Ending the HIV Epidemic Initiative:

Utilizing Community Health Workers across the HIV Care Continuum

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March 2, 2022

Community Health Center
Association of Mississippi

Together We Care

chcams.org

Learning Objectives

- Understanding the role of Community Health Workers
- How to integrate Community Health Workers into primary care teams
- How UDS Measures are associated with HIV Care Continuum
- How to utilize Plan, Do, Study, Act Activities to support the HIV Care Continuum
- CHWs ability to increase patients' health outcomes for Persons Living with HIV

Community Health Workers

Community Health Workers (CHWs) are important members of the primary health care workforce who can effectively improve chronic disease outcomes.

- CHWs are trained laypeople who often share similar socio-economic, cultural, linguistic, and other identities as the people they serve.
- CHWs have been shown to improve self-management and health outcomes for people living with a variety of chronic conditions, such as asthma, diabetes, and cancer.
- Evidence suggests that CHWs have a positive impact on people living with multiple chronic conditions and play a crucial role in helping low-income people living with chronic conditions access preventive services and cost-effective treatment.

Are you currently using CHWs?

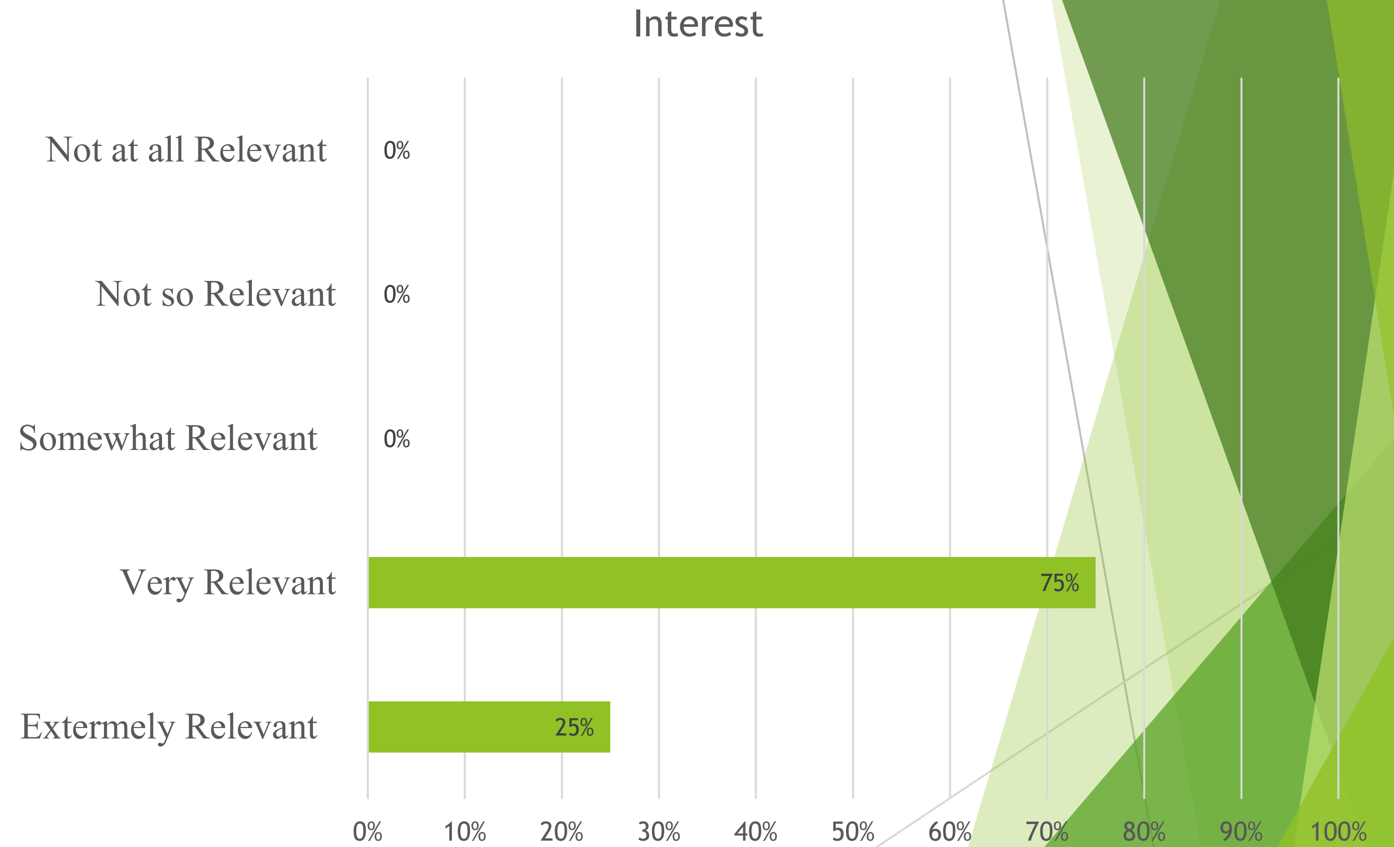
Community health workers go by many titles, depending on where they work, who they work for and what they do.

CHW TITLES

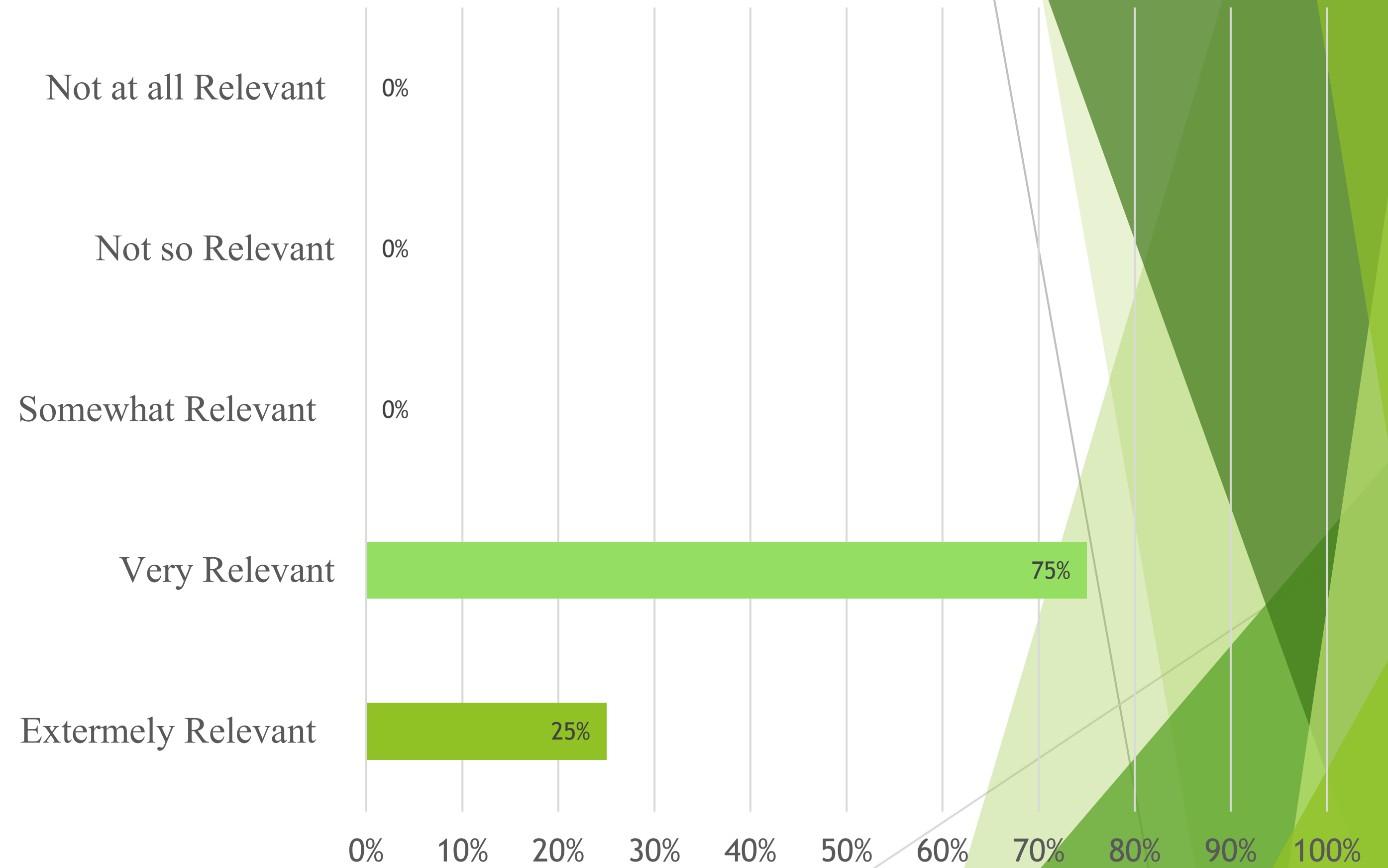
peer educator
counselor
linkage care coordinator
worker
outreach
PROMOTORA
patient navigator
health system navigator

Community Health Worker Survey

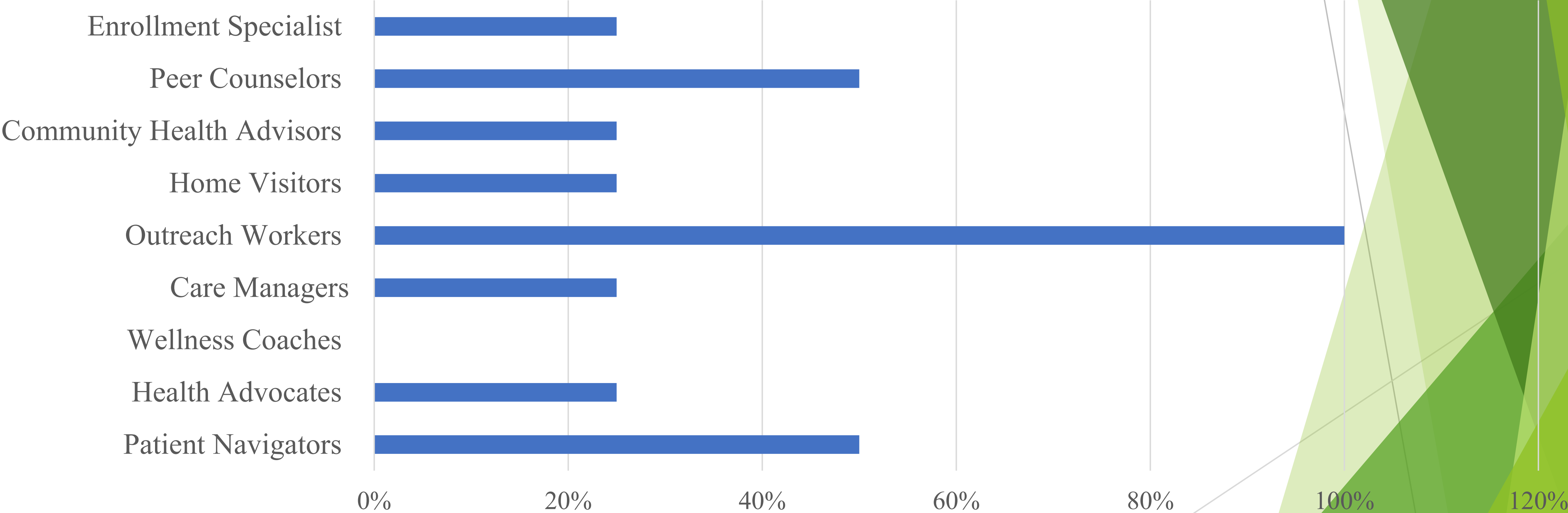
Q1. After reading the descriptions above, how interested are you in learning more about Community Health Workers?



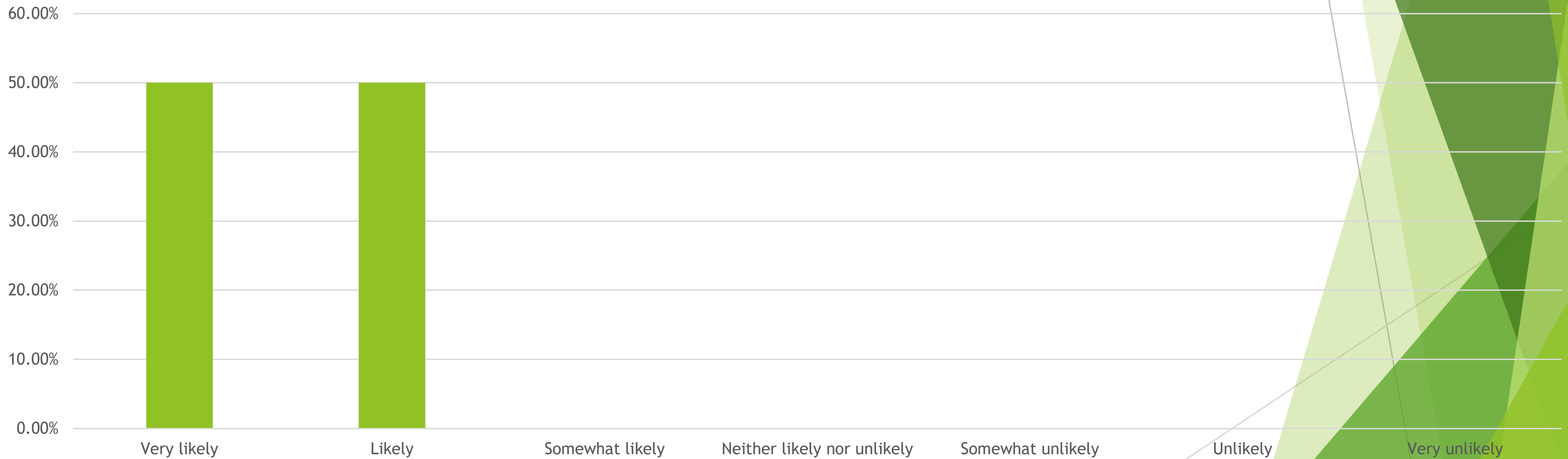
Q2. How relevant are Community Workers to your organizational needs?



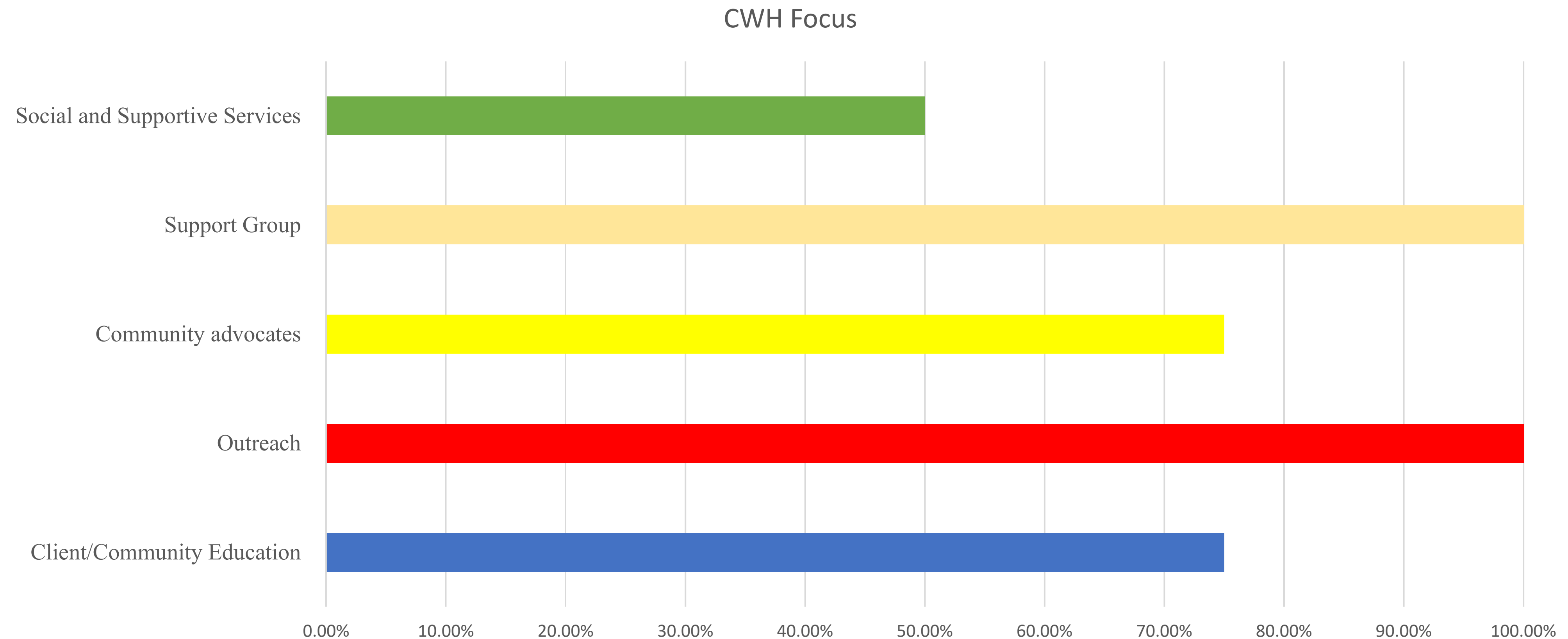
Q3. Community Health Workers may be known by other titles, please check any that exist within your organization. Check all that apply.



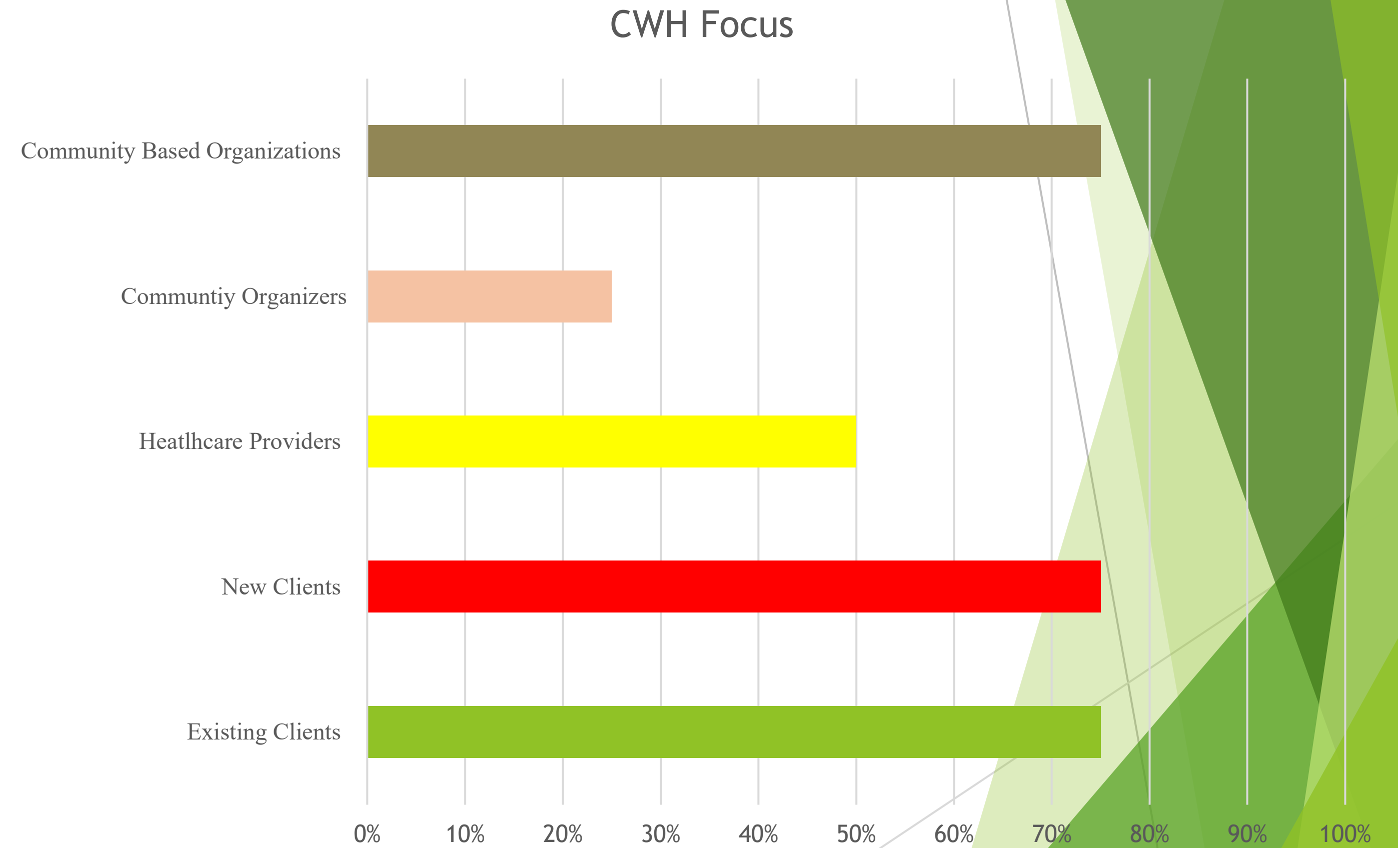
Q4. How likely is your organization willing to integrate Community Health Workers as part of the Care Team?



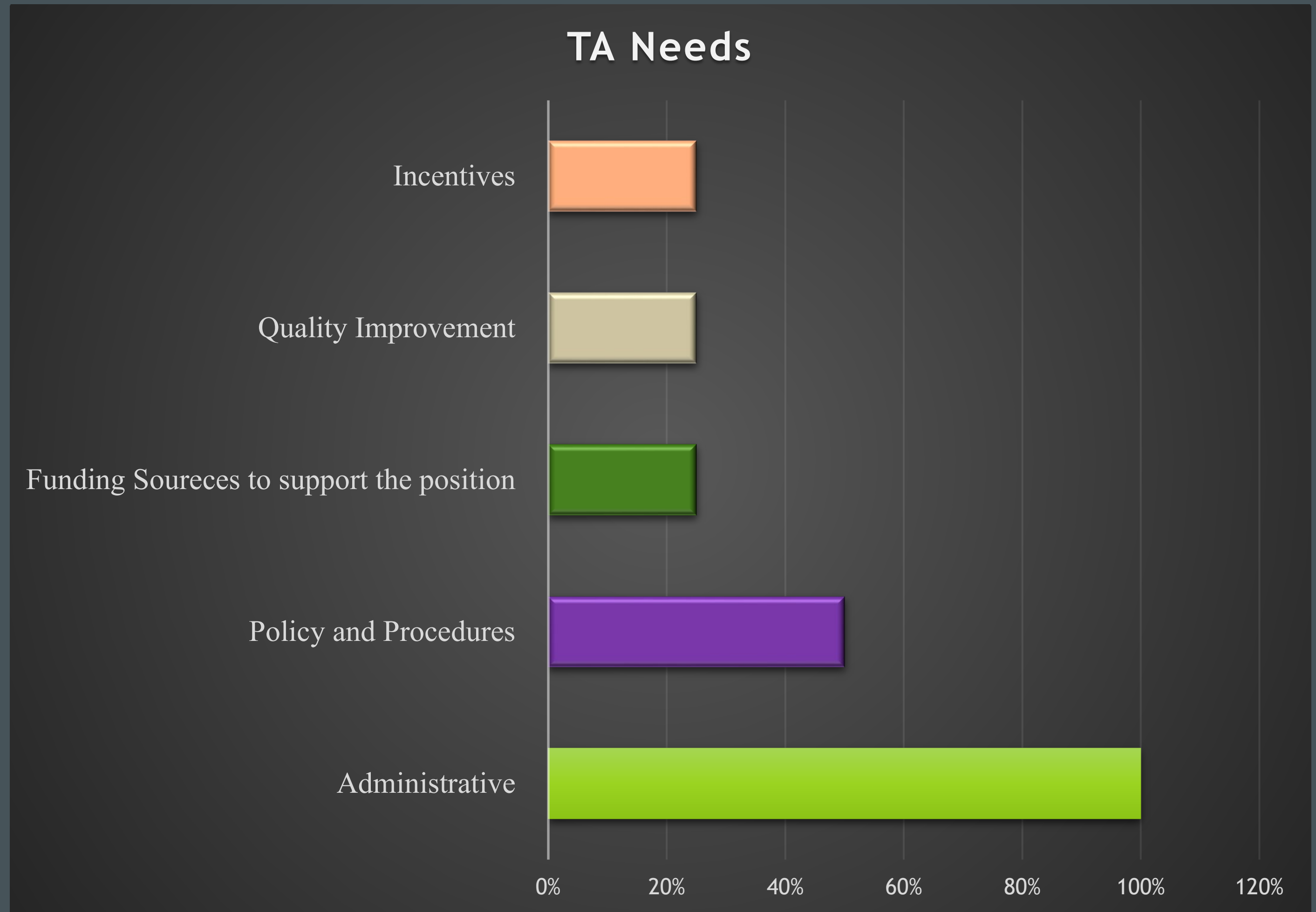
Q5. What would you see as a Community Health Workers Primary focus? Check all that apply.



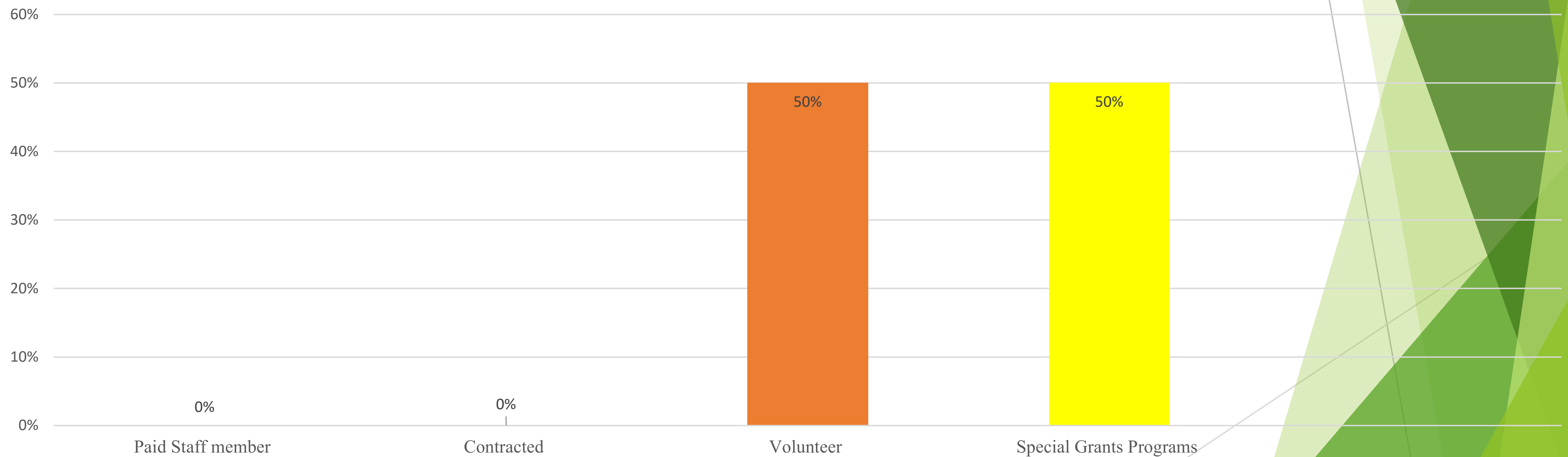
Q6. Who would the CHW work with primarily? Check all that apply.



Q8. What kind of technical assistance would your organization need to incorporate CHWs into your care team?



Q10. If your organization is utilizing a CHW, how are they being compensated?



Integrating CHWs into the Primary Care Team

How Can CHWs Enhance HIV Care Team

- A CHW can enhance the HIV care team by working in partnership with case managers, nurses, doctors, social workers, and other services providers to address the medical, social, and supportive services needs of the people living with HIV.

CHWs Enhance HIV Care Team

- Assisting, educating, and supporting people with HIV to become aware of their status;
- Linking and engaging people with HIV into medical care;
- Helping people with HIV adhere to treatment; and
- Explaining health benefits and other types of available assistance to people with HIV

Community engagement tactics with HIV Care

Organizations employing CHWs view them as being effective in improving health services as a result of factors such as:

- **Connecting with hard-to-reach populations** that other health workers may have avoided
- **Coaching clients** in ways that are culturally appropriate to facilitate positive behavior change
- **Developing trusting** and caring relationships with clients
- **Communicating with clients** to provide or collect information
- **Motivating clients** by using motivational interviewing and other behavior change techniques
- **Addressing client needs**, especially around social determinants of health (SDoH)

Including CHWs in Health Care Settings

Pre-implementation

- Decide on the community
- Assess the landscape
- Determine reasons for integrating CHWs in Health Care Settings
- Identify key stakeholders
- Engage key stakeholders to develop goals and objectives

Implementation

- Framework and models
- Facilitate inclusion of CHW into HC setting
  - Formal agreements
  - Scope of practice
  - Supervision
  - Trainings
  - Electronic Health Records

Evaluate

- Organize and manage the evaluation
- Frame the evaluation
- Pilot-test and start off with "Small Successes" Early on
- Conduct a full Evaluation
- Share Evaluation results

Sustain

- Consider financing mechanism

Source: https://www.cdc.gov/dhdsp/pubs/docs/CHW_Integration_Checklist.pdf

What is the HIV Care Continuum

The HIV care continuum is a representation of the extent to which individuals living with HIV are diagnosed, engaged in care and benefiting from antiretroviral therapy in terms of full viral suppression (undetectable lab values).

The value of the continuum in managing the HIV epidemic is compelling: individuals engaged in care can manage HIV as a chronic condition and simultaneously reduce the risk of transmitting the virus to others.

Model for HIV Care Continuum

Ryan White HIV Core Clinical Performance Measures

- HIV Viral Suppression
  - *Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.*
- Prescription of HIV Antiretroviral Therapy
  - *Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy1 for the treatment of HIV infection during the measurement year*
- HIV Medical Visit Frequency
  - *Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.*
- Gap in HIV Medical Visits
  - *Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year*
- PCP Prophylaxis
  - *Percentage of patients aged 6 weeks or older with a diagnosis if HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis*
- Annual Retention in Care
  - *Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.*

Why is the HIV Care Continuum Important to Health Centers?

- HRSA CY 2020 UDS Reporting made changes to Tables 6A, 6B and 7: Quality of Care Measures
  - This was done to align UDS Clinical measure with Center for Medicare and Medicaid (CMS) and electronic-specified clinical quality measures (eCQMs).
  - HIV Diagnosis is identified as a UDS measure, Table 6A:1-2 (Symptomatic/Asymptomatic Human Immunodeficiency Virus (HIV))
  - The HIV Screening measure, CMS349v2, captures the percentage of patients aged 15-65 at the start of the measurement period (December 1- November 30), who were tested for HIV (to be reported on Table 6A:Line 21, Table 6B: Line 20a).
  - The number of Pre-Exposure Prophylaxis (PrEP)- associated management of all PrEP patients (Table 6A: Line 21e).

Why is the HIV Care Continuum Important to Health Centers?

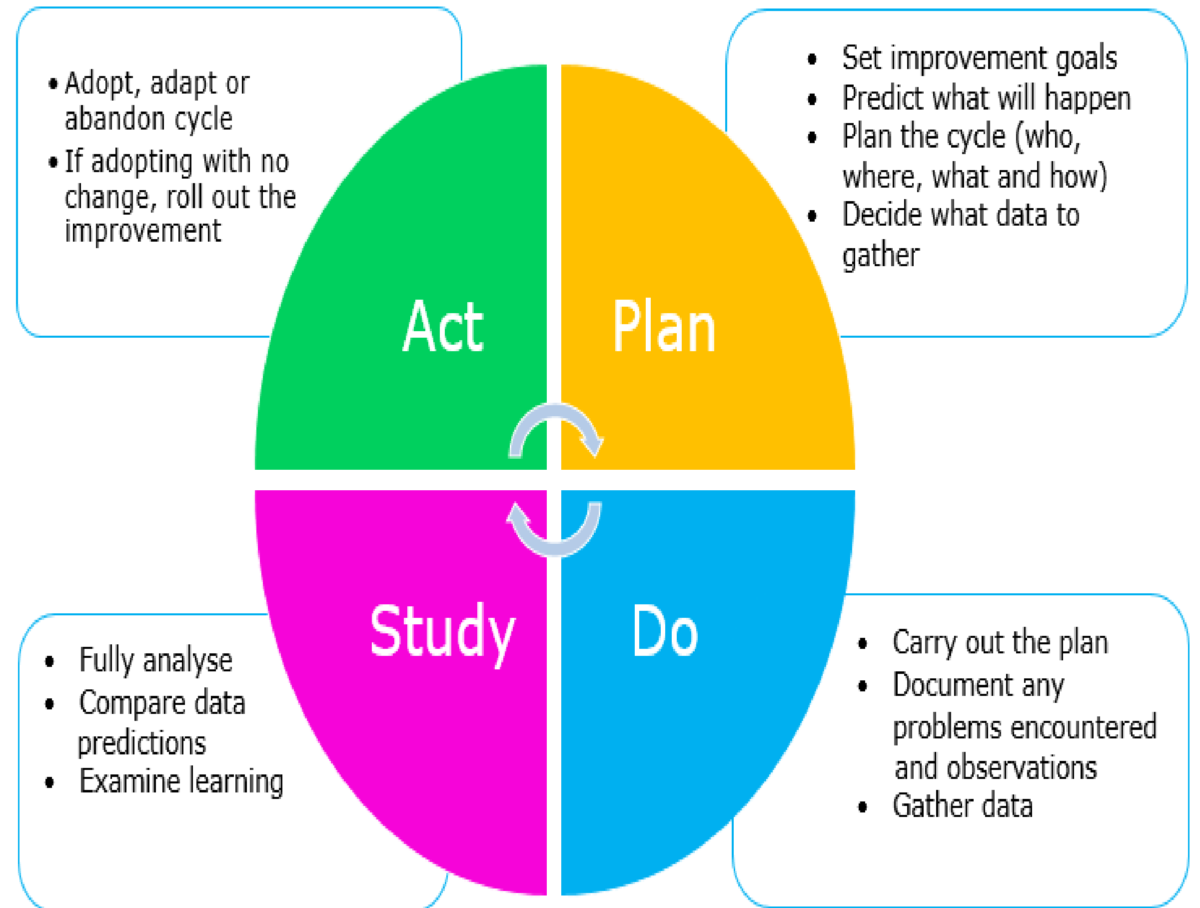
- HIV Linkage to Care (Table 6B: Line 20) no eCQM
  - Looks at the percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis.
- HIV-Positive Pregnant Patients, Table 7: Line 0.
- The addition of the HIV screening eCQM will further support efforts to promote early detection and care of HIV in health center patients.
    - https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2020_UDS_Approved_PAL.pdf

How do CHCs ensure they capture these changes in UDS Measures for HIV?

- Agencies should develop outreach protocols and policies to address the HIV Care Continuum five stages.
- Agencies should train staff and newly develop policies and implementation of those policies and procedures.
- Agencies should quarterly provide their staff with updates and trainings
  - https://healthhiv.org/programs/hpcp/
  - MS AETC https://aidsetc.org/aetc-program/mississippi-aetc
  - www.chcams.org

How do CHCs ensure they capture these changes in UDS Measures for HIV?

- Health centers should add the revised HIV measure as part of their quality improvement teams measures
- They should conduct Plan, Do, Study, Act (PDSA) activities to test the implementation of the program activities

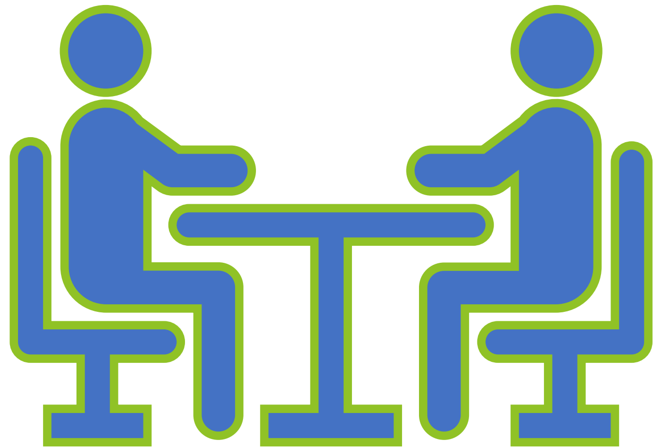


PDSA Cycle

First	In the First PDSA cycle, Participants will work to develop policies and procedures or workflow analysis to integrate CHWs into the Care Team and your EHR for persons living with HIV/AIDS. This will include the development of your own planning, implementation, and evaluation of this PDSA Cycle.
Second	The Second PDSA cycle, Participants will identify a target HIV clinical performance measure (viral load suppression, HIV treatment adherence, Medical visit frequency, or Gaps in HIV medical visit) to have the newly onboard CHW work with a cohort of patients to test the change in the selected performance measure.
Third	In the Third PDSA cycle, Participants will choose if they want to revisit the same PDSA from Cycle 2 or select a new clinical performance measure to focus on during Cycle 3.

Sample PDSA Activities to conduct by the agencies in the collaborative

- Same Day PrEP Start
- Increase HIV Screening among persons 15-65
  - Opt-Out Testing Policy
  - Comprehensive HIV Outreach and Engagement Plan
- Increase access to primary HIV care within clinical setting
  - All providers within the organization should be willing to prescribe PrEP
  - All providers should be willing to retain their existing patients who test positive for HIV or AIDS
- Examine your agency's efforts toward monitoring HIV Care Continuum measures.



Evaluating your activities

- You must establish a denominator and numerator for your activities
- Define how you want to tell your story
- Share your finding with team and upper management
- Provide feedback to patients so they can take ownership of their health
- Evaluation data will prove beneficial in the grant writing process

Questions and Answers

Thank You!!

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