Community Healthcare Network

Medical Affairs - HIV Programs and Services

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COMPREHENSIVE RISK COUNSELING SERVICES PATIENT RETENTION IN CARE

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A LITTLE ABOUT US

Community Healthcare Network (CHN) is a not-for-profit organization that provides access to affordable, culturally-competent and comprehensive community-based primary care, mental health and social services for diverse populations in underserved communities throughout New York City.

Facts:

- Incorporated in 1981 from a group of isolated family planning clinics under Community Family Planning Council.
- First organization in New York City to bring HIV care and Counseling and testing services to women's health.
- In 1989 becomes a Federal Qualified Health Center.
- In 1999 CFPC became Community Healthcare Network and Catherine is appointed CEO/President
- Under the new leadership CHN becomes one of NYC's premier community provider for medical and social services for those living with HIV and at risk for HIV.

PROBLEM NEEDS ASSESSMENT

- Clients presenting with dual diagnosis one or more STI's at their initial visit at the Brooklyn sites
- CRCS staff identified high risk behavior at their initial visit
- Co-existence of HIV infection and a newly diagnosed STI
- Role of a new partner and her/his knowledge of index client's status

- Lack of an appropriate sexual history and or discussion about sexual health between provider and patient

PATIENT HISTORICAL PERSPECTIVE

- Centers are located in low income areas
- Central Brooklyn considered the epicenter of Black AIDS America
- Unemployment
- Educational background
- Immigration status and access to healthcare
- Sex and age grouping
- Lack of cultural and linguistic competent services
- Health Literacy
- Cultural do’s and don’ts(own’s backgrounds)

THE STAFF AND THE HIV TEAMS

- Teams are part of a multi-disciplinary approach that includes treatment adherence staff, nurses, social workers, nutritionists, case managers and medical providers
- Cases are reviewed prior to the clinical session and tasks are divided amongst the team
- Team works also includes client involvement (think medical home)

PROGRAM ASSESSMENT

- CRCS staff met to discuss new referrals, the fact that most presented with two or more STI's
- Engagement in care: individual and group intervention
- Discussion of partner involvement
- Navigation strategies and introduction to the clinic
- Need to follow up of test of cure and reaching out to partner (s)
- When do we talk about HIV

HIV AND INTEGRATION OF CARE

- All HIV services are delivered in an integrated manner
- The goal is to get more active participation from the client in assessing the risks STI infection and hence reduce exposure to HIV
- Consideration of partner involvement is always of paramount importance for both, clients and staff
- This model works with lowering stigma toward HIV and sexual health and behavior
- Health Education becomes part of every visit and every message

STRATEGY

- Comprehensive Risk Counseling Services(CRCS)
- Who gets referred to CRCS
- Interaction of the clinical team and the Staff of CRCS
- Inclusion of sexual health and sexual risk behavior in the curricula for open discussion
- Aggressive partner notification
- Self evaluation and goals reviewed by participants regularly:VL, CD-4, incidence of STI’s, schooling housing and other environmental factors
- Availability of team support at any time to validate participant's progress

CHN AND THE HIV PROGRAMS

1. Counseling, Testing and Referral Services
2. Access to Health Care
3. Treatment Adherence
4. Mental Health
5. Case Management
6. Reproductive Health
7. Transgender Health Services
8. Education, legal referrals and follow up with outcomes

CRCS SERVICE ANALYSIS

- **Aspect of Care:**
  Enrollment and Retention

- **Measure: 30**
  Clients to be Graduated annually to meet CRCS program deliverable
  Referrals and retention to Primary Medical Care
  Referrals and retention in social support services

METHODOLOGY

Conduct outreach, enrollment in CRCS

Referrals to: primary medical care and social support services

Each client will receive eight (8) individual risk reduction counseling sessions

Group sessions are optional

Period covered January 01 to April 30, 2010

MEASUREMENT

- **Goal: 100% of clients enrolled in CRCS will graduate annually**
- **Sample size: 30**
- **Benchmark source: Internal and comparison to previous year ended June 30, 2009**

Benchmark rate: 80% of program requirement (20 clients)

CRCS

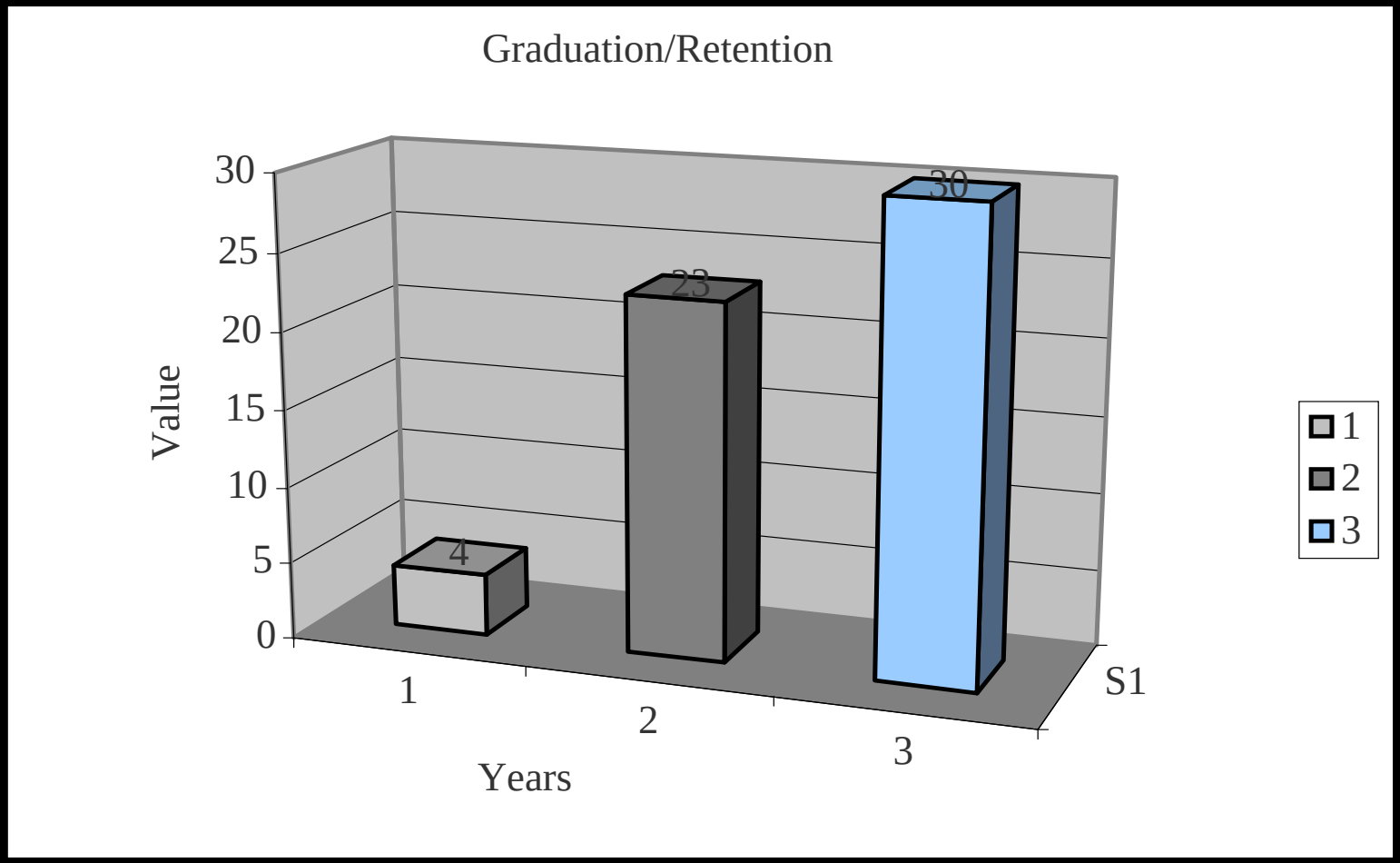
Numerator	Denominator
Number of clients graduated	Expected number of clients to be graduated (30)

DEMOGRAPHICS

Age		
17-20	=	10%
21-24	=	13%
25-30	=	25%
31-35	=	3%
36-40	=	8%
41-49	=	20%
Over 50	=	21%

Gender
Male: 69%
Female: 31%

RESULTS


Graduation/Retention
30
25
20
15
10
5
0
Value
4
23
30
1
2
3
Years
S1
1
2
3

REFERRALS AND LINKAGE TO CARE

Primary Medical Care = 30 (100% retention in primary care)

CABS	=	12
CH	=	13
Negative	=	05
C&T	=	30
COBRA	=	CABS -10, CH- 8

Mental Health = 12

100% have been seen by the social worker, nutritionist, and TA

QUALITY ASSURANCE

- **100 % of clients enrolled in CRCS is retained in PC**
- **100% of clients have had reduction in VL and increase in CD4**
- **100% of Clients who are negative remained negative at the time of graduation**
- **100% of all clients (clients with STI co-infections did not have a re-infection as of April 30, 2010**
- **100% of clients who are HIV+ and have graduated from CRCS did not get a co-infection**

CRCS LESSON LEARNED AND CONCLUSIONS

1. Giving the increase number of younger clients enrolling in the program, we have changed the way we communicate with clients (texting and emails)
2. We established a very active referral linkage with the DOHMH-Fort Greene – Flatbush Ext office where we get all new diagnosed patients
3. We respond promptly to clients needs and stay in communication with them constantly
4. Increased retention was directly related to our excellent customer engagement and support
5. CRCS direct involvement in coordination of PC and support services
6. Integration of the weekly group session
7. Patients that are seeing utilizing the team approach, will stay in care longer

This is a classical example of knowing and understanding CRCS clients:

"When the waitress asked if I wanted my pizza cut into four or eight slices, I said, 'Four. I don't think I can eat eight."
-- Yogi Berra

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Thank you