Implementation Strategies for Citywide Rapid Start Program

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INTRODUCTION

Organized by the City of Phoenix Fast Track Cities Initiative (FTCI), collaboration among multiple stakeholders led to the initiation of a citywide Rapid Start Program in September 2018. The City of Phoenix (the City) joined FTCI in October 2016. In 2015, our HIV continuum of care was at 85-51-50. Many of our newly diagnosed individuals were not linked to care, started on ART, or retained in care. To address these issues, rapid ART initiation after diagnosis was adopted as a citywide goal. We identified many obstacles and have worked to resolve those through interagency collaboration, support, innovative task-shifting and funding, and buy-in from stakeholders.

LESSONS LEARNED

Resources were used to accomplish this task with assistance from:

CITY POLITICAL LEADERSHIP

- The City acts as the central point of contact between all stakeholders including:
  - Arizona Department of Health Services (ADHS)
  - Maricopa County Department of Public Health (MCDPH)
  - Ryan White (RW) Part A/B Programs and AIDS Drugs Assistance Program (ADAP)
  - HIV Care Directions (Case Management)
  - Aunt Rita's Foundation, all AIDS Services Organizations (ASO), and other related community based agencies
  - Maricopa County Integrated Health System (MIHS) including RW clinic and County Hospital
  - Local HIV providers
  - HIV Specialty pharmacies
  - Pharmaceutical companies
  - Arizona State University (ASU)
- Dedicated city staff to organize and assist in regular public meetings.
- The City appointed FTCI Ad Hoc Board members with Councilmembers as co-chairs.
- City assistance in public and social media campaigns using existing departments and coordinating with other City Programs.

STRONG SUPPORT FROM ADHA & MCDPH

- HIV Prevention Program, ADHS.
- Ryan White Part A Program, Maricopa County.
- Ryan White Part B Program, ADHS.
- Maricopa County Department of Public Health HIV/ STD Clinic.

TECHINICAL ASSISTANCE

- Technical assistance from San Francisco Department of Public Health, CDC, and other FTCI peers.
  - Using existing programs from other US cities as a template and adapting their programs to fit the City healthcare system structure.
  - Using existing resources, such as educational brochures.

COMMUNITY ASO BUY-IN & COLLABORATION

- Strong support from all community ASOs to coordinate and streamline services and programs.

MEDICAL COMMUNITY PARTICIPATION

- Involvement of local HIV medical providers
- Development of Rapid Start Providers list.
- Training of clinic staff on Rapid Start Program.
- MIHS RW clinic conversion of all patient intake-visits into Rapid Start provider visits.
- Collaboration between County Hospital ER/inpatient and RW clinic.

INTEGRATION OF FUNDING

Program funding for HIV testing staff/supplies, confirmatory lab costs, Disease Intervention Specialist (DIS) staffing, consumer education materials.

- Ryan White Part A funding for Early Intervention Services (EIS) staff to navigate clients through program enrollment and linkage to care.
- Later, Ryan White Part B funding to allow MDCPH staff to provide Rapid Start Navigation using internal staff, and eventually bridging medication and providing initial medical consult using MCDPH providers.

STREAMLINED APPROVAL FOR RW/ADAP ELIGIBLE CLIENTS & EARLY INTERVENTION SERVICES FOR COORDINATION OF IMMEDIATE AND LONG-TERM CARE

- RW Central Eligibility direct collaboration with clinical agencies (RW clinic, county STD clinic, county ER, Southwest Center for HIV, Terros) to get same-day RW/ADAP approvals for Rapid Start patients

CREATION OF RAPID START NAVIGATOR

- A single-point of contact for engagement in care, regardless of payer source.
- Very crucial to connect newly diagnosed clients to other HIV services and HIV providers with minimal warm hand-off.
- Develop a strong relationship between Rapid Start Navigator and Rapid Start clinic staff to ensure creation of a direct communication channel for immediate referral.

EDUCATION OF HEALTH CARE PROFESSIONALS ON NEW APPROACH

- Community-wide kick-off presentation with all key stakeholders (ADHS, County Public Health and STD clinic, Medicaid program medical directors, RW clinic staff and medical providers, private practice office staff and medical providers).
- RW in-clinic re-working of patient-intake visit-flow to prioritize same day Rapid ART initiation, including reassignment of tasks and resequencing of staff-patient interactions.
- County Hospital ER training on rapid referrals to RW clinic of newly diagnosed patients, pending ER implementation of initial ART dispenses.
- Staff education at Rapid Start clinics on screening Rapid Start patients, immediate appointment, novel patient scheduling, and warm hand-off.

CREATION OF UNIVERSAL MESSAGING

- Utilizing U=U (Undetectable equals Untransmitable) at all points of care.
- U=U is a very simple but powerful message for newly diagnosed patients for self-empowerment, encouraging Rapid Start, and improving patient adherence and retention in care which can impact both patients' health and public health.
- Emphasizing a universal message at all points of care will ensure patients receive consistent messaging to help them clearly understand, accept, and adhere to HIV care.

RECOMMENDATIONS

Strong support from the City of Phoenix has been a key driver in the roll-out of Rapid Start. It is crucial to collaboratively involve all stakeholders to work through interagency barriers and develop innovative approaches to accessing and utilizing needed services and support to ensure continuous and long-term retention in care to fulfill the last 90 goal of continuous viral suppression.