Successful First Appointment to Increase Retention in Care

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AETC AIDS Education & Training Center Program Southeast

Disclosures

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AETC Program National Centers and HIV Curriculum

- **National Coordinating Resource Center –** serves as the central web –based repository for AETC Program training and capacity building resources; its website includes a free virtual library with training and technical assistance materials, a program directory, and a calendar of trainings and other events. Learn more: https://aidsetc.org/
- **National Clinical Consultation Center –** provides free, peer-to-peer, expert advice for health professionals on HIV prevention, care, and treatment and related topics. Learn more: https://nccc/ucsf.edu
- **National HIV Curriculum –** provides ongoing, up –to-date HIV training and information for health professionals through a free, web –based curriculum; also provides free CME credits, CNE contact hours, CE contact hours, and maintenance of certification credits. Learn more: www.hiv.uw.edu

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Learning Objectives

By the end of this session:

- *Each participant will be able to explain the importance of intakes to retention in care*
- *Each participant will compare their agency's intake procedures to VCCC's*
- *Each participant will critique their intake procedures and have 2-3 suggestions to improve their agency's retention in care*

Agenda

- Overview of VCCC
- How patients get to us
- Engaging in care/intake process
- Lessons Learned

HIV Care Continuum

The history and mission of the VCCC

- The VCCC is the result of several years of evolution in care that reflect the **changing needs and challenges** of people living with HIV.
- The comprehensive nature of the care we provide is the result of **unique and complex issues** addressed with **dedicated resources.**
- The model developed fits well with the goals and mission of a Primary Care Medical Home.
- 30th Year of Service to Nashville and surrounding areas

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Mission Statement

- To provide quality medical care for patients with HIV and AIDS by:
- Providing comprehensive **cost-effective, innovative, state-of-the-art** medical procedures and treatments;
- Caring for individuals with HIV/AIDS with **dignity, compassion and hope**;
- Helping these individuals and their caretakers access related services;
- **Collaborating with healthcare institutions** and organizations through research and education;
- **Uniting the business, public and medical sectors** to support the Center

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VCCC Patients

Over 11,000 patients enrolled (about 3,700 active; 300 new per year)

- Ages 16-87 years
  - 3% under age 25
  - 40% 25-44
  - 52% 45-64
  - 6% >65
- Gender
  - 20.2% female
  - 1.4% transgender
  - 78.4% male
- Race/Ethnicity
  - 43% African American/Black
  - 1.7% Asian and Other
  - 55.3 White/Caucasian
  - (7% Hispanic/Latino ethnicity)
- Income
  - 43% below federal poverty level
  - 64% below 200% of federal poverty level
- 50% substance abuse
- 40% mental health diagnosis

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VCCC Services

Evolution of services is based on patient need

- Clinical and Laboratory Evaluation (Primary Care, Colposcopy, Obstetrics and HIV)
- High Resolution Anoscopy
- Elastography Scanning for Liver Disease
- Psychiatric Care and Mental Health Services
- Clinical Pharmacy Services and Patient Assistance Program
- Nutrition Services
- Intensive Case Management
- Health Insurance Navigation and Ryan White Enrollment
- Transitions of Care Case Management
- Coordination of Home Care, Hospice, Infusion Transfusion Services
- Clinical Trials Access
- PrEP Clinic
- Medication-Assisted Treatment/Substance Use Disorder Clinic/Syringe Service
- Dermatology
- Inpatient Care Direction
- On-call Services
- On-site COVID testing and vaccination
- On-site monkeypox vaccination and treatment

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VCCC Staff

- 10 Attendings – Dually Boarded in Internal Medicine and Infectious Diseases
- 4 Primary Care Nurse Practitioners
- 1 Pharmacist
- 5 Case Managers – RN
- 2 Psychiatric Nurse Practitioners
- 2 Behavioral Health Consultants – LCSW
- 1 Registered Dietitian
- 5 Masters level Social Workers
- 3 Triage Nurses – RN
- 5 Clinic Nurses – LPN
- 1 Medication Assistance/Prior Authorization Coordinator – LPN
- 2 Referral Specialists
- 3 Patient Service Representatives (PSR)
- 6 Administrative Staff

How do patients get to us?

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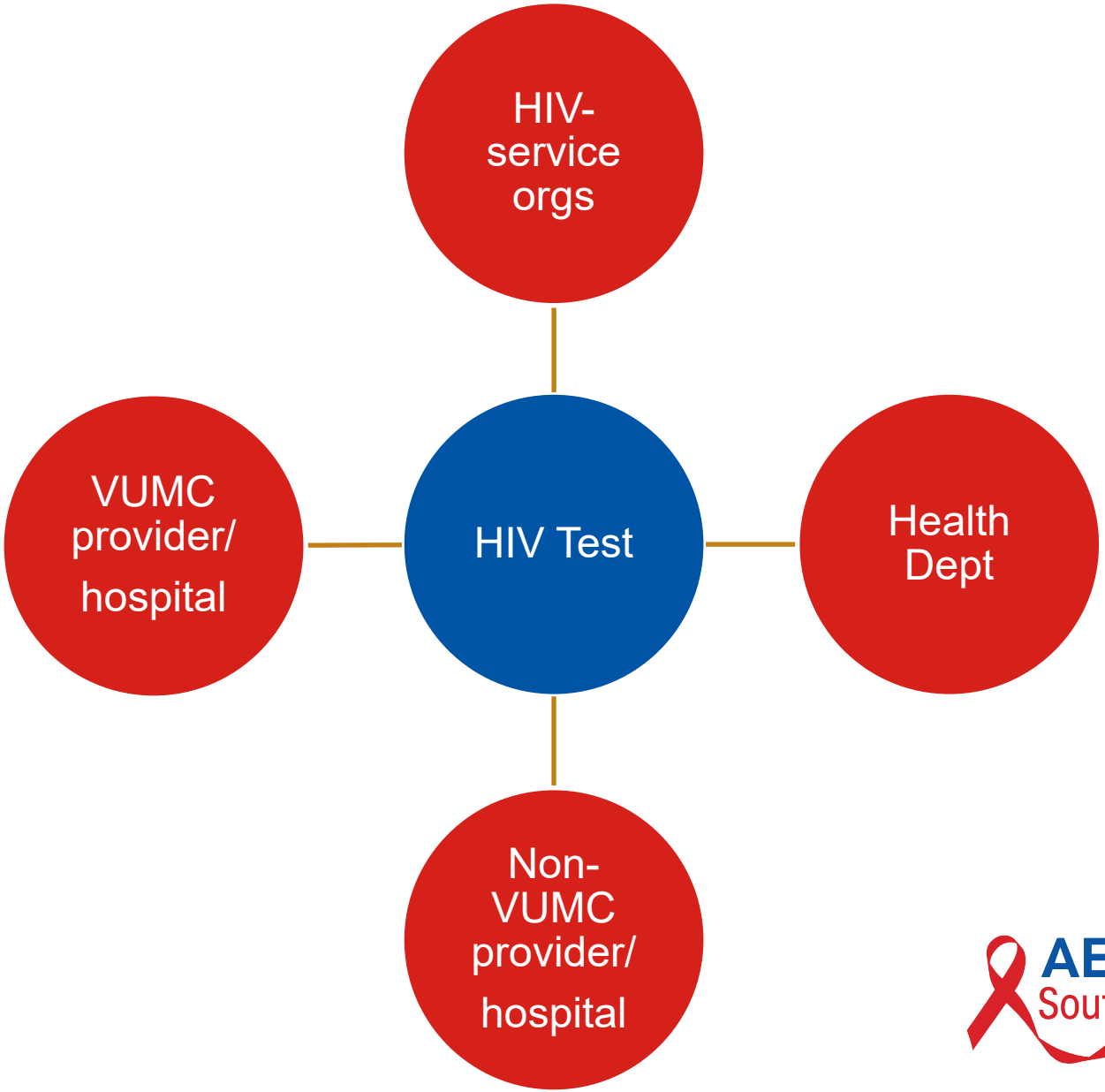

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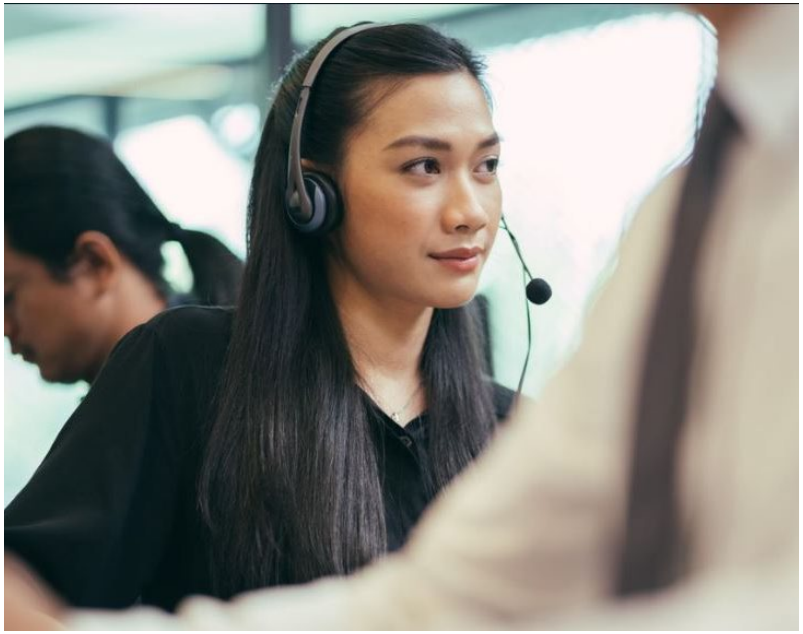
Patient calls VCCC to schedule appointment

- Call Center
- Establishes EHR chart with demographic information
- Call center sends message to SW team



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MSW calls patient

- Establishes that pt has proof of HIV+
- Schedules intake appointment
- Details what to bring

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Reminder call

- Assess for transportation barriers
- Reminder of documentation needed
- Where to go
- Sets expectations

Intake

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Intake purposes

90-minute appointment for all new patients to clinic

- To establish care at VCCC
- Enroll in Ryan White services (if eligible)
- Provide brief solution-focused therapy
- Address barriers to staying in care
- Help pts choose their provider
- Get baseline labs

TN Ryan White Eligibility

- <400% FPL
- Resident of TN
- HIV+

2024 Federal Poverty Guidelines for the Ryan White Part B Program

ANNUAL

Family Size	100%	200%	300%	400%
1	$15,060	$30,120	$45,180	$60,240
2	$20,440	$40,880	$61,320	$81,760
3	$25,820	$51,640	$77,460	$103,280
4	$31,200	$62,400	$ 93,600	$124,800
5	$36.580	$73,160	$109,740	$146,320
6	$41,960	$83,920	$125,880	$167,480
7	$47,340	$94,680	$142,020	$189,360
8	$52,720	$105,440	$158,160	$210,880
9	$58,100	$116,200	$174,300	$232,400
10	$63,480	$126,960	$190,440	$253,920

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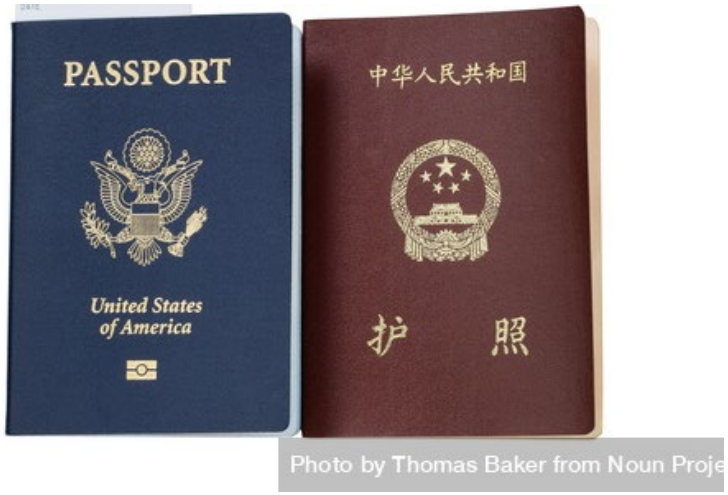
Documentation

- Proof of identity (photo ID)
- Proof of residency (bill with date)
- Proof of income (2 paycheck stubs in a row)



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Ryan White Services

HIV/AIDS Drug Assistance Program (HDAP/ADAP)

- No insurance
- Care covered at VCCC
- Prescriptions at ADAP pharmacy

Insurance Assistance Program (IAP)

- Insurance premiums (ACA)
- Outpatient Copays
- Prescription Copays

Goal: Get all patients insured

- Better for the patient to get all the care they need
- Better for our providers to serve patients
- Better for the healthcare system

Jose

- New diagnosis, lacks immigration status
- Spanish-speaking
- Living with partner who does not know HIV status
- Day laborer
- No family in US
- Depends on friends/partner for transportation

Brenda

- Living with HIV for 20+ years
- Virally suppressed
- Employed full-time
- Long-term partnership
- Lots of social support
- Does not qualify for Ryan White—income >400%

Newly diagnosed patients

- Provide supportive therapy, acknowledge grief
- HIV education to patient and support system

All new patients

- Overview of clinic departments and services
- Assess for RW eligibility
- Assess strengths and barriers to staying engaged in care
- Help pt choose provider

Assessment

- Substance use disorder
- Literacy
- Health literacy
- Housing
- Support system
- Food security
- Transportation
- Employment
- Mental Health

Provider Choice

HRSA goal is linkage within 30 days of diagnosis

- Assess goodness-of-fit
- Personality of pt, provider and nurse case manager
- Pt schedule
- Pt medical complexity
- Provider special interests
- Schedule first medical appointment 14 days after intake

Walk pt to lab

- Far from clinic
- During walk, can continue assessment/developing rapport
- All new patients get same baseline labs

Follow up

- None if patient does not qualify for RW
- Annually for those that need to recertify
- Increased engagement with patients may lead to better retention in care

Rapid ART Start

- Confirm positive test within last 30 days on SW call
- Complete intake as usual
- Meet with nurse case manager for assessment and ART start

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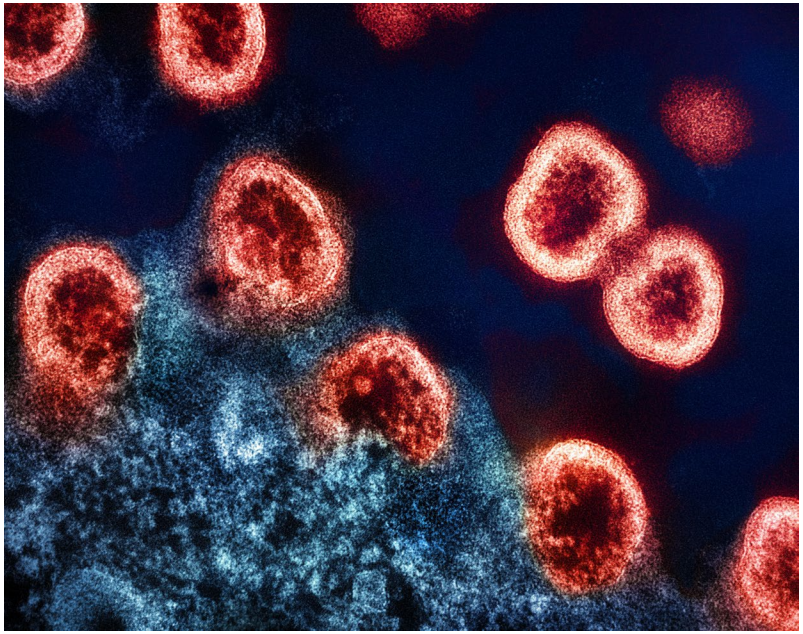
Putting it all together

- Establish rapport
- Address barriers to care
- Match with best provider



Recommendations

- Trauma-informed, well-trained, well-paid admin staff answering the phone when patients call
- Schedule complex intakes in longer slots
- More follow up care like reminders for visits, checking in after first appt

HIV Care Continuum

Thank You!

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