
**Care Coordination Services Department (CCSD)**

Cook County HIV Integrated Program (CCHIP)

Ruth M. Rothstein CORE Center (CORE)

Social Services Department

# Outline

I. What is HIV|AIDS

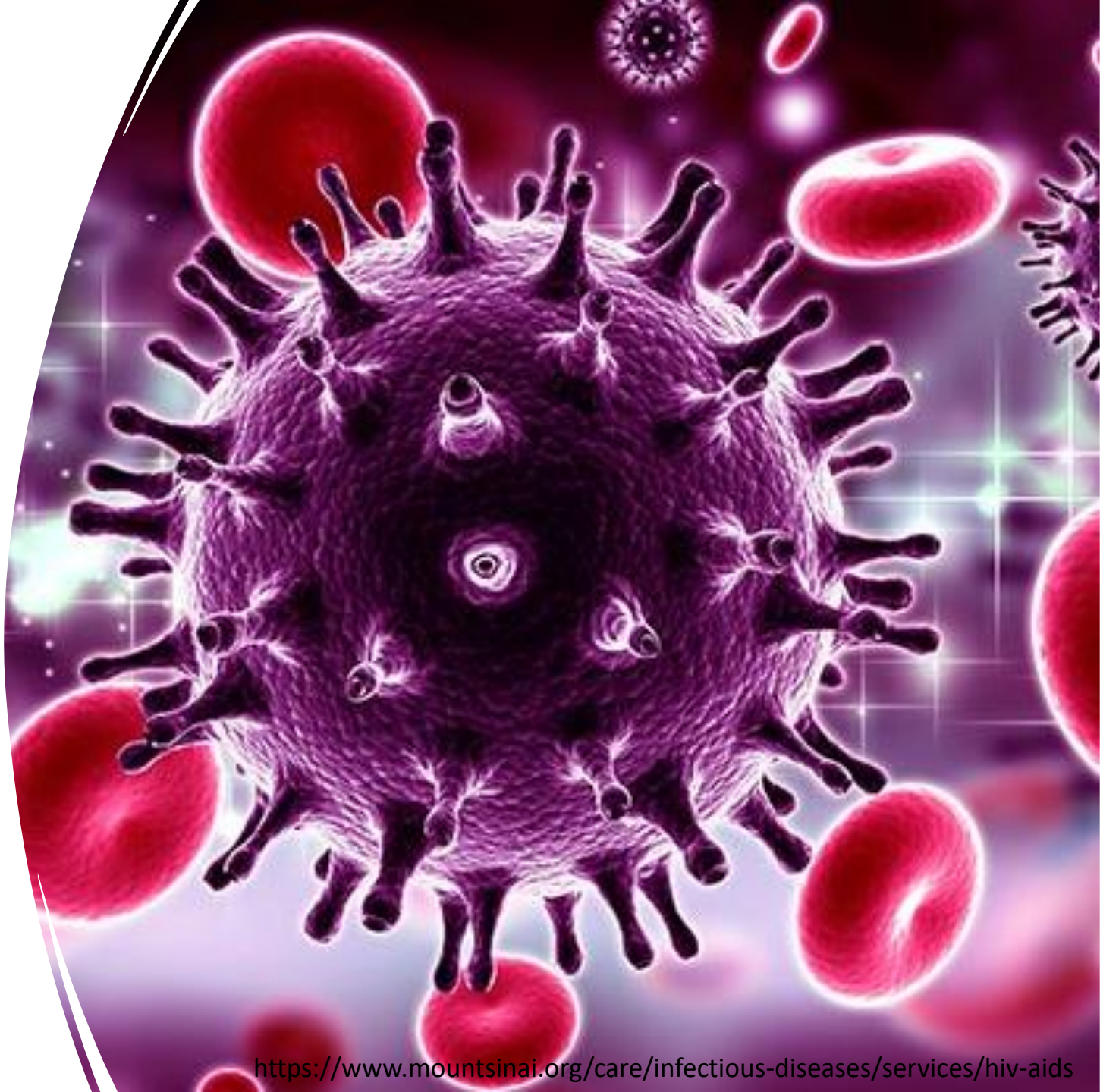
II. Strategies to Engage Clients

III. Who We Are

IV. What We Do

V. Working Together

# HIV AIDS



https://www.mountsinai.org/care/infectious-diseases/services/hiv-aids

# What is HIV|AIDS

HIV Human Immunodeficiency Virus - attacks the immune system

Transmitted by

- Blood to Blood contact (unclean needles, etc.)
- Unprotected vaginal, anal, or oral sex
- Mother to baby by pregnancy, labor, or nursing

AIDS is caused by HIV =weakened immune system.

- CD4 of < 200
- One or two additional opportunistic infections (Toxoplasmosis, KS, etc)

No longer a death sentence

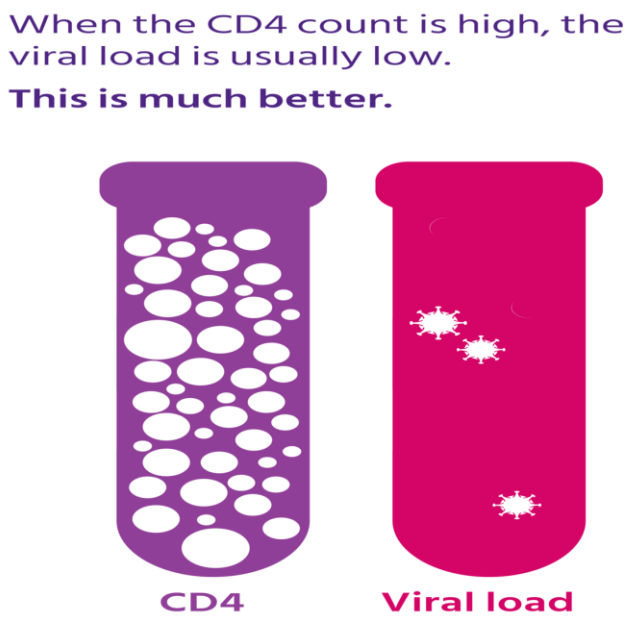
# Clinical Markers

**CD4 Count**

- Number of cells that are part of your immune system

**Viral Load (VL) Count**

- Number of virus in the blood

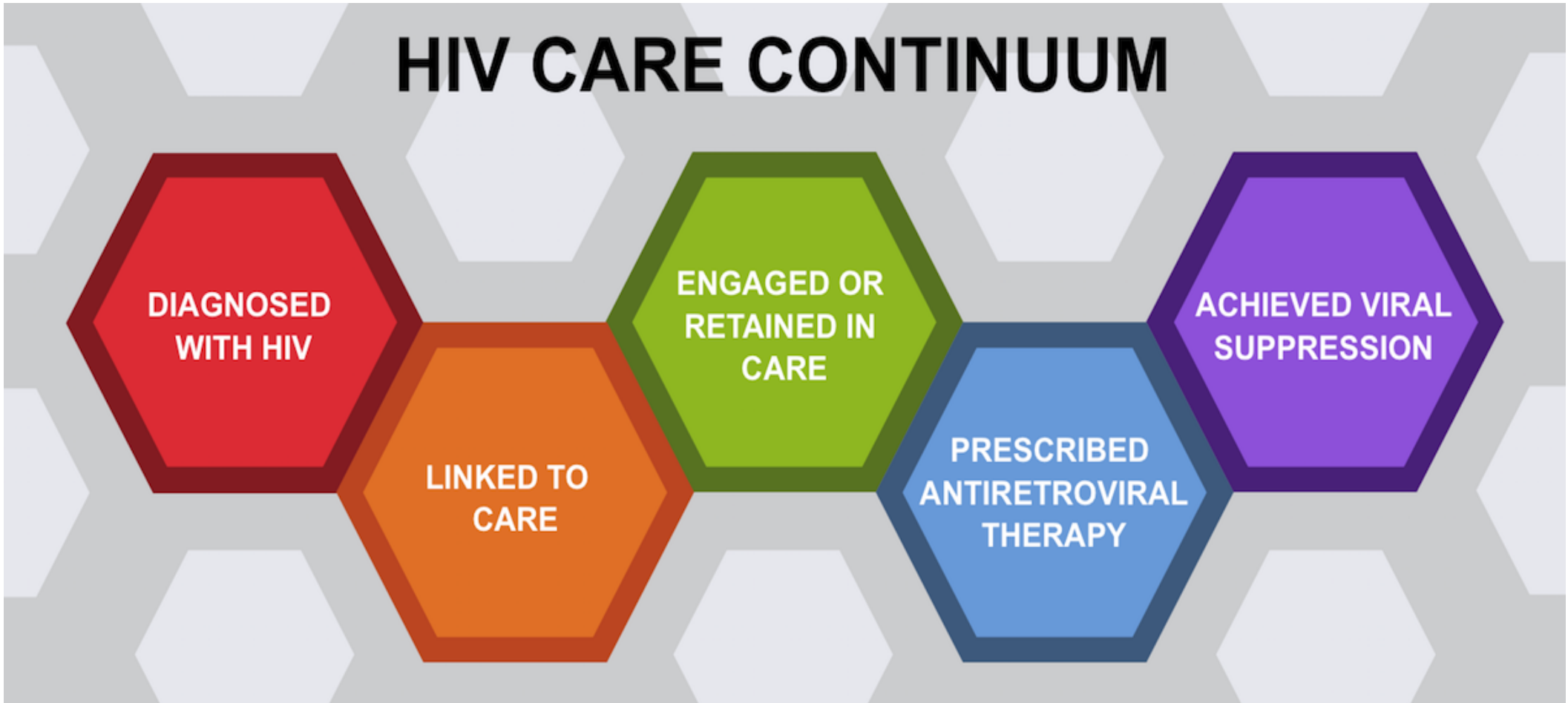




https://www.aidsmap.com/about-hiv/basics/cd4-and-viral-load


= 83% Undetectable

*Viral Load of less than >40 copies/mL*

www.CDC.gov




The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication

# Medical Care

- HIV Provider = Primary Care Provider
- Appointment every 3 – 6 months or longer
- Clinic Markers: CD4 & VL
  - Goal= become undetectable (<40 copies/mL)

Clients can be on one pill once a day

- Must take every day & not miss doses


# Medications

- **MAP/ADAP Medication Coverage**
  - Completed every year
  - Obtain Medications via Walgreens C&M Specialty Pharmacy.

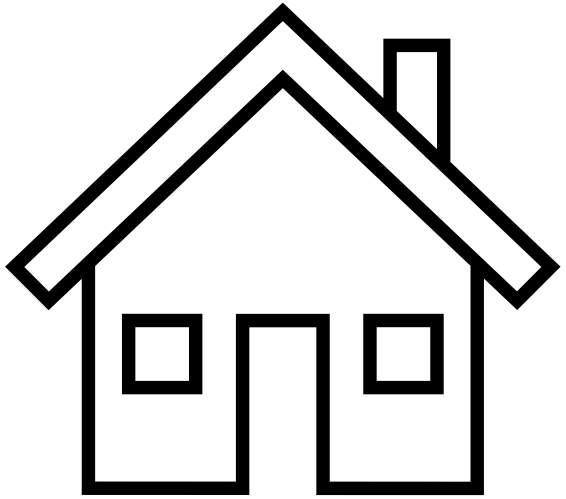
  - Medications can be delivered to local Walgreens, clinic or home
  - Many clients opt out of home delivery

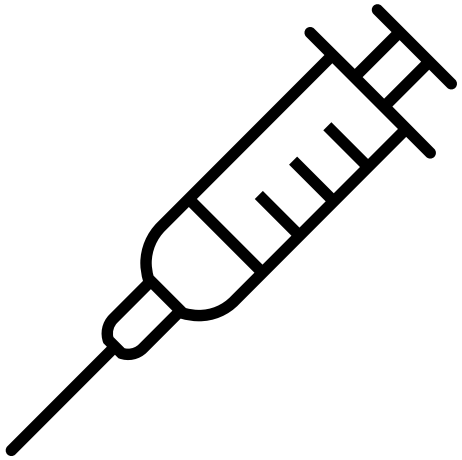
  Insurance Plans have their own pharmacy requirements

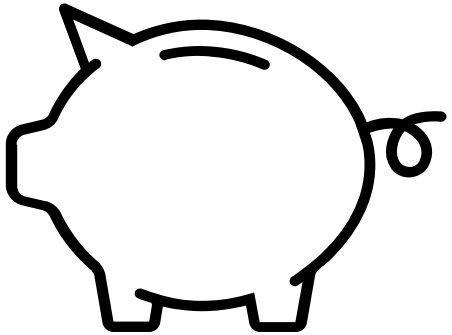
# Engaging Clients

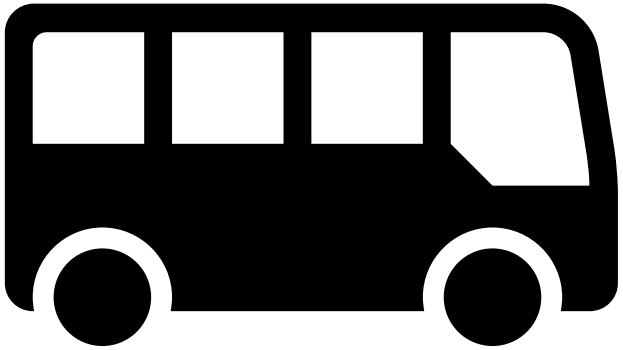
# Barriers To Care

- Psychiatric or Behavioral Health Diagnoses
- Low Educational Level
- Limited Support System
- Disclosure & Stigma
- Work Schedule
- Child Care









# Barriers to Care- Strategies

- Listen & learn about your clients
- Meet them where they are at
- Set them up to succeed
- Do not take things personal

- Prioritize a diverse team – when possible, hire Peers

# Linkage

- Offer them linkage to one of our Cook County HIV Integrated Program(CCHIP)
  - Home
  - Outside HIV Care
- Call with them to set up the first appointment
- Get as much contact information as possible
- Conduct Reminder and well-being calls
- Provide resources, i.e., set them up the first time, such as transportation
- Give them direct access to staff instead of a general number

# Reaching Out

- Use two identifiers
- Best to engage in-person in a private area
- If you must engage in a public area do not mention HIV/AIDS or CORE Center.
  - Use Provider Name or mention address (2020 W. Harrison Steet, Chicago, IL )
- Keep your interactions very basic- No big words or abbreviations

*Listen & Learn*

# Stigma & Disclosure

Stigma continues to affect disclosure & HIV care

Do not assume your client has disclosed their HIV status

- Including significant other, partner, husband, wife.
- Have shared other diagnoses\conditions such as cancer, etc.

Ask about disclosure when alone with client

Do not pressure your client into disclosing

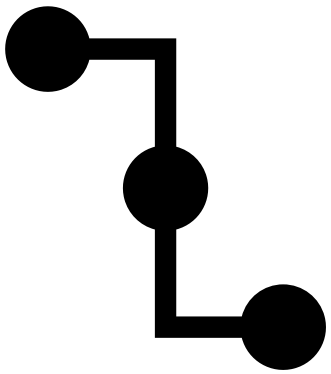
# Talking about HIV

- Always refer to the diagnosis as HIV
  - Best to not say AIDS (even if CD4 <200)
- Ask about Medications
  - In the last two weeks, how many times have you missed a dose?
  - issues or concerns?
- Confirm refill history
- Ask about medical appointments

# Calls

- Ask, “are you able to talk freely? Are you alone? Is this a good time to talk?”..etc..
- Keep the calls brief and concise, a lot of our clients have government phones with limited minutes.
  - If number is not working, call again at the beginning of the month
  - Try all numbers since they often change phones

  Be aware of your surroundings- especially when working remote
- When leaving a message, do not mention HIV/AIDS or CORE Center; leave a general message with appointment information.



# Outreach Visits

- Observe your surroundings
- Go in pairs, especially when going into a private residence
  - If possible, take someone that is from the same community or speaks the same language.
- If you feel unsafe do not proceed with the visit
- Wear comfortable shoes, nothing flashy
- Wear proper PPE
- Take a general outreach letter to leave behind

# Homeless Clients

- Lifestyle Choices
- Some have a phone, but often change numbers or lose phones
- Ask where they hangout or frequent
  - Emergency shelters
  - Mailing Address
  - Family

If no phone, ask them to call or stop by periodically

# Navigating Family & Friends

- If you can ask in advance, ask if they will be accompanied, if yes…
  - Is the person aware of HIV status
- Introduce yourself
- If meeting your client at a CCHIP site, do not assume they are aware
- if client provides contact information for follow-up get a release of information

# Who We Are

# Cook County HIV Integrated Program (CCHIP)

KEY

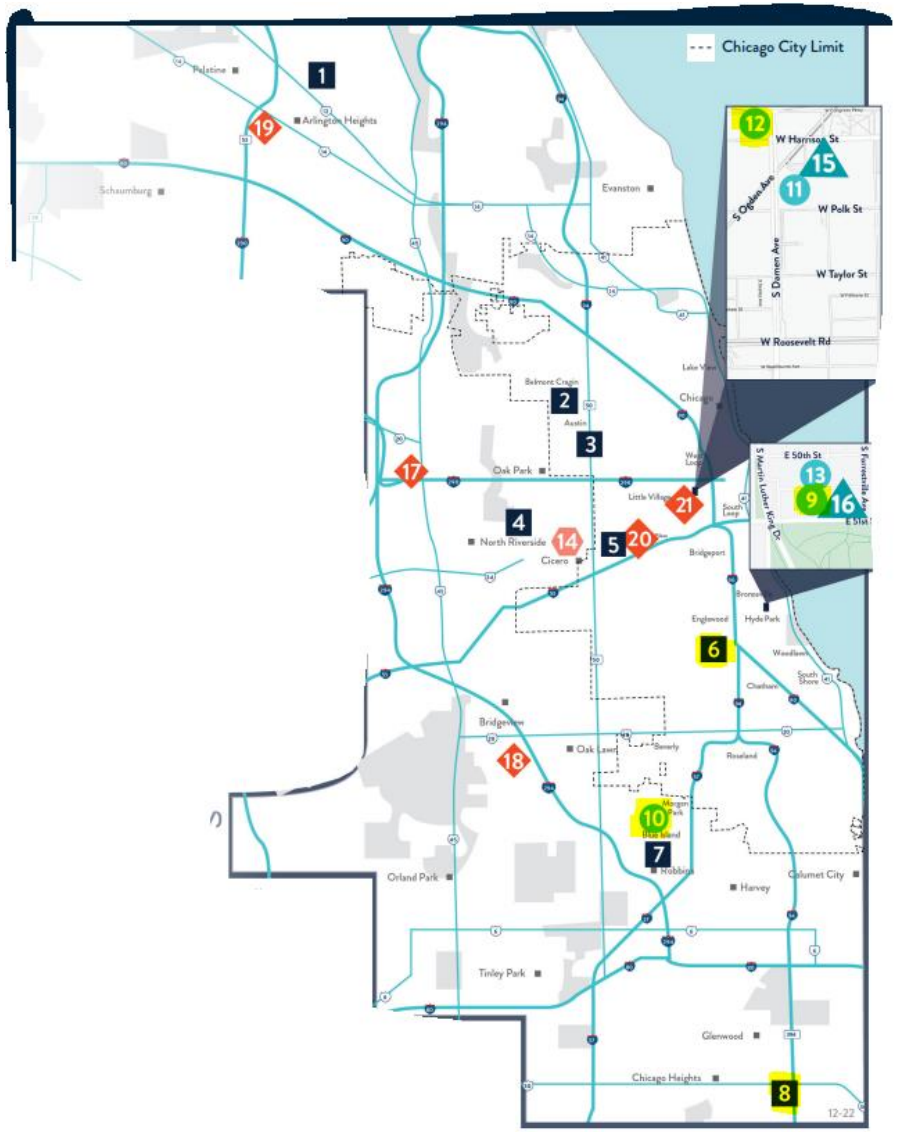
9. Provident Hospital Clinic

6. Austin Health Clinic

8. Cottage Grove -SSHARC

10. Blue Island - SSHARC

12. Ruth M. Rothstein CORE Center (CORE)



# Ruth M. Rostein CORE Center (CORE)

Established in 1998

One of the largest HIV Clinics in the U.S

4,182 = Clients

65% ≥ 45 years or older

African American\Black

61%

Latino\Hispanic

28%

# CORE


## Primary Care

Adult, Women, Adolescent, Bilingual, Peds, OB

- Patient Centered Medical Home Model
- Health Education,, Behavioral Health\Psychiatry, Dental Care, Peer Services & Case Management Services

## Specialty Care

Dermatology, Hematology\Oncology, Hepatitis, Nephrology, Neurology, Cardiology

## Sexual Health Clinic 1st Floor

# What We Do

# CORE Clinic Experience


Before Clinic

- Clinic List
  - CM Status, Benefits, High Risk Clients
- Pre-Clinic Meeting

During Clinic

- Case Management Intakes or Reassessments
- Behavioral Health
- Chemical Dependency
- Benefits

# CORE Clinic Experience


**After Clinic**

- Educational Sessions
- Support Groups
- Food Resources
- Housing Navigation
- Legal Services

Other services and programs as needed…

# Care Coordination Services Department

Cook County Health & Hospitals System

JHSH HIV Inpatient

**Six Month Intense Navigation Program**

- **Barriers Assessment – If meet Criteria offered services**
- HIV Education & introduction to CORE Clinic
- Navigator Match-up
- Appointment Reminders and follow-up calls
- Referral follow-up
- Initiation of Case Management Services

JHSH Emergency Room

JHSH Campus Outpatient Clinics

***ALERT System***

- **Chart Review**
- On-campus Outreach
- Brief Resource Assessment
- Appointment Reminders & follow-up calls
- Appointment Scheduling

THE CORE CENTER


- Navigator Greets Client
- Outpatient Communication Facilitation
- Appointment Reminder calls & Check-ins
- Home Visits
- Re-engagement & Outreach
- Continuation of Case Management Services

**Client tracked for ≥6 months**

- Future reminder & missed appointment calls
- Linkage to Case Management Services and other CORE clinic resources

**Client tracked for ≥ 2 appointments**

# Care Coordination Services – Highlight


- Initiation of services at  hospital bedside
- Weekly emails sent to clinic team with a list of new patients scheduled
- Navigator flows client through their first CORE clinic visit
- Team Approach - Navigator & Case Manager are assigned to each client

# Care Coordination Services – Intersection


Interdisciplinary Care Team (ICT) Meeting

- Every 3rd Wednesday of each Month
- Discuss mutual clients to develop/update service plan
  - Updates
  - Collaborate
  - Decrease duplication of services
- Client Hospitalizations
- Assistance with information needed from medical home

# Case Example

69yr old Male, DX 7/15/2004

*HIV+, CKD, HTN, blindness, hypertension, CVA, cognitive impairment likely vascular dementia, urinary incontinence*

- Treatment Coordinator assisted with sending orders for 1) underpads and gloves, and 2) urinary catheter.
  - Following month order for catheter bags
  - Scheduling post hospitalization appointment

- Treatment Coordinator informed pt. is going into hospice

# Working Together

# Moving Forward


## Actively communicate and follow-up

- Reach out to CCHIP staff to collaborate
- Attend Pre-clinic virtual meetings
- Discuss your clients in the ICT Meeting

# What if…


You have a client that is HIV positive who has been out of care and off medications for 2 years.

Your client who is engaged in care at the CORE is stating he will run out of HIV medications in less than 5 days.

# Care Coordination Services Department – Presenters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Erick Lopez Gonzalez, Patient Navigator
Kai Spiegel, Medical Case Manager
Lynette Partlow, Non-Medical Case Manager
Donna McIntosh, Housing Navigator
Cesar Lopez, Medical Case Manager

# Questions….