

WEST TEXAS GROUP

For questions:

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Possibilities

Perfect World

- Open apt database, appts can be made remotely within one week
- Geographic Co-location of all services
- Streamlined Communication B/T HSDA agencies (e.g. weather closures) gen info
- Additional FTE for Link to Care
- Streamline intake (do not repeat admin functions – e.g., eligibility, intake); create a tool that will travel with pt so they don't have to start over with each new step
- Expand testing area (many disparate populations – refugees, military, prisons, etc.) (overlapping infxns)
- Use new CDC guidelines (preliminary + results) to get pts into providers.
- \$1,000,000 for West Texas
- Open Prevention Database (International + National)
- Biometric system (clients) to flag + individuals + has health info on it
- Secure system to alert providers of pt moves + transfers
- Shuttle system B/T Providers
- Transportation vouchers
- Outcome-based funding
- On-going training for providers
- Provider accountability
- Latitude to implement programs that fit unique communities (within guidelines)
- Regularly scheduled region-wide meetings of decision-makers / leaders to share info, coordinate, plan, implement, etc.
- AAs run mtg; CDHS as participant
- HSDA's match regional boundaries – redraw lines
- Stakeholders would be chosen by geographic area, not regions or HSDA's (e.g. San Angelo)
- Mobile van for testing + treatment
- Telemedicine / teleconferencing
- Be a model for state → replicate

KEY STAKEHOLDERS

LHDs

IC Nurses in hospital

MH-SA

Nsg schools

Med schools

SW schools

Bi-national Health Comte (Two Hearts, One Nation)

Oil Co HCPs

LGBT Reps

Faith-Based Providers

Outreach Workers

Promotoras

Mexican Consulate

NM HD

HIV + Individuals

Transport Providers

TDCJ Prisons

NEXT STEPS – ORG MEETING IN APRIL 2015

- Dalton:
 - Location – Lubbock
 - Options – Tech Nsg School – ACB STAR Institute (Plan B)
 - Lubbock Christian University
- Coordinate with Cardea (food, facilitation, supplies, planning conference calls)
- Est Planning Comte
 - Dalton, Rhonda, Elena, Oscar, Irene, Maria, Floyd A, Nancy O

CENTRAL TEXAS

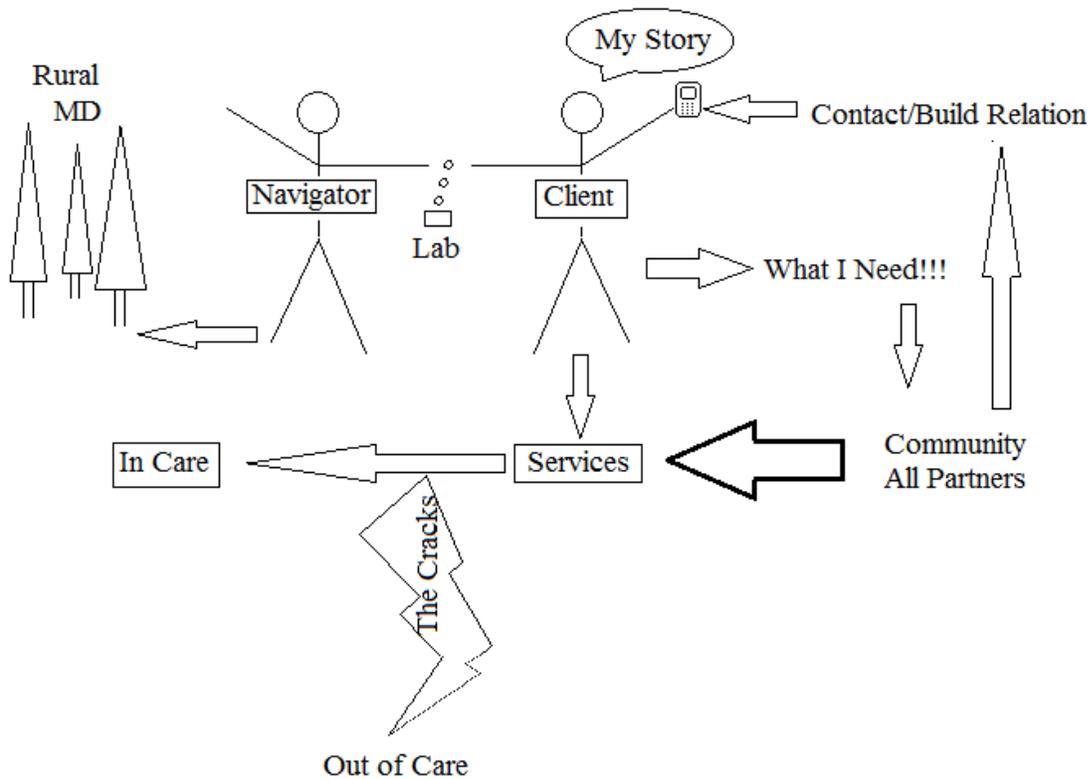
OUR JOURNEY

- Intro Co-Facilitators
- Reflect on Ann's Presentation
- Purpose + Guiding Statements
- Intro Members
- Ground Rules
- Start / Cont Conversations
 - Possibility
 - Ownership
 - Commitment
 - Dissent
 - Gifts
- Document Consensus @ 3:15
- Plan Tomorrow's Report Back



Possibilities

Engage new Resources



Client centered support in care:

- Peer advocate (successful)
- Seamless

Fragility of system

Ownership

Easy to focus on measures / reporting instead of building relationships

Repetitive paperwork

“Tribal” use of resources

Self-protection

Referral Patter as a +

OUR GROUND RULES

Be present & participate

Stick to agenda

Respect!

No Interruptions

Accept feedback as gift

Refer to system

Limit outside tech

Have Fun

1. Map out our PERFECT community – What Linkage Should Look Like
2. What are our next steps for building it? When will we commit to start building? Regional Mtg., Influence Med School Curriculum
3. What Gifts/Stakeholders/Assets/Resources Will We Engage?
 - Clients @ regional mtg as team member
 - Influences
 - Black chapter
 - Scott & White
 - 2 mobile vans
4. Tomorrow's Presenter(s)
Liza

Spectrum of Engagement Symposium

Central Texas Group

What would a perfect community look like?

- Circular, seamless river
- One stop shop (DIS, testing, medical care) example – super HEB
- Home visits (mobile testing van)
- Culturally appropriate services
- 100% linkage; 100% participation in care
- Patients in control of care
- Equal opportunity for all (normalize HIV treatment)
- One time sign in (phone app sign in/ID Swipe care sign in)

Next steps

- Regional meeting by 3/31/2014
- Influence medical school curriculum
- Supportive policy for treatment access (EAP, Jury Duty)

Gifts, Stakeholders, Assets, Resources

- Clients involved in regional meetings as citizens
- Medical school
- Partners working together
- Aunt Bertha search engine
- Faith Based Organizations
- Influencers (BCC, LULAC, IT)
- Mobile vans
- Existing relationships (Scott & White, etc.)

HIGHLIGHTS of Civic Engagement Restorative Community Model

Community exists for the sake of belonging and takes its identities from the gifts, generosity, and accountability of its citizens. It is not defined by its *fears*, its *isolation*, or its penchant for *retribution*.

We are a community of *possibilities*, not a community of problems.

We come together to create a new possibility through *have a conversation we have not had before*.

We *currently* have all the capacity, expertise, programs, leaders, regulations, and wealth required to end unnecessary suffering and create and alternate future.

PARKING LOT

#1. CIRCULAR SEAMLESS RIVER

One stop shop (Dis Surv, PBC) Clinic, medical leave

Home visits (MTV - meet the client) Where they are home

Culture appropriate services provisions

#2. Have patients, clients to linkage meetings.

#1. 100% appts, 100% of client time

#2. Supportive policy; other info FU mtg. #2 end of March

#2/3. Be involved in "new" medical school planning

#3. Partners working together

#1. Patients in control of medical care

#1. Equal opportunity for ALL! Normalizing HIV care w/other chronic diseases

#1/#3. One time signing in

#3. Aunt Bertha search engine. (User friendly)

#3. Faith based organizations

CENTRAL TEXAS – Report Back

#1. Perfect Community – What would this Look like?

- Circular seamless river – lazy river
- One Stop Shop (DIS, testing, medical care)
- Home visits (MTV)
- Culturally appropriate services
- 100% linkage, 100% participation
- Patients in control of care
- Equal opportunity for all
 - Normalize HIV treatment
- One Time Sign-in
 - Phone app sign in
 - Swipe ID cards

#2. Next steps –

- Regional mtg by 3/31
- Influence medical school curriculum
- Supportive Policy for treatment access (EAP)

#3. Gifts/stakeholders/Assets

- Client involvement in regional mtgs
- Medical school
- Partners working together
- Auntbertha – search engine
- Faith based organizations
- Influencers
 - BBC LULAC
 - IT
- Mobile vans
- Existing relationships S&W

DALLAS

- Need endpoint person at each agency
 - Call-visit-make sure the point person is correct
 - Go to events
 - What's the benefit? Providers, consumers
- New DIS Link to Care will help
- Monthly meetings is needed to improve like/maintenance to care
- Incentives are effective for testing & appointments
- Use internet & new technology
- Need to collect similar documents for clients – Link together to speed up the system
- Building Bridges between systems
- Have difficult presenters / topics

- What possibilities exist for a successful pathway for medical linkage?
- What does a perfect cascade look like?
- What are the components?
- How would it work?

How would you begin to build a better linkage to care system?

- Medical Treatment Providers
 - ASOs
 - Dallas Co HD-DIS
 - AIDS Arms
 - AHF
 - Parkland
 - Amelia Court
 - UTSWMC
 - Uptown Physician
 - Patrick Daly
 - Nelson Tebedo Transgender
 - Former MLK Clinic
 - Los Barrios
 - Health Svcs of North Texas
- Having a point person at each agency
- Syndicate Member
- Shorten time between Dx & visit to medical provider
- ARTAS to engage folks in the meantime
- Incentive Sessions

- Peer Partnerships
- Shorter time for test results (Lab Results)
- Using blood for confirmatory test & use same sample for CD4 + UL
- Testing Agencies transporting ppl to appointments
- Collaboration

NEXT STEPS

- Meg Space: Sonny
- Attendee List – Tony
- Create a purpose – Candace & Curtis
- Objectives Agenda
- Explore legal issues associated with sharing of client info. – Candace
- Food-training contractor – Cheryl
 - Can assist conference call
- TX HIV Syndicate (work being done)
- Set up work group – Sonny

The Dallas Group has agreed to:

- Secure a meet space
- Identified someone to put together an attendee list
- Draft purpose statement for meeting(s) with objectives & agendas
- Incorporate TX HIV Syndicate successful linkage group work
- Set up group site
- Explore legal issues associated with sharing of client information

Q: If the meeting were 100% successful, what would you envision?

- All people walk away thinking linking is their responsibility. All of us have the same goal.
- Walk away with a clearer understanding of how linking to care and our role in the process are expected to look.
- The event will be successful if members who are experienced in prevention and linking to care are able to share how/why they have been successful.
- A better understanding of common issues with linking to care and how they are were alleviated.
- Active and relevant partnerships between agencies that can create or enable a seamless transition for our mutual clients along the continuum of care.
- What is the definition of linkage to care?
- The meeting showed data for the state of Texas, which was very helpful and reiterated our success and our efforts.

- Highlighted the common barriers and experiences of our clients, which are universal across the state. We are all in the same boat.
- Success is working together as community.

Q: What would you see? What would you hear? What would it look like?

- Increase virally suppressed.
- Increase in out of care individuals who seek linkage.
- Increase in newly diagnosed who keep up with medical care for at least an entire year.
- Percentage of individuals out of care decreased.
- Increase in percentage of individuals achieving viral suppression.
- I would like to hear positive stories from clients about their personal diagnosis and linkage journey
- 99% in care
- 99% suppressed
- Satisfied positive patients
- No long waits for anything
- Faster appointment times, red carpet treatment from diagnosis or re-enter to care. Less resistance to clients who have dropped out of care.
- Within my agency we work well regarding linkage but it would be helpful to:
 - Have reporting systems to track success, linkage, etc.
 - Have a more universal working system with all community partners and not just between our agency and the county health department.
 - Increase in viral load suppression.
- Agencies are reporting during collaborative meetings that their clients are making their appointments on a more regular basis.
- The percentage of individuals that are virally suppressed is increased.
- Collaborative system of care, whereby all agencies were engaged in service continuum and information on clients is shared when needed.

BIG GROUP NEEDS

- Zip Code - Level testing data by age, race, risk by each org (org can run the report themselves)
- TX Med program drop-out data
- Any reporting going to other silos agencies
- Most recent contact info on lost clients (AU sources)
- Transparency of client info, not just data (Sharing) to assist coord + client-centered care
- Reporting back to HIV Prev partners to confirm if client is out-of-care or linked/re-linked
- HIV Prev/Test sites would like to be called to see if they still have contact with client & know how to reach them

INTEGRATE VARIOUS PROFESSIONAL CULTURES

- Support across spectrum

Linkage = not on meds/see md

Crcs/clear

BIG GROUP SYNTHESIS OF NEEDS

PURPOSE & OUTCOME

- Change the conversation
- Discuss Regions idea/vision
 - Indiv
- Identify stakeholders/gifts
- Regional meeting/communication
- Summarize Report to large group

CIVIC ENGAGEMENT AND THE RESTORATION OF COMMUNITY

To create a community of accountability & belonging – we seek conversations where the following is true:

- An intimate & authentic relatedness is experienced
- The world is shifted through invitation rather than mandate
- A focus on communal possibility
- A shift in ownership, even though others are in charge

GROUP UNDERSTANDINGS

- Arrive & start on time & end on time @ 4:15 pm (break on time)
- Be present & participate
- Stick to agenda, use parking lot other issues
- Listen respectfully to all
- No interruptions, side convos
- Appreciate feedback as a gift
- Comments are not personal but system based. When issue come up discuss systems, not individuals/agencies
- Manage Technology (phones, laptops)
- Diversity of thinking & dissent are given space
- Commitments are made without barter
- The gifts, or each person & our community are acknowledged and valued

5 TYPES OF CONVERSATION

IDEAS

- Host a regional meeting to inform community about benefits of Linkage
- Clients are treated as people first, and documentation (numbers) come later

GROUP INTRODUCTIONS

Name, organization, your role in linkage & re-engagement to care, what stood out to you from this morning's conversation?

Corpus Christi

ID STAKEHOLDERS

1. Local Consumers
2. Local Medical/Health Authority
3. Community Leaders
4. CEOs, Chairperson from ASO
5. DSHS-DIS
6. Media Representatives
7. Criminal Justice Rep
 - US Border Patrol/CBP/ICE
 - Southwest Keys
 - IES
 - Willacy Detention IMM
 - La Villa IMM
 - Bayview Detention
 - TDCJ Jails
 - County Jails
8. Foundations

VISION IN COMMUNITY WHERE YOU LIVE

- No wait time to intake → Care
- Eligibility documentation
- Immediate Medical Treatment
 - PR
 - Labs
 - CD4
 - VIRAL
- Financial Resources not an issue for medical care
- ADHERANCE by client
- Personal hand-offs to the next agency / service
- Adequate staff and agency resources

Bi-Nat Partners

ID Stakeholders

Hospitals

Jails

ICE

Pharmacists

Detention centers

Local CAB's

Local colleges

GPC/PCB/OB-GYN

Com Health Centers

Psych

Local Health Department

- Webb/Cameron/Hidalgo
- Nueces County LHD

DIS

Universities

Public Health

Southwest Keys

Religious Leaders

County Judges

Rehab

TX Behavioral / Mental Health

ISDs

CMS Offices/Medical/Medicinal

WIC

Labs

Federal/State \$ for Sab House Prev

Halfway houses

Housing ??? / HUD

Food banks

CBOs

Funeral Homes

State Reps

State Assembly Reps

LAREDO

MEDIA

Immigrant youth Det Center

Alternative Lifestyle Clubs

Faith Based Comm

Politicians

ISDs

DIS

Migrant Farm worker

Councils/Advocacy Groups

UMOS

Drug Reps \$

Bring food + literature

Local CAB

Mental Health Prof

Universities / Colleges

ICE/Border Patrol/La Migra

Comm Health Clinics

Bi-National Partners/Capasits

ALLU

Rehab / Halfway houses

Mehudone

HUD – Colonia's Leadership

Libraries

MSM frequented businesses / sex environments

ID STAKEHOLDERS

Funding Agency Rep

Testing Agencies – CBO/HD

Hospital Administrators

Medical Providers – Any/All

HIV Specialists

Correctional Facilities

Pharmacies

CASE Manager Funded Agencies (ASO / CBO)

Data Systems Rep

Community Members

Patients

Community Resources Rep

Social Services

VISION IN COMMUNITY WHERE YOU LIVE

1. Prev Staff
 - Tests, notifies, educator on linkage, + Provider referral for linkage to care
2. Meets with Medical Case manager | assessed, intake, care plan, acuity scale, labs, electronic record, provides options for Medical Care Provider
3. See Medical Provider
4. Access Medications
5. Continues to Engage in Treatment adherence activities with MCM

FOUNDATIONS

BEXAR

Magic Q / VISION 1

- People showing up for appts / have support network (transparency, etc.)
- Patients would know what services are available
- More providers in network
- Barriers removed – so PT can learn / be educated about HIV care
- Lower Viral Load in Community
- No Wait to Access Doc

VISION 2

- Staff are able to engage entire community without segregation
- Greater latitude to employ all resources. No unnecessary barriers
- Letter from DSHS supporting the above
- Clients call say “I made it to my appointment”; Provider calls, “Hey, you patient made it.”
- Equivalent funding for services as we use with TXDOT

VISION 3

- I can pick up phone and call provider directly to obtain info on patient
- Representation of all professionals in the continuum of HIV care
- Plan for newly diagnosed youth/youth
- Clearly defined and Standardized procedures

VISION 4

- Updated HIV 210.org (Planning Council)
 - Create downloadable App
 - Local
 - Provider friendly
 - Client friendly
- No Stigma
- Greater accessibility to CARE/Services
- Trust resources

WHAT ARE YOU DOING

- Internal meetings to streamline
- Quarterly meeting – Improving
- Syphilis Task Force Meeting / Prevention
- Embed Case managers w/ Outreach team – create pathway

- Breaking down internal/external Silos
- Linking Prelim pos to care prior to confirmatory
- Interagency coordination for linkage to care Ex: DIS comes to appt

PATHWAYS (Community)

- Primary Care Clinic – fills gaps
- Dr. Taylor: Conducting comprehensive study in continuum of HIV care
- Explore data related to undocumented individuals who are engaged in Care
- Military looking at STD practices
 - Military supports PHFU
- Utilize DIS in the Community

STAKEHOLDERS

- Dr. Martinez / Dr. Parra / Dr. Bromely / Centro Med
 - Could address MAPA / provide ed
- Board Members:
 - Physicians as champions
 - Dr. Montoya (new board member with extensive HIV experience)
- Military Connection
 - Ray Navarro – Champion
- Relationships with VA
- Schools (Public Health)
 - Needs further development

NEXT STEPS

- Comprehensive Regional Meeting
 - Invite all reps of spectrum
- Frederic will retain space
- Robyn will be in charge of communication

SOUTH TEXAS LINKAGE

South Texas Marriage

- Recognition of Continuous Cycle Communication with everyone
 - Can Laredo call Corpus
 - HIV Surveillance can help
 - Under “Continuation of Care” it can be done
 - Can each area work on this?
- Quickly
- Inclusion + Communication
 - Mobilize others in community with other HSDA's + non-HIV agency
- DSHS involvement
 - Regional meeting planning
 - 3 meetings?
 - What do we need from each other?
 - Can the leaders travel?
- Local evaluation
- Regional evaluation

LAREDO

Manny

Doctor

Personnel presenting activism

Represent at ve from HIV CBOs, ASOs, Criminal justice, etc.

Religious Community

DIS

Rept. Back

CORPUS

ED's x wellness foundation + West brook clinic

Health Department

1 provider from Client svc + Doctor's?

Advocate – client x 2

Region 11

Rept. Back

VALLEY

X3 VAC staff

Client Advocate

DIS Provider

Hope Foundation
Rept. Back

ADD

MHSA

STD

AA

QU Mgmt with AA

STDC

PRELIM +

Diagnosis

Referral

Collaboration

Initial contact

Medical F/U (DR.)

Coverage/resources

Public Health F/u (PES)

Exchange of Info/Education

Client Willingness

Client Self-Assessment

Counselor Dedication

Assessment

Bio/Psych/Social

Intake

Info on RX of training

IDs, DOC

Financial assessment

Emotional support

Transportation

SA/MH Agency (Sami's MH+SA)

DATA System

Housing

CPS

Activities around Linkage

LABS

Medications

Dr. Visit – who + how long to 1st appt. – explain options

Family Member to adherence

ARTAS CLEAR

Gaging knowledge @medical care

Immigration status

Tarrant County Region

MAGIC QUESTIONS

DREAM, Linkage, Relink, & Retain

- Communication – what the overall picture of care looks like
- Actively follow someone
- Comprehensive client centered
- Documentation shouldn't delay care
- Democratic governor
- Care does not require \$ or insurance
- Clients are treated equally as human beings
- Diagnosed and starts ARV same day
- Cross training & collaboration
- More visibility of services offered
- Universal access databases – across the continuum; includes shared consent and centralized eligibility
- Real time data
- Affordability of PREP
- Funding is not a barrier for the client
- Flexibility to work on regional priorities
- New technology – point of care confirmatory

WHO ELSE WOULD YOU INVITE TO SUPPORT THIS WORK?

Tarrant County Adult Health Services

Other Agencies that dx/link clients

May need to look at data

NEXT STEPS

- Discuss regional mtg
 - ID volunteer to find free gathering space
 - Lisa (TCHD) or Randy as backup
 - ID Volunteer to communicate w/training contractor (planning)
- Everyone from Tarrant Co that was in this conversation wants to be involved w/planning Reg Mtg
- Other commitments?
 - Lisa – ask about data

VALLEY

VISION IN COMMUNITY WHERE YOU LIVE

1. Establish / maintain relationship
2. Immediate contact + lab work or two insti while awaiting confirmation
3. Fear & anxiety reduced
4. Partner elicitation initiated
5. Intake process started and within 7 days pt has MD appt. / or Day one
6. Along with Medical, address psychosocial

LIASON

- South Texas - Maribel
- Corpus - Andrea
 - Location for mtgs
 - Invitations – use community leaders
 - DSHS Letterhead – Richard (Shelly)
- Laredo – Maribel & Manny
 - Location for MTGs
 - Invitations – use community leaders
 - DSHS Letterhead - Richard/Shelly
- Valley – Oscar
 - Location for MTGs
 - Invitations – use community leaders
 - DSHS Letterhead - Richard/Shelly

ID STAKEHOLDERS

1. Local Medical Health / Health Authority
 - Dr. Melendez HCAA
 - Dr. Castillo CCHA
 - Media
 - KGBT & KRGV
 - Univision
 - Fox
 - Valley Morning Star
 - The Monitor
 - Brownsville Herald
 - Q94.5
 - 100.3
2. Chairperson for ASO
3. Chief Executive Officer
4. DSHS – DIS

5. Hospital – CID Nurse
 - VBMC/HGN Med Center / VRMC KHAPP / EDIN RH / Doctors Hospital McAllen MC / Rio Grande Reg / Mission LMC / Dr. Hospital – Laredo / Starr Co Hospital
6. Mental Health Authority
7. Media Representatives (Awareness)
8. Consumers – SHOULD BE FIRST
9. Substance Abuse Rep
10. Jail / Prison / Detention
 - Detention Centers: Cameron County & Hidalgo County, Willacy County Jail, La villa Immigrant Detention Center, Port Isabel ICE Detention Center
11. Immigration rep
 - Southwest Keys, LUPE, Capasits
12. Partnering Clinics / Satellite Clinics
 - Community Health: Brownsville community Health Center, Su Clinica Familiar, Nuestra Clinica Familiar, Planned Parenthood
13. Patient Navigators
14. Medical Providers
15. Pharmacies
16. Housing Authority

FOUNDATIONS