March 10, 2022

Jennifer Hawkes, Northern Health Regional Specialized Support Team

Land Acknowledgement

We are grateful to live, work, learn and play on the ancestral lands of the Lheidli T'enneh. We honour and respect the lands, cultures and people through the work we do with our communities.

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Regional Specialized Support Team (Chronic Disease Program)

team email SST@northernhealth.ca
webpage https://HIV101.ca
Phone: 1-888-645-6495
Fax: 1-844-440-4454

Heather Swanson,
Primary Care Assistant

Brenda MacDougald,
Social Worker

Cell/text: 778-349-5216
Fax: 1-844-440-4454
MS Teams, email

Jennifer Hawkes,
Pharmacist

Cell/text: 250-961-8474
Fax: 1-844-440-4454
MS Teams, email

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Fax or phone us for referral – we can do outreach in Prince George

Call our toll free line 1-888-645-6495 OR

Brenda cell 778-349-5216
Jenn cell 250-961-8474

All Sites and Facilities

HIV/HCV Specialized Support Team Consultation Request Referral Form Page 1 of 1

Patient name: ____
Address: ____
Phone #: ____
Email: ____
PATIENT LABEL

Primary care provider, specialists, community agencies, communicable disease nurse, detox staff, acute care staff or the person themselves may make a request for consultation.

Name: ____ **DOB:** ____ **PHN:** ____

Best way to contact person: ☐ Phone ☐ Address ☐ Email ☐ Text ☐ Other: ____

Person would prefer consultation by: ☐ In-person ☐ Phone ☐ Telehealth videoconference

Referred by: ____ Phone #: ____ Email: ____

Community pharmacy: ____

Other physicians/specialists/specialized services: ____

Does this person have a primary care provider (family doctor, nurse practitioner)?
☐ Yes → Name: ____
☐ No

Type of consultation required:
☐ **Nurse practitioner**: Opioid agonist treatment, provision of temporary primary care, and linkages to permanent primary care homes
☐ **Pharmacist**: Optimizing and accessing medications, side effect management, drug interactions/information, PrEP
☐ **Dietician**: Optimizing nutrition, weight gain or loss, food safety, monthly nutritional supplement
☐ **Social worker**: Optimizing social determinants of health, advocacy, community resources

Reason for referral (note any challenges/questions/goals)

Health issues/medical problem list

☐ Addictions	☐ Diabetes	☐ HIV	☐ Osteoporosis
☐ Cancer	☐ Dyslipidemia	☐ Hypertension	☐ Renal dysfunction
☐ Cardiovascular disease	☐ Hepatitis B	☐ Mental health condition	☐ TB (active or latent)
☐ COPD	☐ Hepatitis C	☐ Neurological disorder	☐ Other: ____

Please send completed form to SST confidential fax number 1-844-440-4454 or phone toll free 1-888-645-6495. Please attach any relevant investigations and/or consults.

Administrative use	
Date received: ____	Date primary care provider notified of consultation request: ____

10-000-5190 (LC - Rev. - 11/17)

What are we missing?

- Outreach Life Skills and/or Peer worker (we often rely on local ICM, ACT or HASP teams)
- Trauma counsellor
- Nurse practitioner
  - Interim medical care for unattached or travelling patients
  - Facilitate connections to primary or specialist care for those wishing to reconnect with care
  - Complete medical forms for income assistance, disability and diet supplements
  - Transition patients from corrections for OAT and other medications
  - Order labwork (baseline or monitoring HIV, HCV or PrEP labwork)

Where are we?

- Offices located in Prince George - Professional Building on 3rd Avenue
- Provide outreach care (PGRCC, CINHS, Needle Exchange, shelters, home visits, acute care visits, Positive Living North). Provide virtual care (phone, email, text, video)
- We aim to serve people in a patient centered way where they are at. Very rarely is this appointment based.
- People can self-refer, but the connection is often ideal if it is 'in the moment' they are seeking assistance.

What do we do?

- Assist clients to access resources, services and medication treatments
- Maximize contributions of existing resources (collaborative care, mentorship, networking)
- Direct client care – complex patients, additional supports required, build trust, assertive outreach, adherence support
- Education, awareness, capacity building
- Connect to primary care and have a standardized and seamless 2-way communication with primary care
- Connect to specialist care (Dr Hamour, other regional specialists, dieticians)
- **Fill Gaps in service and help overcome barriers to service**

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Do you know the population that we serve?

- Listen to the story, empathize, ask permission

- Try not to say ‘no’ or ‘I can’t help you’ – instead:
  - Let me find a resource that can help you
  - What do you need? Is this something that you need today?
  - Can I check in with you again (or pass on your information for someone to check in with you) to see how you are doing?
  - Do you have a few minutes to stay on hold while I look into that for you? How can I reach back out to you? Offer options like email or text.

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Our population

- Frequently needs care at the point of contact or opportunistic care (ie labs when they are already going for other labs or admitted to acute care)
- Ask about current connections and ways to contact/places to leave a message for them
  - Community pharmacy
  - Community organization (Positive Living North, Needle Exchange)
  - Email
  - Phone – do they need wifi or do they have phone minutes?
  - Do they prefer texting?
  - Trusted friends, family, professionals?
- Update charting with details of how to best reach out to them

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What does our Social Worker do?

- Assess individual/family needs and establish a connection with appropriate services (housing, counselling, transportation, communication, food security)
- Advocate for access to programs and supports completion of forms (PWD, income assistance)
- Build patient capacity to manage their health and strengthen connections to care
- Coordinate, case manage & support communication between health care service providers around complex client needs & goals
- Assist with MH, behavioural programming
- Provide education and resources as requested

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What does our Pharmacist do?

- Facilitate access to medications (streamlining ordering, coordinating dispensing frequency and adherence aids such as blister packing, funding/drug coverage)
- Advise on medication selection, drug interactions, side effect management
- Optimize co-morbid medications for those with HIV or HCV
- Provide guidance on medication monitoring for PrEP, PEP, HIV, HCV
- Support patients in treatment readiness, adherence and ongoing engagement in care
- Disease state and medication education

Complexity Surrounds HIV, and "new" HCV

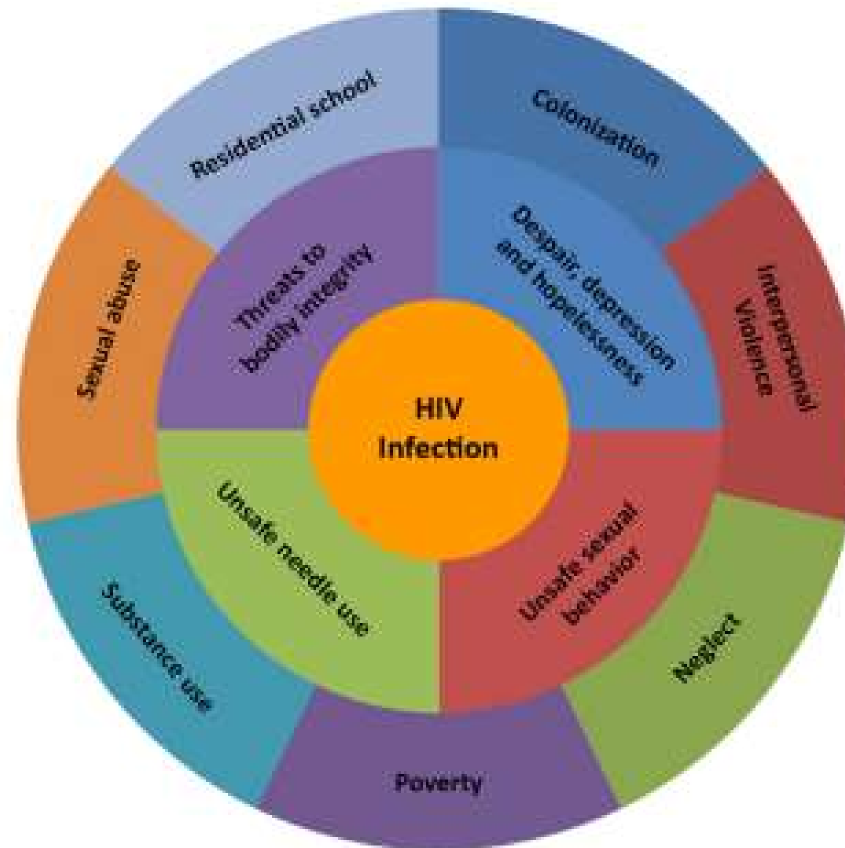

Figure 1. Risk for HIV infection.

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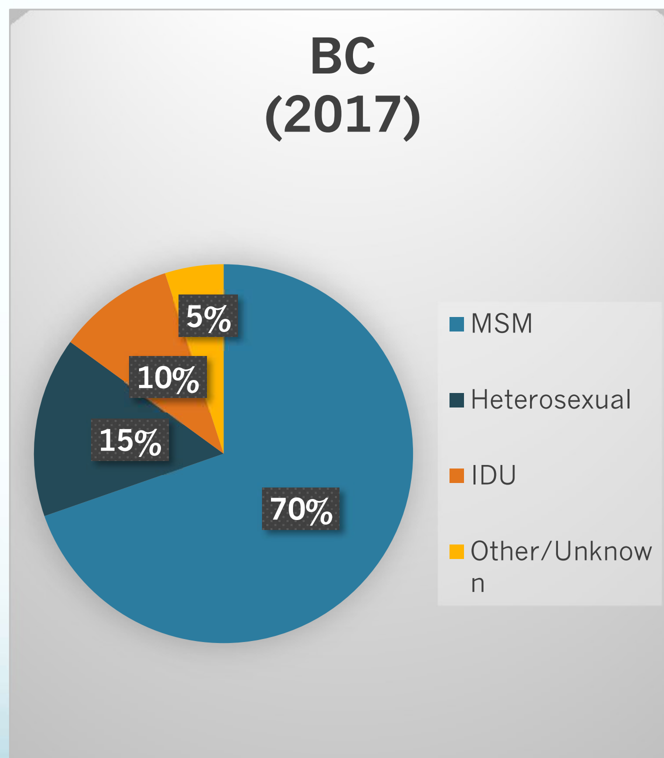
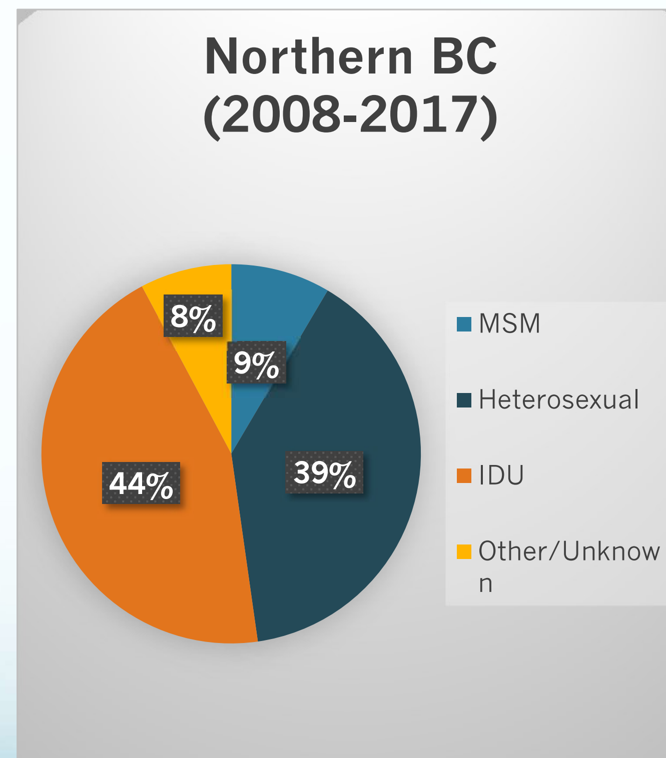
The North Does Have Different Modes of HIV Transmission





BCCDC HIV Annual Report, 2017

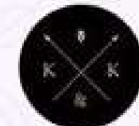
“we have lots of names to describe the populations who are negatively affected by systems of inequality (such as colonialism) who have unearned disadvantages”

https://www.youtube.com/watch?v=a30a_NiT5zc

- Disadvantaged
- Marginalized
- Vulnerable
- Key population
- Priority population
- Hard to reach populations
- Hard to serve population

MARGINALIZED PEOPLE DO NOT HAVE TO:

- Be nice to you
- Educate you
- 'Debate' or Prove their oppression to you
- Make you feel comfortable
- Give your 'opinion' equal weight to their experiences
- Earn your respect in order to be treated as human
- Always remain calm in the face of dehumanization



@kaliandkalki

Indigenous face widespread inequities

Indigenous have been disproportionately represented in BC's HIV epidemic

- 8-17% of new diagnoses in BC and 33.3% of new diagnoses in women in 2017 (comprise 6% of population)
- 2021 36% of those living with HIV are Aboriginal in NH (comprise 17.5% of population)

- Colonization
- Loss of language
- Loss of culture
- Indian Residential Schools
- Intergenerational trauma
- Ongoing discrimination

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Cultural Safety:

- Cultural safety is an outcome, based on respectful engagement.
- We must continually strive toward:
  - Recognizing our biases and racist assumptions
  - Addressing the many power imbalances inherent in the health care system
  - Understanding and challenging culturally safe practices/policies/systems
- San'yas Indigenous Cultural Safety Training – Learning Hub

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Strengthening engagement in care:

- Recognizing our biases in our processes
  - Meeting people 'where they are at'
  - Offering options to our 'typical' processes
    - Ask for invitations to reach out (options and details charted)
- Charting as a way of communicating the 'story' to other care providers/professionals (Its more than just the medical story)
  - Best way to communicate and personal preferences
    - Share alternative approaches and responses
  - Current barriers to care (no minutes on phone)
  - Secure invitations to assertively reach out
- PSR handout Psychosocial Rehabilitation Model
  10-040-6185.pdf (northernhealth.ca)

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Case – Newly diagnosed HIV

- 50 year old woman newly diagnosed with HIV
- Comorbidities of hypothyroid, hyperlipidemia, alcohol use disorder, depression, fetal alcohol syndrome
  - Support and guidance to navigate the system
    - Bloodwork, vaccines, appointments, education, stigma reduction, not quite ready for an HIV/HCV service organization
  - Transportation barriers – outreach visits
    - Connect with medication adherence support team for bloodwork
  - Relationship building
    - When to see primary care, when to see specialist, reinforce importance of adherence

Case - Telehealth

- 45 year old male living in a rural community
- Comorbitities of HIV, Hepatitis C, Chronic Pain, Depression, Addictions
  - Receives methadone treatment and HIV treatment via telehealth appointments
  - Currently unable to access a primary care home in his community
  - Needs an advocate to seek care
  - Our team checks in via phone, text & email to maintain connections with health care and HIV treatment
  - He reaches out to our team sporadically as well
  - Link to the virtual care clinic via telehealth
    - This will allow treatment of his depression as the emergency department won't start this treatment

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Case – Provide Testing, Link to Care & treatment

- 58 year old male living in a rural community
- ? Hepatitis C, Chronic Pain, smoker
  - Has a primary care provider, but takes 2 months to get an appointment
  - Partner connected to a ICM team and just started HCV treatment, she wondered if we can help him get tested and potentially treatment too
  - Our team supported his partner's primary care provider to prescribe HCV treatment and her ICM team delivered to her weekly
  - Lab requisition for testing provided by our team, our team follows up on results
  - Results show HCV RNA detected - referral sent by our team to Dr Hamour
  - Linked to HCV care and treatment via telehealth
  - Our team follows up to ensure he attends appointment, starts on HCV treatment, tolerates HCV tx, reminder of post-treatment labwork

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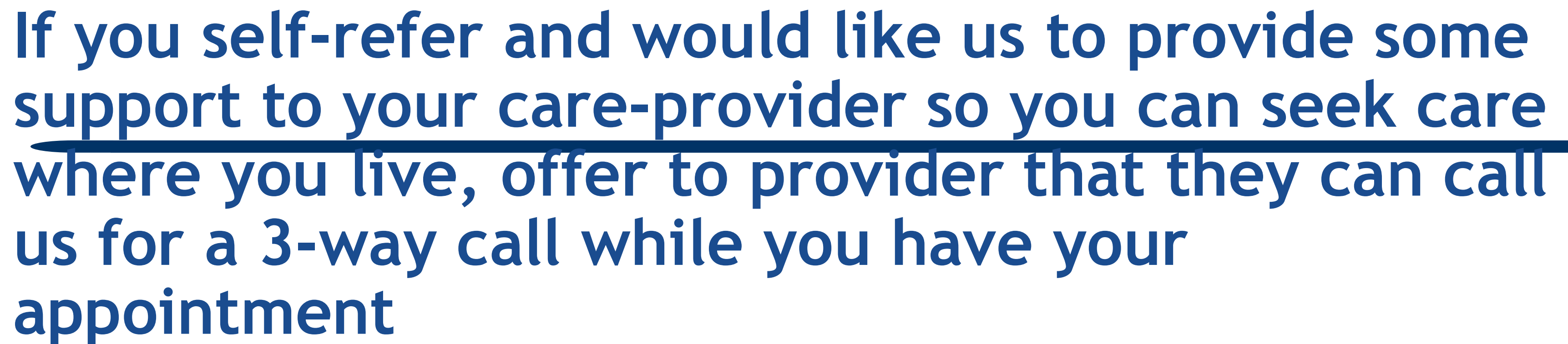

If you self-refer and would like us to provide some support to your care-provider so you can seek care where you live, offer to provider that they can call us for a 3-way call while you have your appointment

- Connect to our team for ongoing support/case management including supporting you to follow through with a care plan
- Specific questions about HIV, HCV, HIV pre-exposure prophylaxis
- Supporting an initial assessment for pre-exposure prophylaxis (PrEP)
- Supporting required labs for baseline HIV, HCV or PrEP assessment

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Virtual Primary Care Clinics & New Resources

- Northern Health Virtual Primary and Community Care Clinic
  - 1-844-645-7811
- First Nations Health Authority Virtual Doctor of the Day
  - 1-855-344-3800
- Options for Sexual Health Virtual Care Clinic
  - 1-800-739-7367
- Support for Addictions questions:
  - BCCSU 24/7 Addictions Medicine Support Line 778-945-7619 - to provide consultation to prescribers, pharmacists and nurses with questions on addiction and/or safe supply
- Lifeguard App
  - launched June 15, 2020 – *caution* emergency services response times may vary and people require a smartphone to use the app

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Peer Support

HIV

- Positive Living North
  - 1-888-438-2437
- Peer Navigators
  - 604-828-8090 or
  - peernavigation@aidsvancouver.org
- VIVA confidential group for women
  - 1-866-482-3445 or
  - vivawomen@gmail.com

Hepatitis C

- Help4hepbc.ca
  - 1-888-411-7578 (phone or text)

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