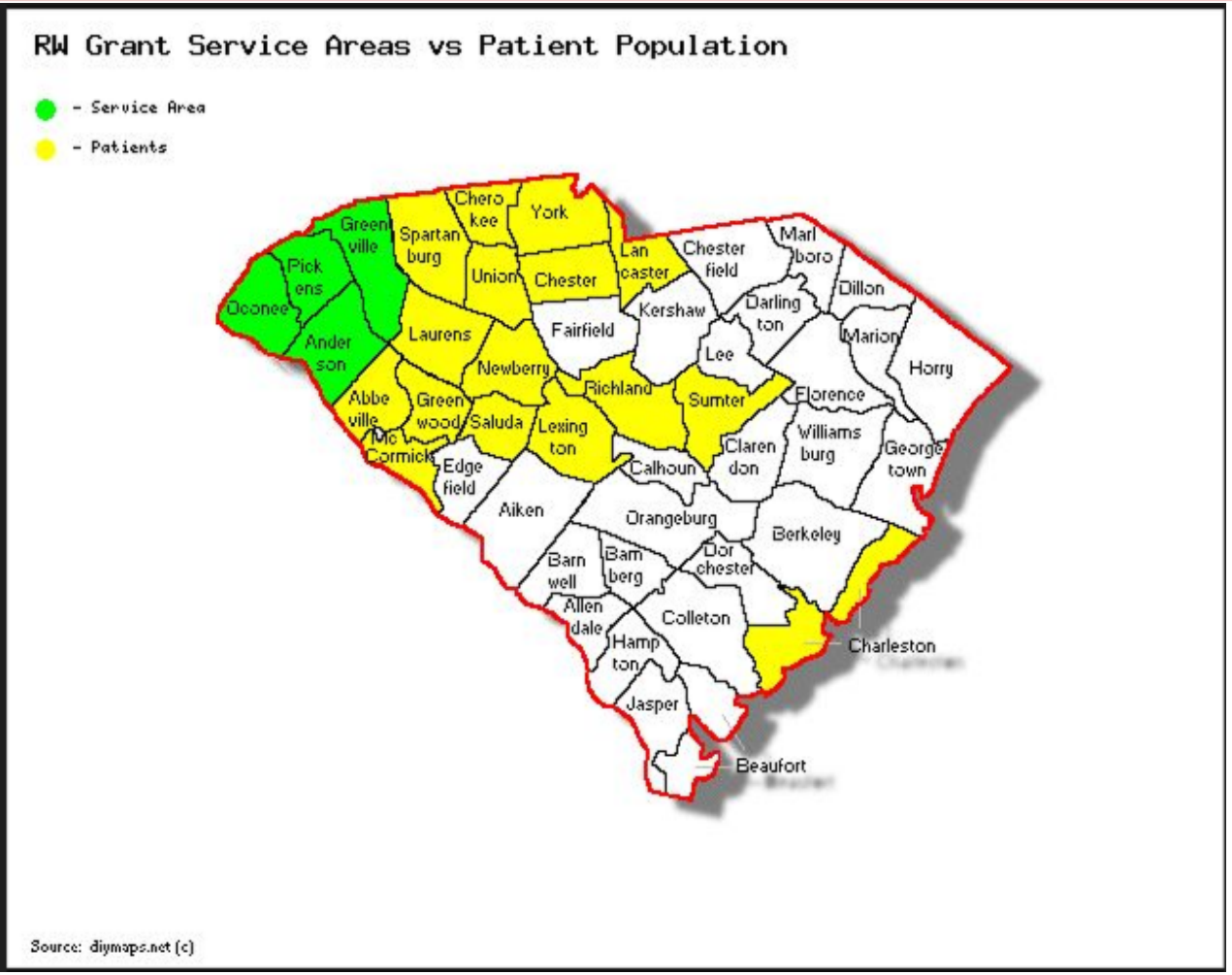
Rapid ART Delivery Project:
A Work in Progress

Doug McCormick, MSN, FNP-BC
Medical Director

2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

AID Upstate Service Area



- 4 counties in Upstate SC are the main focus of the organization/grant (**green**)
- Other select (8) Upstate SC counties (**yellow**) overlap with our service area and contribute to our patient population
- 4 departments:
  - Administration
  - Medical (opened 2017)
  - Medical Case Management (MCM)
  - Prevention & Outreach
- 2 medical offices:
  - Anderson County
  - Greenville County

AID Upstate Medical Patient Population = 1,269

Anderson Office

- Total patients = 454
  - ID = 396
  - PrEP = 23
  - Primary Care only = 35
- Medical staff:
  - 1 ID FNP FTE
  - 0.1 ID FNP FTE
  - 0.1 ID DO FTE
  - 0.2 PCP MD FTE
  - 1 RN FTE
  - 0.2 LPN FTE

Greenville Office

- Total patients = 815
  - ID = 485
  - PrEP = 160
  - Primary Care Only = 143
- Medical staff:
  - 0.7 ID FNP FTE
  - 0.1 ID MD FTE
  - 0.7 PCP MD FTE
  - 1 RN FTE
  - 1 LPN FTE
  - 0.8 LPN FTE

AID Upstate Rapid ART Delivery Project

- **1st Rapid patient 12/18/2020**
- **~ 42 total Rapid patients thru 6/30/2022**
- Initially an informal team from medical, prevention, case management, & administration created a rapid initiation form that all departments would complete as appropriate as a new diagnosis moved through the system (1/12/2021). This form/process was overly burdensome.
- Ultimately a large team consisting of employees from medical, case management, prevention, scheduling, medical records, & administration-facilitated by the COO & medical director-initiated an accelerated PDSA cycle (2/23/2022).
- Finally a much smaller group consisting of the medical director, nursing staff, linkage coordinator, and peer navigator started meeting weekly to discuss rapid ART initiation issues, concerns, & specific patients (4/19/2022). This meeting commit remains a work in progress.

- Added ***Linkage Coordinator*** & ***Peer Navigator*** positions (9/1/2021)
- Linkage Coordinator is an experienced MSW/Medical Case Manager who coordinates entry to HIV care for both newly diagnosed (Rapid) & out of area transfer patients
  - Dedicated position based in the prevention building who coordinates MCM intake and connection to medical care
- Peer Navigator is a longtime PLWHIV-but new to the HIV care team-who assists patients with psychosocial & educational needs as a peer
  - Also based in the prevention building

AID Upstate Rapid ART Delivery Project 2

Start-up Costs:

- Initially:
  - Office furnishings = $2,200
  - Desktop computer, monitors, laptop = $1,819
    - Incidentals = mobile phones/business cards
  - On-going:
    - Linkage Coordinator & Peer Navigator salaries

Capacity Issues:

- More capacity i.e. more open patient slots in the smaller Anderson office vs. the larger Greenville office. Unfortunately most patients live closer to the Greenville office.
- Not enough ID prescribing providers
- Unable to designate medical provider teams nor specific open appointment slots on a weekly basis for Rapid patients
- Currently sending all out of area transfer patients to an alternate RWCA Part C provider

AID Upstate Rapid ART Delivery Project 3

Challenges:

- Not enough ID prescribing providers
- Provider schedules are generally always at capacity
- Difficulty in keeping all team members on the same page, RE: Provider availability, scheduling issues, insurance/medication access issues, patient follow-up
- Impossible to anticipate new diagnoses
- Competing departmental priorities
- Growing issue regarding patient availability vs. open ID provider appts.
- Reluctance on the part of patients to RTC for STI RX when resulted
- Issues defining who is truly a Rapid patient
- What is our responsibility to out of catchment area newly diagnosed?

References

- https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/initiation-antiretroviral-therapy (Updated 12/18/19)
- https://aidsetc.org/resource/rapid-immediate-art-initiation-restart-guide-clinicians (Published 5/19/22)
- https://www.who.int/publications/i/item/9789241550062 (Published 7/1/17)
- https://www.ncbi.nlm.nih.gov/books/NBK557123/ (Published 10/21)
- https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/si/cdc-hiv-crescentcare_start_init_si_ei.pdf (Updated 1/27/21)
- https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/lrc/cdc-hiv-lrc-hiv-care-coordination-program.pdf (Updated 10/9/18)
- https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/lrc/cdc-hiv-RAPID_ART_Program_HIV_Diagnosis_LRC_EI_Linkage.pdf (Updated 12/6/19)

Compassionate HIV and AIDS Care, Prevention, and Advocacy

Trista Anderson
Case Management Supervisor

2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Piedmont Care EHE Start-Up

- EHE funding awarded to Piedmont Care corresponded with opening and start up of new medical practice.
  - COVID
  - Services Offered
    - Onsite Medical Practice
    - Dr., Nurse, Nurse Practitioner, Patient Service Rep, Practice Administrator, and assigned Medical Case Manager
    - Rapid ART
  - Support from current RW services on site
    - MCM, mental health, transportation, insurance assistance, partner testing, orientation and meet and greet appointments.

Piedmont Care EHE Start-Up 2

- Advantages
  - After hours options for clients
  - Increased access for partners of RW clients
  - Rapid response for new referrals or newly diagnosed clients
  - Positive HIV testers immediately linked to medical case management and medical care
  - Home visits
  - Telehealth
  - One-stop shop personalized service
- Successes
  - COVID vaccine access
  - Home visits
  - Cell phone and text conversations with medical team
- Challenges
  - Money
  - Staffing
  - Obtaining sample meds
  - Paradigm shift
  - Communication

Comments from Practice Patients

- “I love that everything is all in one place. I can come to the Dr. and therapy at the same time.”
- “Everyone is so professional and makes me feel welcome!”
- I just wanted to share that one of our clients who sees the practice was in today and said he was “very happy with the care he received, that Yvonne explained/broke down things so he could understand and that he was not going back to his previous provider.”

Piedmont Care

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Missouri Ending the HIV Epidemic - Community Engagement and Communication Planning

Alicia Jenkins, MSA

Chief

Missouri Department of Health and Senior Services

Division of Community Public Health

Bureau of HIV, STD, and Hepatitis

2022

NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Learning Objectives

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

1. Understand the importance of community engagement and communication planning.
2. Have increased knowledge of the various ways for engagement and communication with your priority population, community, and partners.

Missouri Ending the HIV Epidemic Overview

Ending the HIV Epidemic In Missouri

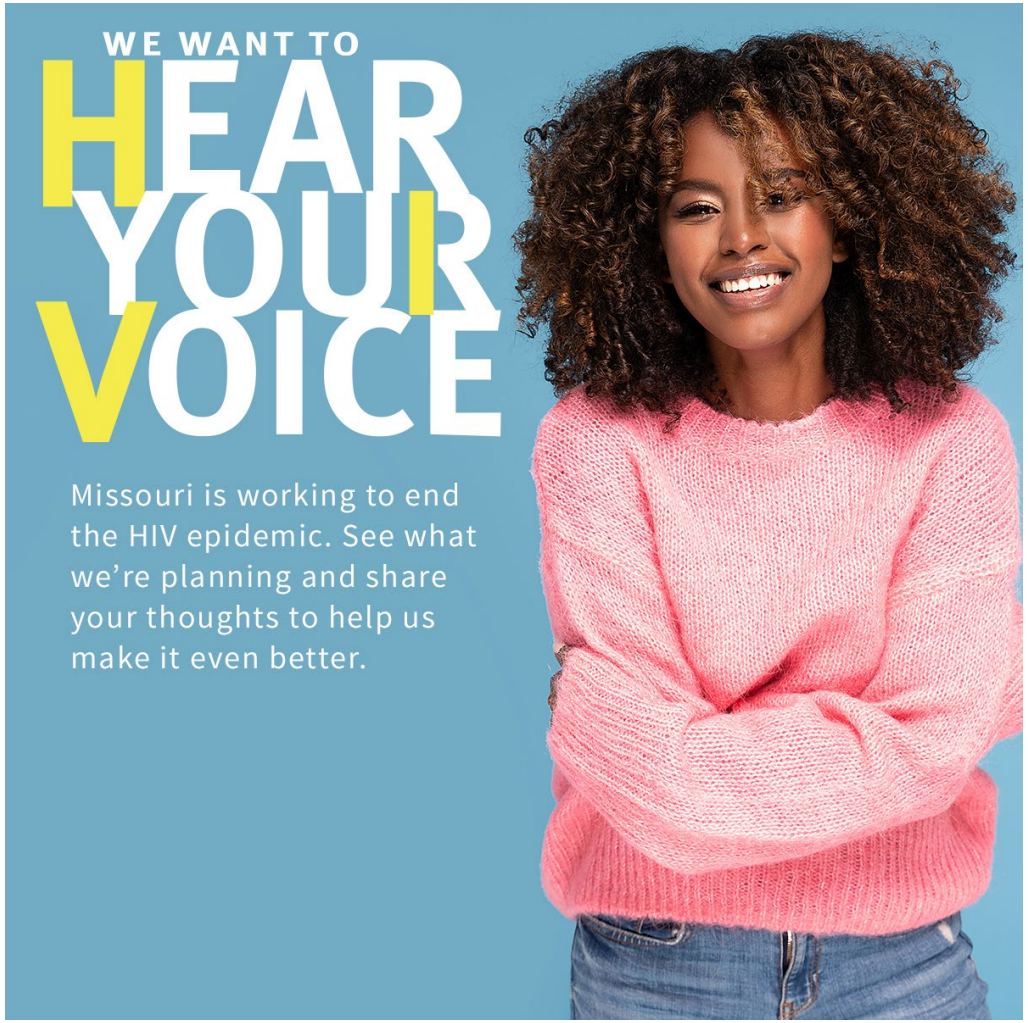
Missouri's Ending the HIV Epidemic Plan

We offer several options for engagement and want to hear from you! Use the comment option if you wish to provide a broad comment on the plan. The feedback option can be used to provide more structured feedback and the email address can be used for questions. We look forward to hearing from you!

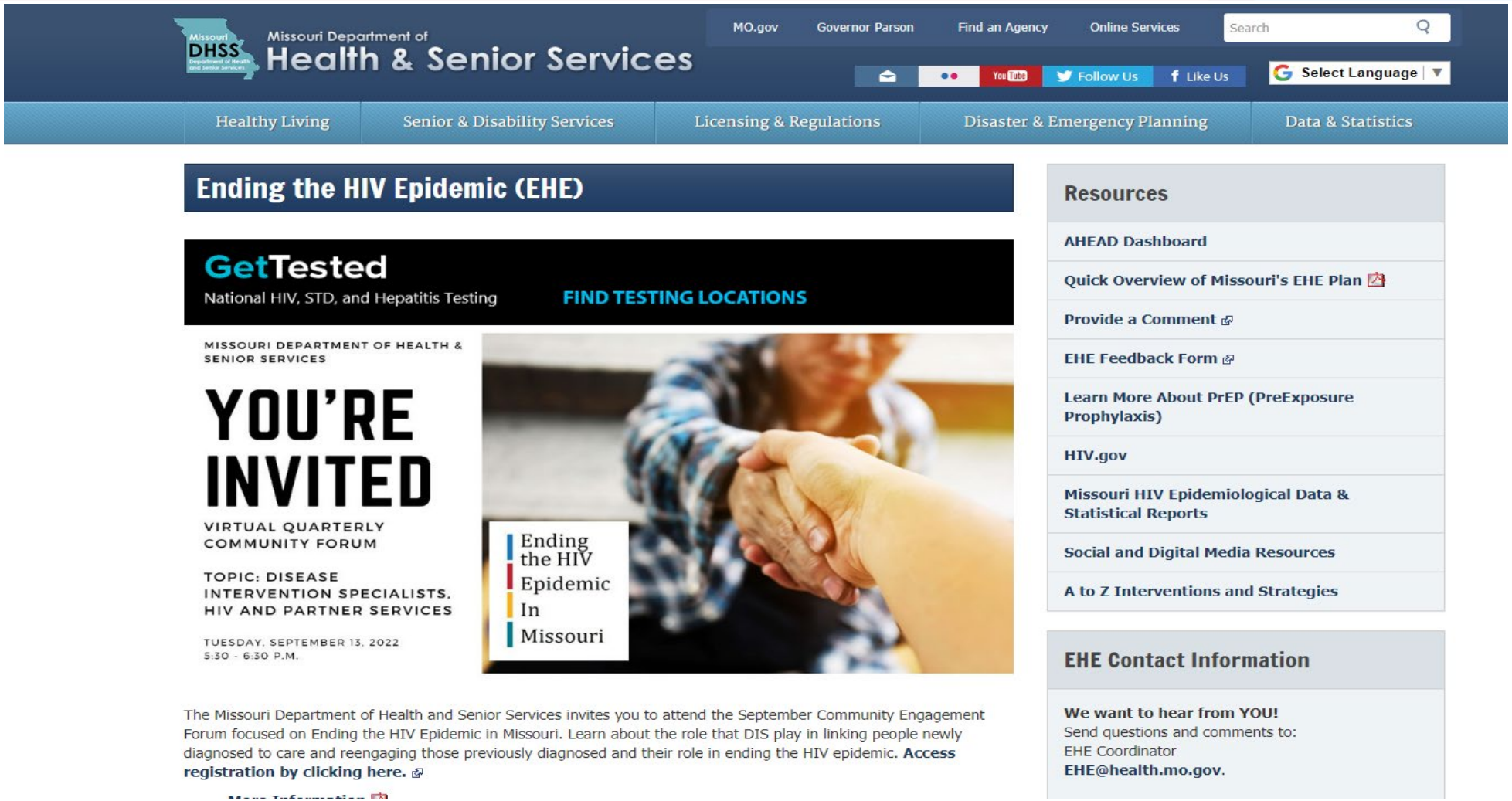
- Quick Overview of Missouri's EHE Plan
- Provide a Comment
- Send Us Your Feedback
- Missouri's Ending the HIV Epidemic Plan

speakuphiv.com/ehe

Overview of Community Engagement Efforts



Speakuphiv.com/EHE



Gaps and Barriers

You're Invited!

VIRTUAL Community Forum

Topic: Older Adults Living with HIV

SATURDAY, JUNE 11, 2022
10 - 11 A.M.
OR
TUESDAY, JUNE 14, 2022
5:30 - 6:30 P.M.

Ending the HIV Epidemic In Missouri

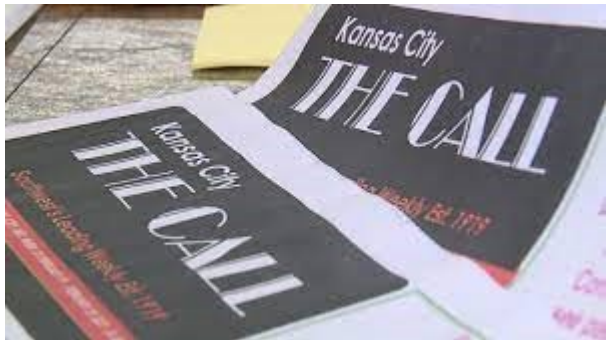
Innovation

WE WANT TO
HEAR
YOUR
VOICE
Missouri is working to end the HIV epidemic. See what we're planning and share your thoughts to help us make it even better.

WE WANT TO
HEAR
YOUR
VOICE

Social Media

- Facebook
- Pandora
- Billboards
- Bus Tags
- Spotify
- YouTube
- Grindr
- Basically, places and spaces where we can reach our target audience

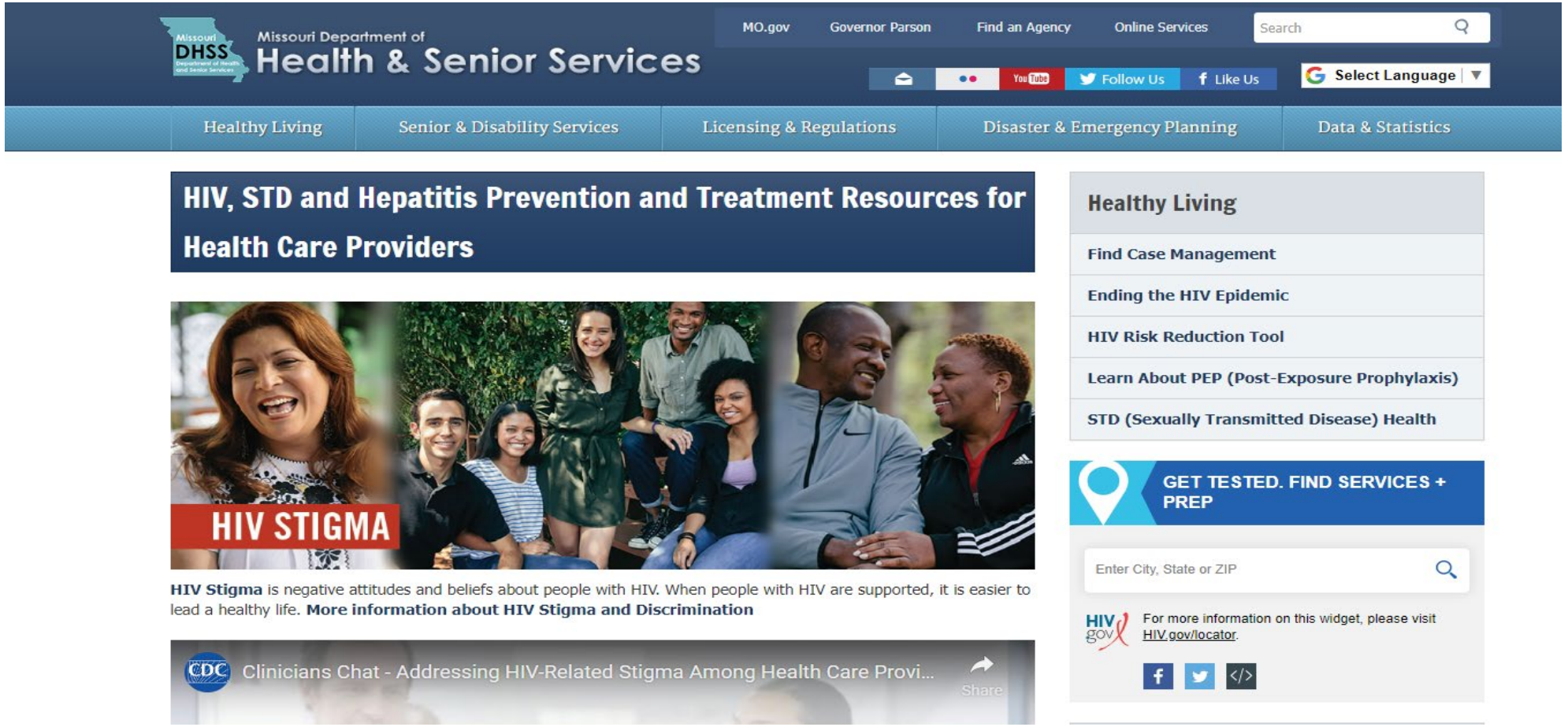


facebook

The St. Louis American

HIV STIGMA Campaign

HIV Stigma Challenges 2



Source: https://health.mo.gov/living/healthcondiseases/communicable/hivaids/stigma-campaign-provider.php

Partnerships

- People living with HIV
- AIDS service organizations
- Local public health agencies (LPHAs)
- Substance abuse centers
- Organizations that serve minority populations
- Community-based organizations
- Public and private universities
- Federally qualified health centers (FQHCs)

Partnerships

MO HEP C
Show Me the Cure

Butler County Health Department
Missouri

APO

Saint Louis COUNTY PUBLIC HEALTH

vivent health

DOORWAYS
HOUSING · HEALTH · HOPE

MPCA
Missouri Primary Care Association

KC CARE HEALTH CENTER

Public Health

DEPARTMENT OF HEALTH
CITY OF ST. LOUIS

Washington University in St. Louis
School of Medicine

CAPE GIRARDEAU COUNTY PUBLIC HEALTH

NNPTC
National Network of STD Clinical Prevention Training Centers

MISSOURI Highlands HEALTH CARE

Missouri Telehealth Network
University of Missouri

MAHEC
MIDWEST AIDS TRAINING + EDUCATION CENTER

Challenges

- COVID-19
- Shared vision for social and digital marketing needs
- Maximizing the use of your dollars

Strengths

- Engaging your agency's communication team
- Continuously challenging yourself and your social and digital marketing team
- Use of focus groups
- Use available resources
  - For example – For several of our social and digital media campaigns, we used CDC materials. This allowed us to redirect dollars to expand our outreach.
- Use of social and digital media analytics
- Ability to reach more individuals

Lessons learned and best practice

Moving Forward

- Give yourself some grace!
- Remember all things begin and end locally.
- Allow for flexibility in your planning and engagement.
- Meet people where they are.
  - For example – In 2023, we will be conducting in-person public engagements.
- Remember to ask your priority population, the community, and your partners about what works to keep moving forward.
- There is no need to reinvent the wheel.
- It doesn't have to be complicated to be great!

Thank You

thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
спасибо
Баярлалаа
рахмат
dank je
tapadh leat
хвала
mochchakkeram
go raibh maith agat
dziękuję
obrigado
bedankt
sukriya
kop khun krap
terima kasih
grazie
arigatô
dakujem
мерси
merci
감사합니다
ありがとう
ευχαριστώ
sagolun
hvala
mauruuru
takk
taiku
mersi
barka
welalin
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faafetai lava
vinaka
спасибі
blagodaram
misaotra
matondo
paldies
grazzi
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dhanyavad
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