2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Data for Decision Making!

Jeff Vollman, MPA

District HIV Director

North Georgia Health District, Dalton 1-2

HIV in North Georgia

The Living Bridge Center is a full service HIV specialty clinic, funded with Ryan White Part B and Part C funds, with a smattering of HIV Prevention funds.

TLBC serves the six county Health District, which consists of the following counties: Whitfield, Murray, Pickens, Gilmer, Fannin and Cherokee.

The vast majority of these counties can be considered rural in nature. Most population centers within the District are up to an hour or more apart. To address the transportation barriers associated with the travel distances, we operate two satellite clinics. Twice a month patients are seen in the Canton Health Department and once a month patients are seen in the Fannin County Health Department.

An Elevator Speech…..

F: Find them

A: Assess them

S: Stabilize them

T: Treat them

Find Them…..

Finding them – HIV Prevention, Education and Outreach

- Targeted outreach to high risk populations
  - Day Reporting Center (Criminal Justice system diversionary program for low level, first time drug offenders) twice a month for all new enrollees
  - Drug Court education/testing for felony level offenders
  - Dalton State College – every month while school is in session
  - PrEP clinic

- Health Education and Outreach Program in the southern part of the District
  - CDS Nurses in southern counties – targeted outreach and education to high risk groups – PrEP evaluation/screening for repeat customers
  - Epidemiologist – Data driven decision making based on predictive statistics on an on-going basis
  - Health Educator tasked specifically with identifying high risk groups, provided targeted education and targeted testing to high risk groups.

Find Them…..Redux

Finding them – HIV Prevention, Education and Outreach

- HIV testing in the Community (2013 to 2017)
  - Passive Testing (health departments): 1,813 to 2,932 (62% increase)
  - Proactive Testing (targeted): 112 to 315 (181% increase)
  - New Positives: 5 to 15 (200% increase)

- HIV Clinic serves as the primary point of contact and entry to the HIV system of care.
  - Established, strong communication networks with the District's Emergency Departments, private infectious disease doctors, jails and detention centers, and public health sites.

Assess Them….

Assess them - In take, medical and social assessments

- All required eligibility checks
  - HIV status
  - Residency checks
  - Insurance coverage assurances
  - Proof of income

- Initial doctor's visit – baseline health status

- Initial visit with a nurse case manager
  - Identification of patient barriers and/or problems list
  - Acuity Scale - medical and social support focused
  - Individual Service Plan for medium and high acuity cases
    - Serves as a trigger for Intensive Case Management versus normal Case Management

Stabilize Them….

Stabilize them – Intensive Case Management Program

- Medical Case Management (both Intensive and non-Intensive) became a priority for our clinic. Increasing the interaction allows for a better understanding of the patient's needs and barriers, and leads to successful interventions that support adherence.

- Medical Case Management Visits (inclusive) – 2013 to 2017 Projected
  - Medically Case Managed Patients (unduplicated): 138 to 147 (7% increase)
  - Medical Case Management Visits (unduplicated): 211 to 502 (138% increase)

- Mental Health Counseling on-site
  - Newly infected get priority,
  - Counselor and Intensive Nurse Case Manager work in coordination with all Intensive Case Management patients.

Treat Them…..

Treat them – Full service medical care, on site dentistry and mental health counseling

- Medical doctor on site Monday through Thursday
- 1 triage nurse, 2 nurse case managers, 1 intensive nurse case manager, one nurse supervisor, benefits coordinator, data manager, 3 support staff
- Two satellite clinics (2 in Cherokee County one in Fannin County)
- On site lab for routine blood draws
- Dental program at WCHD, augmented by contract dentists off site
- On-site nutritionist (cycling through all patients over the course of a year)

And Treat Them….

Treat them – Full service medical care, on site dentistry and mental health counseling

- HIV Medical and Related Care Services (2013 to 2017)
  - Total Unduplicated Patients: 187 to 208 (11% increase)
  - Total New Patients (annually): 22 to 29 (32% increase)
  - Total Unduplicated Medical Care Visits (annually): 1,658 to 1,971 (19% increase)
  - Total Unduplicated Oral Health Care Patients: 62 to 79 (27% increase)
  - Total Unduplicated Oral Health Visits: 77 to 158 (105% increase)
  - Total Unduplicated Mental Health/Substance Abuse Patients: 70 to 85 (21% increase)
  - Total Unduplicated Mental Health/Substance Abuse Visits: 262 to 426 (63% increase)

Have Epidemiologist, Will Travel…

Our first attempt at using data was to measure our Linkage to Care program.

- Serves as the starting place for high acuity patients, newly diagnosed patients and patients with a history of non-compliance with medical appointments.
- Wanted to Compare High Acuity patients with the clinic population overall.
- Wanted to see if there were any seasonal impacts.

What Does the Data Look Like?

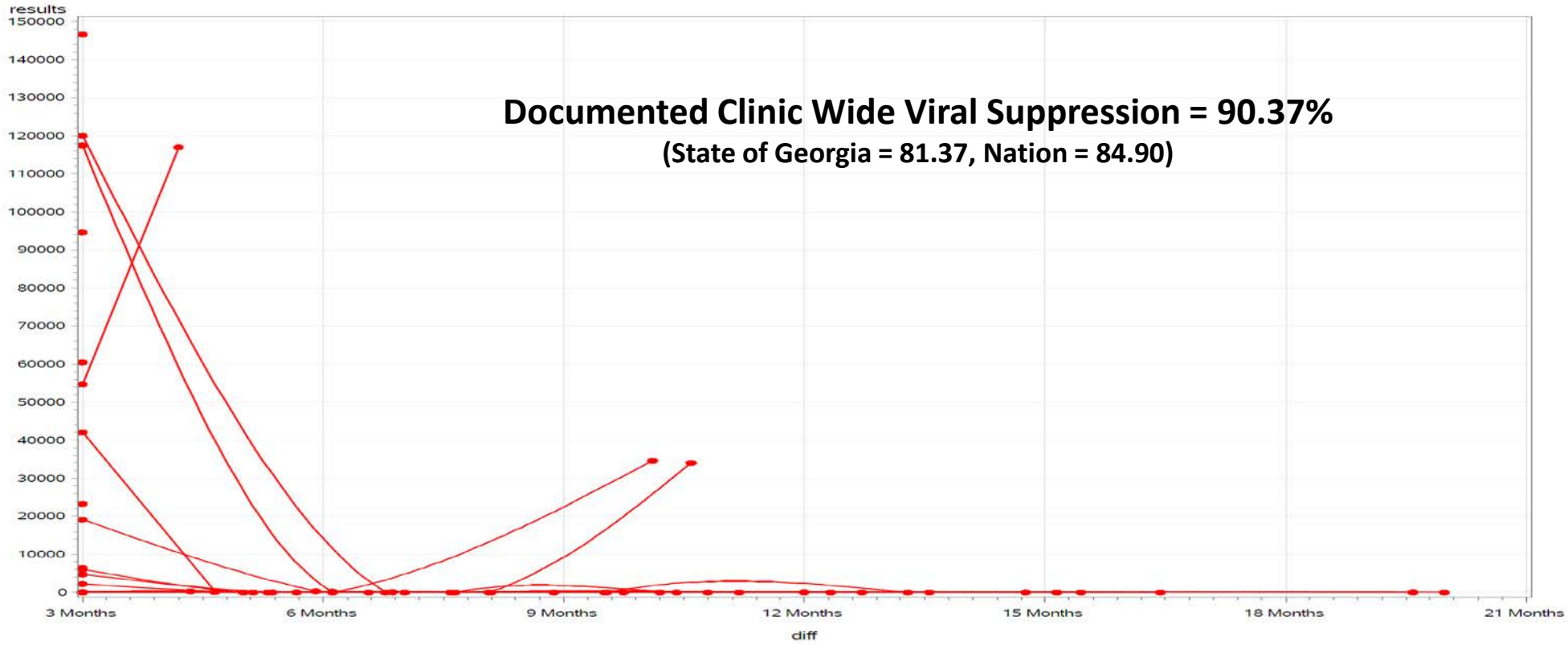
Stabilize Them – Linkage/Retention in Care

Intensive Case Management Program

- Intensive Case Management Nurse Secondary Task is to increase adherence to medical treatment plans in High Acuity patients
- Designed for patients with multiple barriers to medical adherence
- Case load is predominately people with: a) mental health and substance abuse issues, b) consistent interaction with the criminal justice system, c) a documented history of non-compliance (lost to care on multiple occasions, etc.)
- Near daily contact via phone, in person, home visits to address identified barriers, Direct Observed Therapy when needed

- **Current Clinic Wide Retention in Care percentage: 89.94% (State of Georgia = 79.75%, Nation = 75.39%)**

Look at that Slope!!!!



Current case load for Intensive Case Management Nurse is 24. 80% have a suppressed viral load (19). The 5 patients with a detectable viral load are newly diagnosed, not yet on medications and have not had a follow up viral load from the initial medical visit.

Hmmmm….What to do next?

- “True” Out of Care….Really Finding Them!
- Internal/External Care Cascade.....Ensuring our Treatment is impactful, and aimed at improving the entire population.
- Top 10 List! – Finding Them before we have to Find Them!
- Targeted Outreach Maps – Beating the Bushes with Science!