

Improving Marketplace Health Insurance Enrollment for Eligible HIV and AIDs Positive Clients in Need of Specialty Medical Care Services

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Abstract

Nearly 5,500 individuals living in Wake County, North Carolina, are diagnosed with HIV and AIDs (North Carolina Department of Health and Human Services, 2018). Individuals living with HIV and AIDs have complex health conditions that are left unmet and untreated due to gaps in community awareness and self-efficacy in obtaining insurance through the marketplace. These individuals may be eligible for marketplace insurance with premium coverage through benefits under the Ryan White HIV/AIDs program. Nevertheless, many remain uninsured and lack access to specialty care services. The purpose of this DNP project was to improve the health and outcomes of individuals living with HIV and AIDs. The project aimed to increase the number of eligible patients who apply for insurance through the healthcare marketplace by developing a process to reduce barriers to enrollment and increase patient self-efficacy towards obtaining insurance. As a result of a process improvement and workflow change, 38 individuals were successfully enrolled in a marketplace insurance plan with their insurance premium covered.

Keywords: Ryan White HIV/AIDs program, marketplace, insurance, enrollment, premium coverage, process improvement

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Section I. Introduction

Background

The Wake County Health Department Clinic B is a resource-limited clinic that serves a vulnerable population of immunocompromised individuals living with HIV and AIDs. Their mission is “Wake County Human Services, in partnership with the community, will facilitate full access to high quality and effective health and human services for Wake County residents” (WakeGOV, 2020, Our mission). By way of a federal grant under the Health Resources and Services Administration’s (HRSA) Ryan White HIV/AIDs program, the clinic provides primary care services, support services, and medications to low-income patients living with HIV/AIDs. These individuals are eligible for marketplace insurance with premium coverage through benefits under the Ryan White HIV/AIDs program. Nevertheless, many remain uninsured. Challenges in completion of insurance enrollment include limited resources in transportation, housing and food insecurities, mental health, and access to support.

Organizational Needs Statement

The organization recognized that many clients do not apply for insurance in the federally-funded marketplace despite their financial eligibility. As a result of this gap, clients cannot receive the necessary referral and health services needed to maintain optimal health status. The National HIV/AIDs Strategy (NHAS) acknowledges a need to reduce the transmission and health disparities of HIV and AIDs by increased access to care (Department of Health and Human Services, 2017). According to NHAS, a 2020 goal is for at least 85% of newly diagnosed clients to receive healthcare within one month of diagnosis (Department of Health and Human Services, 2017). In 2013, only 66% of newly diagnosed clients in North Carolina (NC) received healthcare within one month (North Carolina Department of Health and Human Services, 2016).

Specific to the Wake County clinic, there are 26 individuals whose reported income demonstrates eligibility for federally-funded insurance. Yet, the clients remain uninsured and endure prolonged wait times for referrals with an average wait time of 45 days.

In reflection of goals set by the NHAS, there is a great need to improve the process of assisting clients in obtaining accessible health insurance benefits while fostering fluidity through the challenges of transportation, language barriers, and social limitations. The project aim was to assist these individuals and the community in understanding their eligibility for health insurance under HRSA's Ryan White program. In addition, this project sought to promote self-efficacy in insurance enrollment to increase access to specialty medical care and treatment.

A Healthy People 2020 goal for improved access to healthcare services was a priority for this population (HealthyPeople.gov, n.d.). Bridging the gap between access and enrollment in health insurance will increase access to healthcare benefits and improve health outcomes. An additional Healthy People 2020 goal was to reduce HIV-associated health disparities and health inequalities (HealthyPeople.gov, n.d.). Individuals living with HIV and AIDs have complex health conditions that are left unmet and untreated due to gaps in community awareness and self-efficacy in obtaining insurance through the marketplace.

Lastly, a Healthy People 2020 goal was to improve population outcomes with communication strategies and health information technology. Individuals living with HIV and AIDs in Wake County are missing out on federally-funded insurance benefits that are available to them by HRSA's Ryan White program. The aim and provision of this project was to improve supportive networks, community education, and implement an effective process of achieving access to healthcare and insurance enrollment.

This project relates to the Triple Aim as it intends to improve the health of the population of patients living with HIV/AIDS. It enhances the care and experience of care for individuals within this population. With implementation of a process for insurance enrollment, patients will have access to healthcare, marketplace premium coverage, specialty care services, and medication therapy. Increased rates of insurance enrollment can reduce healthcare costs associated with uninsured medical treatment. Consequently, connecting individuals with existing federally-funded benefits will increase access and the availability of other insurance services to others. Additionally, insured individuals are likely to have better controlled HIV disease and therefore improved health outcomes.

Problem Statement

Nearly 5,500 individuals living in Wake County, North Carolina, are diagnosed with HIV and AIDS (North Carolina Department of Health and Human Services, 2018). Health insurance coverage and access to health services were priorities for improvement. Many of these individuals may be eligible for health insurance benefits through HRSA's Ryan White program, which will cover private insurance costs, expanding access to primary care services and specialty referrals. Lack of community awareness of the benefits available through the Ryan White program ensues unnecessary barriers to consistent medical care, appropriate HIV/AIDS primary care, and optimal patient outcomes for persons living in Wake County.

Purpose Statement

The purpose of this DNP project was to improve the health and outcomes of individuals living with HIV and AIDS. The project aimed to increase the number of eligible patients who apply for insurance through the healthcare marketplace by developing a process to reduce barriers to enrollment and increase patient self-efficacy towards obtaining insurance.

Section II. Evidence

Literature Review

The search strategy first used for this DNP project was to review insurance enrollment strategies, a streamlined process of enrollment, or a tool to promote patient self-efficacy in health insurance enrollment. PubMed, PubMed New, Proquest, CINAHL, and Scopus were all used to review the literature using key terms including expand, uninsured, insurance, enrollment, HIV, barriers, self-enrollment, and strategies. Mesh terms used include health insurance exchange, medically uninsured, HIV, Acquired Immunodeficiency Syndrome, and patients. There was a total of 111 article results using these methods, however the articles provided marginal data regarding a streamlined process or tool to mitigate the identified problem. An adjustment to key terms and the search strategy revealed data related to marketplace health insurance, which piloted the discovery of strategies to assist in decision-making and improved health literacy. Due to the exclusivity of the patient population, adjusting the search terms to include insurance enrollment and process helped to provide data that could be transcribed to efforts for low-income and vulnerable populations, which could also be used for the population of patients living with HIV/AIDs.

Levels of evidence available for this literature review of the project problem were levels V-VII. Limits were placed on the literature search including a date of publication within five years, peer-reviewed, full-text, and the English language. Abstracts, methods, and the results section was reviewed for each remaining article. Relevance to the project idea or mitigation of the project problem provided additional inclusion and exclusion criteria. The number of articles remaining after inclusion and exclusion criteria were applied was four articles. If the article was applicable to the project aim, the article was read in entirety.

Current State of Knowledge

There was insignificant data and research specific to a streamlined process or tool for insurance self-enrollment and self-efficacy related to the target population. The literature did not clearly identify benchmarks, guidelines or an intervention specific to the target population, however generalized interventions for consumer insurance enrollment were evaluated and applied to the target population. Likewise, there is significant support and a call for need regarding improved access to health care by way of interventions to overcome barriers such as transportation, health literacy, and technology. Identified methods to increase health insurance understanding and enrollment include local and community outreach and educational campaigns which offer opportunities for reducing the stigma and increasing health literacy and awareness. Best practices to support healthcare literacy and self-efficacy with decision-making include efforts of clear communication regarding patient eligibility and insurance benefits to facilitate understanding (Housten et al., 2016).

Current Approaches to Solving Population Problem(s)

An appropriate intervention to mitigate the identified problem of insurance enrollment and health literacy within the target population is to provide local outreach and educational campaigns. This approach was identified as a priority intervention to increase patient understanding of insurance benefits and self-efficacy toward obtaining insurance through the marketplace. An additional approach to mitigate the project problem is to facilitate social workers as primary support for health insurance enrollment on-site and in person. This approach was chosen as a priority intervention within the literature as a method to increase patient satisfaction and understanding of the insurance process. This approach can improve enrollment rates and overcome barriers of technology, language, and health literacy.

Evidence to Support the Intervention

The marketplace is a complicated process of searching and enrolling in health insurance. In a literature review, an effective intervention to improve health insurance enrollment and self-efficacy is to offer outreach and education to consumers within the community (Call et al., 2015). Community outreach and educational campaigns can be held at local community centers, college campuses, and the Wake County clinic. At an educational campaign, individuals can learn of their options and insurance benefits available through the Ryan White program and ADAP including available federally-funded insurance premium coverage on the marketplace.

An educational campaign can provide resources for self-enrollment via technology approaches or in-person assistance. Local outreach and educational campaigns can provide discussion of the eligibility criteria and documents needed for enrollment as well as the enrollment process accessible online via the marketplace. Patients feel greater support and control of their health decision-making when they are informed about their insurance options and understand how healthcare can benefit them (McManus et al., 2019).

In addition to local outreach and educational campaigns, the literature supports an approach to increase patient health literacy and enrollment with in-person certified application counselors, social workers, and/or assistors (Selwyn & Senter, 2016). These assistors should be trained and prepared to discuss options with the patients and have access to resources for language and literacy barriers in order to assist individuals in enrollment at designated community sites. This role can be fulfilled by current social workers and support staff within the clinic. Social workers are in positions to develop trusting patient relationships and can best assist these individuals by identifying and overcoming barriers, considering the specific needs of the individual in insurance enrollment, and then monitoring patient adherence and retention to care.

Social workers can provide clear and plain language, positive engagement, and effective communication (Housten et al., 2016). This vulnerable population needs support to overcome significant barriers of limited resources including disproportionate affects of homelessness, food insecurity, mental health, and transportation that prevent them from accessing health care and insurance. On-site social workers and support staff are best equipped with available resources that can assist in closing the loop of insurance enrollment by identifying specific patient needs.

Evidence-Based Practice Framework

Identification of the Framework

Execution of this project involved use of the Plan-Do-Study-Act model. This model facilitates a clear and concise process to guide quality improvement and process change (Langley et al., 2009). Identifying the project need influenced the decision to use this specific model as the culture and process of insurance enrollment needs improvement. There was a need for change to a process in identifying patient care service needs and assisting patients in obtaining marketplace insurance. Interventions and methods to carry out the process change were discussed. Once the interventions were tested, analyzing the successes and failures helped to determine if additional changes were necessary to facilitate improvement or enhancement of the processes to develop a standard workflow.

Ethical Consideration & Protection of Human Subjects

There are many challenges presented when providing care to a vulnerable population. This clinic serves individuals with complex health needs who are also disproportionately affected by limited resources in transportation, food, housing, and social support. Access to care and improved health outcomes are directly related to improving the standards of care of those individuals living with HIV and AIDs. The project goal and interventions endorsed the clinic

mission to facilitate access to high quality and effective health and human services to the residents of Wake County. The interventions provided equality of care and were available to all individuals without burden.

No direct patient care by the student occurred for this quality development project, therefore protecting privacy and confidentiality of the target population. Ethical considerations included providing respect for persons within the target population, protection from harm or prejudice, and facilitating improved access to care. There was not a potential for harm to the target population as the project aimed to improve a workflow process and offer general community education regarding insurance eligibility and enrollment. There was no participation in research. There were no concerns regarding the intent of this quality development project, which aimed to promote patient self-efficacy and control of health decision-making.

In preparation for the approval process, I completed the social, behavioral, and educational phenomena CITI modules provided by the university. I applied the information learned within these modules to ensure that all work and efforts of the project aim promote equality, respect, beneficence, and confidentiality. A program evaluation self-certification tool was completed providing key characteristics of the project to determine credibility and purpose. The qualtrics survey and quality self-certification tool will complete the process for project approval from the IRB.

Section III. Project Design

Project Site and Population

The project site is the Wake County Health Department Infectious Disease clinic. This clinic is a resource-limited clinic that serves an uninsured vulnerable population of individuals living with HIV and AIDs. The clinic includes a team of providers, social workers, and clinic support to facilitate patient access to equitably care and federally-funded resources. Lack of community awareness of the benefits available through the Ryan White program ensues unnecessary barriers to consistent medical care, appropriate HIV/AIDs primary care, and optimal patient outcomes for persons living in Wake County.

Description of the Setting

Services provided in this clinic include primary care, social services, case management, and medication therapy but are disproportionately affected by housing and food insecurity, mental health, and substance use. The project aimed to implement effective educational strategies and materials for a local population health message and/or educational campaign. In addition, marketplace enrollment was made available in-person with a trained clinic navigator.

Description of the Population

Nearly 5,500 individuals living in Wake County, North Carolina, are diagnosed with HIV and AIDs (North Carolina Department of Health and Human Services, 2018). Many of these individuals may be eligible for health insurance benefits through HRSA's Ryan White program, which will cover private insurance costs, expanding access to primary care services and specialty referrals. This population is disproportionately affected by barriers to access to care including housing, transportation, poor adherence, recent incarceration, and low healthcare literacy.

Project Team

The project team was made up of seven individuals including myself, all with unique roles to the project and within the clinic. Dr. Chris Evans, a practitioner in the clinic, was the site champion for the project. He helped to identify the project need and problem. Dr. Robert Dodge was the co-site champion and has been caring for this population within Wake County for nearly 30 years. Michael McNeil was a key asset to the team in that he provided data support and clinical role development for the social workers and support staff. Dr. Tillman was the project faculty member for this DNP project. She provided project process development, guidance, intervention recommendations, and modification. Shannon Utley was a social worker who agreed to assist in the implementation of on-site marketplace enrollment of newly identified patients. Lastly, David Buss was the patient support advocate who became the trained on-site navigator.

Project Goals and Outcome Measures

The project goals included improved access to healthcare and improved health outcomes for people living with HIV/AIDs by way of improving federally-funded marketplace enrollment for eligible clients. These goals included a focus on the development of a process to assist patients in obtaining insurance by identifying and overcoming barriers in self-efficacy and understanding in obtaining eligible health insurance. Outcome data included the measurement of the process changes. The process measurement tool included an Excel grid with weekly enrollment data. The project was considered an implementation change and not research, therefore IRB approval was waived.

Description of the Methods and Measurement

Methods to monitor project updates and team communication included weekly emails to include a SBAR to communicate the PDSA cycle and improvement process. This served as a report template to continuously report back to Dr. Evans and the team of project progress and PDSA changes. Measurement of the implementation project included weekly on-site meetings to collect a run chart of data obtained by the social worker and the project team towards the process change. This process measurement consisted of a grid to include the number of patient discussions related to marketplace insurance, the number of patients who were assisted through the process of enrollment, and the number of patients who successfully enrolled in marketplace insurance. In addition, the social workers documented barriers to the interventions, suggestions, and/or comments. These evaluations were displayed on the run chart of patient enrollment data.

Discussion of the Data Collection Process

Data collection occurred weekly in the form of an itemized grid to identify initiation of marketplace discussion with patients and connection with available resources for enrollment. This data collection process served as an opportunity to visit the project site and communicate with the project team regarding interventions that were working well and/or not working well. This weekly report discussed observations, recommendations, and feedback to assist with the PDSA cycle.

Implementation Plan

To meet the goals identified for the problem statement and project aim, key interventions included the development of a population health message to be presented at the clinic, local health departments, and local community centers. This educational campaign intended to review eligibility criteria and documents needed for enrollment as well as provide guidance of the online

enrollment process accessible via the marketplace and on-site in the clinic with the social workers and/or navigator. In addition to an educational campaign, a key implementation intervention for this project was to change the workflow process for new patients to include discussion and enrollment of marketplace insurance. Social workers and patient support staff were trained and prepared to discuss insurance options and premium benefits with the patients and have access to resources for language and literacy barriers in order to assist individuals in enrollment at designated community sites. Ongoing revision of the process change intervention occurred throughout the implementation.

Timeline

This project timeline for Summer 2020 included weekly meetings with Dr. Tillman to review the project progress. Additionally, biweekly email correspondence occurred with the team to facilitate continuous communication and team collaboration of the project progress. Section three of the DNP paper was completed by July 20th, 2020. The formal letter of support was completed by July 20th, 2020. A virtual meeting with the social worker occurred by July 20th, 2020. See Appendix A for the Summer 2020 timeline. The project implementation began on-site in Fall 2020 and will be completed by Spring 2021. Biweekly meetings with Dr. Tillman and the team continued into the fall and spring semesters. On-site meetings occurred biweekly starting on August 12th, 2020. See Appendix B for the Fall 2020 timeline. Project synthesis and dissemination began in Spring 2021. See Appendix C for the Spring 2021 timeline.

Section IV. Results and Findings

Results

During the project implementation, I collected outreach data for patients who were identified as of highest need for specialty care referrals and were already within a provider donation service in the county known as Project Access. These patients were identified as eligible for marketplace enrollment and Premium/Copay Assistance Program (PCAP) under the Ryan White HIV/AIDS Program. I collected data for each patient including patient demographics, financial eligibility for PCAP, method of patient contact, time spent in making contact, and methods of patient education regarding insurance and premium coverage eligibility. Additionally, I collected data of patients who requested enrollment assistance with the marketplace navigator. I documented patient responses of their newly informed eligibility status. Lastly, I collected open enrollment data of the individuals who were successfully enrolled in a marketplace insurance plan after this implementation. With this effort, a total of 78 individuals were identified as eligible for marketplace enrollment and premium coverage due to their current income status and presentation of specialty care needs.

Originally, I expected to reach every patient by phone to discuss their eligibility for marketplace enrollment and premium coverage. I expected that each patient would be elated to learn of their benefits under the Ryan White HIV/AIDS Program for health insurance premium and copay coverage. I expected that at least 50% of patients would want in-person assistance with marketplace enrollment and navigation due to these patients being an uninsured vulnerable population with limited access to resources. I expected at least 10% of patients to successfully enroll in a health insurance plan after this implementation.

At the completion of implementation, I only reached 52 of the 78 patients who were identified as eligible for marketplace enrollment and premium coverage. I was able to refer 26 patients to the marketplace navigator for assistance with marketplace enrollment. I collected post-open enrollment data of how many patients successfully enrolled in marketplace insurance of those I directly referred. I evaluated the number of patients successfully enrolled in marketplace insurance on site after this project implementation to validate the importance of providing on-site marketplace assistance towards efforts of increased insurance enrollment rates.

I also evaluated comparison data from 2019 for Wake County as a region regarding marketplace enrollment and premium coverage participation. I found there was a 50% increase in the number of clients enrolled in PCAP from 2019 to the year 2020. Lastly, evaluated provider and staff observations post-open enrollment to conclude their perspectives on utilization of the student role in patient outreach as well as the role that was developed for on-site marketplace assistance. Clinic staff reported a positive improvement of clinic education of insurance eligibility and marketplace enrollment after this project implementation. These efforts increased clinic awareness and support towards patient outreach and clinic advocacy towards marketplace enrollment.

Outcomes Data

I gathered quantitative and qualitative data of patient outreach towards efforts of marketplace eligibility notification and enrollment. Quantitative data collected during this project implementation included the date of patient outreach, age, number of phone call attempts, and minutes spent in discussion with each patient. Qualitative data collected during this project implementation included the patient's HIV/AIDS clinic provider, race, gender, Project Access enrollment, if the patient was reached via text message notification, if the patient was notified of

their PCAP eligibility, education of available resources for marketplace assistance and enrollment, and if the patient was enrolled in a marketplace insurance plan as a result of this implementation.

A PDSA framework was used to measure process changes throughout the project implementation. I also used the SBAR tool as a structured form of communication and project monitoring among the project team. This was implemented along with weekly email correspondence with the team regarding project progress and updates.

This project implementation did result in outcome measures. Those outcome measures included successfully contacting patients identified as eligible for marketplace enrollment and premium coverage and referring them for marketplace assistance with a navigator on-site. Additionally, patients were informed of their eligibility of insurance benefits of Ryan White HIV/AIDS PCAP, which resulted in an outcome measures of patient education and awareness. Lastly, as a result from outcome measures, a new patient referral process and targeted staff training was identified as necessary to support the education and needs of the patient population.

As a result of these efforts, clinic staff and providers were better prepared for patient identification of eligibility, identification of special circumstances regarding enrollment qualifications, and the on-site navigator identified patients who were also eligible for family insurance plans. Also, the clinic now is equipped with a designated staff member who can see patients as a marketplace navigator. Due to COVID restrictions, the state did not provide the health department with certified navigators, so as a result of implementation and student project recommendations, a clinic staff member completed training to become a marketplace navigator.

Discussion of Major Findings

Gaps identified during this project implementation and evaluation include communication barriers with attempts to notify patients of their eligibility. I originally anticipated that patients would be easy to reach since I was calling from their provider's office. I found that patients often were difficult to reach due to loss of income and inability to afford phone services or simply diversity in work schedules and discomfort with answering a call from their provider's office.

Also, during my efforts as a patient coach, I discovered the state online marketplace resource was out of date and not accessible to patients. I expected that all resources would be up to date and readily available for patients. However, no one was able to schedule appointments online in Wake County for navigator assistance due to this web-based glitch, making access to resources even more difficult for patients. There were consistent barriers of limited resources including state funding and limited patient income, which deterred patients from accepting responsibility of co-payment costs despite the premium coverage eligibility.

Section V. Interpretation and Implications

Cost Benefit Analysis

This project could potentially cost the organization at least one part-time income to continue efforts of consistent and frequent patient outreach. In nine weeks, with approximately 60 hours of on-site engagement, I was only able to make outreach efforts towards a total of 78 patients. This consisted of calling the patients at least three times over the course of the project implementation, sending each patient a text message regarding their eligibility, discussing specific eligibility criteria and enrollment with each patient either directly or by voicemail, and directing patients requesting navigator appointments with a referral to the appropriate staff. Additionally, this role included returning patient voicemails and providing up to date marketplace education and resources for the clinic staff and providers. Generally speaking, someone with a master's degree in social work will be paid on average \$25.00 per hour according to the current offering on the Wake County career website. Depending on the part-time hour requirement, the role this student playing in the project could be considered as a future paid position. An estimated cost of a part-time employee at 20 hours per week would be \$500.00. Given the possibility of this position being in a part-time status, no additional benefits, insurance, or retirement would need to be considered for a cost-benefit analysis.

The project benefited the organization because the student did not require any costs in order to complete the project implementation. There was no use of a budget towards efforts in patient outreach related to technology, equipment, computer training, or office space. The benefit to the organization includes a successful process change to implement clinic staff marketplace training at no cost and increased efficiency in available resources including office space and reduced workload on the current social workers.

Additionally, patient enrollment in marketplace insurance will reduce budgetary costs of uninsured patient financial support. Based on the number of services provided and missed reimbursement, the average annual cost per person for HIV/AIDS visits and medications is \$25,000.00. The average monthly premium cost per person in North Carolina is \$482. By enrolling 38 individuals in marketplace insurance, that alone costs less than the average annual cost for HIV/AIDS care per person.

In comparison, the potential cost of paying a part-time employee to complete the role the student played in the project would be approximately \$1,500.00 for 60 hours of on-site work. There were no unexpected costs that affected this project implementation. In general, since there were no out of pocket costs to the organization for this project implementation, there were no financial investments on the part of the facility. Instead, the project encouraged efficiency of staff and clinic support towards patient insurance enrollment by training a current staff member to facilitate appointments for enrollment on-site. Additionally, the project revealed the need for staff education and clinic collaboration towards increasing client outreach and referral for PCAP.

Resource Management

A clinic staff member was available to work from home during the pandemic and complete marketplace enrollment training at no additional cost to the clinic. He assisted in successful outcomes because he was cognizant of the specific patient needs for those living with HIV/AIDS and eligible for Ryan White benefits. The staff member already had a clinic-provided computer and scheduling system to prepare for patient appointments and assist with marketplace enrollment. There was no additional hardware or software required for this project initiative. The clinic already had a separate and private office setting to provide social distancing and nourishment for patient appointments. Additionally, the staff member was already equipped with

access to the electronic medical record, affording him direct access to patient demographics, documents for eligibility, and patient referral needs.

Organizational resources that would have benefited the outcome of this project include availability of advanced technology with the electronic medical record to assist in the referral process of identifying eligible patients. This might include the addition of pre-screening during the patient check-in process or flag identification with any major income, living, or insurance changes. This resource would have assisted in the efficiency in identifying patients as eligible for premium coverage and marketplace enrollment. Additionally, an organization email account available to the student would have benefited the project implementation as this could have been instrumental as an additional outreach attempt made by the student.

The organization has multiple staff members who were working primarily from home due to the pandemic. Those included social workers, patient coordinators, and patient support advocates. Considering that marketplace training did not cost the organization any additional monies, the organization could have benefited from additional staff becoming proficient in marketplace enrollment and Ryan White benefits. The organization was previously provided interactive tablets for every patient room for preventative care and education. An initiative to increase patient education and community awareness of the Ryan White HIV/AIDS benefits of PCAP might include providing interactive education on the tablets regarding these topics and a method of efficient patient identification that can prompt patient referral for PCAP. I believe that it would be extremely feasible to re-allocate these resources in order to promote increased availability to health care to the patients of this clinic. A major consideration for re-allocating resources would involve behavioral change and consistent staff incentive and support. Current

tasks fulfilled by social workers would not be overwhelming or missed if the staff can agree on a reasonable amount of effort to improve patient outreach.

Implications of the Findings

A vulnerable population is in need of outreach and support with increased awareness regarding Ryan White benefits and marketplace enrollment. This project involved the hardwiring of an on-site process to provide patients with consistent and clear outreach and discussion regarding health insurance coverage and access to specialty care health services. This process was identified as insufficient to support the patient need and as a result of the DNP project, 38 out of 78 individuals reached were successfully enrolled in a marketplace health insurance plan. Charitable partnership for referrals should not be an avenue of client dependency in relation to access to care. Charitable partnership helps bridge the gaps of efficient access to care for those in need and provides cost-free services to individuals who are not eligible for a subsidized healthcare option. This project signifies the importance of access to healthcare and how providing good and just healthcare supports health equity.

During this project implementation, patients reported appreciation of the efforts made towards improving their access to healthcare and their understanding of insurance benefits. Many patients voiced their gratitude for the outreach and support in promoting health equity and access to healthcare. A succinct workflow process was vital toward efforts in patient outreach, patient education, connection with resources, and successful patient insurance enrollment.

Implications for Patients

As a result of this project initiative, a process for patient outreach and education identified patients eligible for marketplace insurance enrollment and premium coverage. Marketplace enrollment increases patient access to specialty care services while freeing up

available state and county healthcare programs like Project Access for patients who are not eligible for Ryan White benefits. For example, if a patient is not eligible for Ryan White, Medicaid/Medicare, or marketplace health insurance, Project Access is available in certain counties. Transitioning those enrolled with Project Access to a health insurance plan through the marketplace not only increases their access to specialty care services but provides an opening with Project Access. Additionally, as a result of implementing a navigator role, patients and their families are provided access to healthcare.

Implications for Nursing Practice

Nursing practice is far more in depth than solely following a set of clinical practice guidelines and refilling prescriptions. In a resource-limited clinic like Wake County Health Department Clinic B, providers and staff must advocate for their patients and their families in ways that go beyond clinical practice management. This project initiative addressed key messages and gaps in the care process within the clinic regarding patient outreach, community support, and patient outcomes. Overcoming the barriers as addressed throughout this paper will improve access to healthcare and improve health outcomes for people living with HIV/AIDs.

Impact for Healthcare System(s)

A health care system that can effectively and efficiently provide patient education, support, and navigation for achieving health care needs represents patient-centered care. The literature supports an organizational approach to increase patient health literacy and enrollment with in-person insurance assistance. By healthcare systems providing on-site navigators who are best equipped in identifying specific patient needs, patients are connected with essential resources to assist in closing the loop of health insurance availability and successful insurance enrollment. This impacts access to care by providing patients with in-person assistance of

insurance enrollment, eliminating potential barriers to healthcare, while decreasing emergency room use for chronic disease management and primary care. Improving a clinic process of assisting clients in obtaining accessible health insurance benefits will impact healthcare outcomes and also assists in overcoming the barriers of transportation, language barriers, and social limitations. Community is developed with a consistent patient-centered approach to improve access to healthcare while working to overcome diverse patient barriers of inequalities.

Sustainability

The organization does plan to continue efforts in improving insurance enrollment to increase access to health care for the identified patient population. The organization will continue the project efforts of patient outreach and marketplace navigation throughout the open enrollment period. Additionally, the organization has voiced a wish to have future students to continue the patient outreach and project initiatives of assisting patients in obtaining insurance and overcoming barriers in self-efficacy in obtaining eligible health insurance. The organization can afford to continue this project, as there are reasonable expectations for the current staff to also assume responsibility for the outreach actions fulfilled by the student during implementation. This project initiative can be easily spread to other health departments and clinics as a process change to improve patient enrollment and access to specialty care services.

Dissemination Plan

The dissemination plan included a virtual poster presentation for East Carolina University College of Nursing on April 6, 2021. Attendees will include professors, peers, and the project team. Additionally, a virtual presentation of the project results and poster was intended to take place with the Wake County Health Department Clinic B but was postponed due to the COVID pandemic and burden of short staffing. This presentation is intended to take place instead in the

Fall of 2021 and will invite all clinic staff including providers, nurses, social workers, technicians, and secretaries. The poster presentation can also be offered to be shared within the clinic on project presentation boards. Additionally, discussion of a webinar or video for a sustainability action plan across North Carolina health departments is intended to take place in the Fall. The target audience will be for staff including providers, nurses, social workers, technicians, and secretary. This sustainability action plan was planned in April 2021.

Section VI. Conclusion

Limitations

Due to the project implementation occurring simultaneously with the onset of the COVID-19 pandemic, community and local outreach was limited. I originally intended to complete local community outreach to share Ryan White benefits, eligibility criteria, and documents needed for marketplace enrollment, as well as the enrollment process accessible online via the marketplace. However, this was not completed due to safety precautions taken at local shelters, community centers, and college campuses. Discussion for future recommendations include providing Ryan White benefit education and marketplace insurance education for patients at the time of the annual Ryan White enrollment and renewal.

Due to the COVID-19 pandemic, clinic staff were primarily working from home, limiting the availability and accessibility to patients who were present in clinic for routine appointments. This limited the accessibility for providers to refer patients to the social worker while on-site for appointments, therefore increasing the burden of the many barriers these patients experience. During the project implementation, I discovered the state online marketplace resource was out of date and not accessible to patients. This yielded limitations to patient access because the primary resource for virtual marketplace assistance was not up to date and not accepting patient appointments for the general public.

Lastly, a major project limitation was related to unclear boundaries of roles and responsibilities of the team and student. When the project began, I was unsure of how many responsibilities to obtain from the project recommendations by the team. This resulted in time lost due to faculty redirection, clarification, and new project goals. Communication was a limitation as it was apparent that change would be complicated and not readily accepted within

this clinic. It was advised that staff were conflicted with acquiring new responsibilities along with their already overwhelming task lists. This created some tension at the beginning of the project as the student role seemed uncertain and unclear to the staff. Once a staff member volunteered to fulfil the role as on-site navigator, goals became easily supported by staff.

Recommendations for Others

A recommendation for continuation of this project would include a group of students to work on project efforts in this clinic site rather than one student alone. This will support diversity in thought, creativity, and process management. I believe this clinic can benefit from student collaboration to continue hardwiring the process of patient outreach and increasing patient access to healthcare.

I highly encourage and recommend any future student projects to develop clear and early communication during the planning period. This is crucial to avoid misinterpretation of goals and objectives. This clinic appreciates more on-site engagement and recommends a student or group of students who can be present for implementation more than one day each week. This will encourage frequency of discussion with clinic staff and increase the outreach activity. The pandemic hindered the extent of community outreach completed for this project implementation; however, it would have greatly benefited the efforts and number of patients reached. Lastly, recommendations for evaluation may include pre-planning for efficient understanding of measurable outcomes in order to identify data collection methods and success.

Recommendations for Further Study

Continued study at this clinic site would benefit this organization to support behavioral change and process improvement for patient outreach and effective referral techniques. Continued efforts can include analyzing the barriers in access to care and patient success with

marketplace enrollment in relation to age, gender, and race. The data can be acquired from this project implementation and used to develop a project goal to include overcoming barriers based on the extracted data. Continued efforts are needed to overcome barriers in patient communication. Despite communication efforts that included phone call and text message notification, many patients were not able to be reached. Some recommendations for overcoming communication barriers include using a patient portal that is easily accessible for patient and provider collaboration. This will also provide an avenue for referral and notification of identifying target patients who are eligible for PCAP and marketplace enrollment.

Additionally, recommendations for further student collaboration with this clinic may include identifying what prevented the remaining patients from enrolling in insurance and the development of a plan to overcome any barriers identified. Also, future studies should analyze budget barriers including funding for marketplace navigators and on-site assistors. Implications for the future should include developing a partnership to assist with funding on-site navigators.

Lastly, a future recommendation for study is to develop a process improvement for state-provided premium payments to prevent gaps in healthcare coverage. When evaluating the success of the project implementation, the project team shared that some clients statewide did not have their premiums paid by the state. Reasoning for lack of payment varies including discrepancies in social security numbers and birthdates. This creates a continued barrier to patient care and is considered to be a major limitation if premiums are not paid. This recommendation would be vital as improvements are made related to this process improvement initiative.

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Appendix A**Table 1*****DNP Project Timeline Summer 2020***

Planned	Met
Weekly meeting with Dr. Tillman	May 21, 2020 June 1, 2020 June 24, 2020 July 15, 2020
Biweekly email with project team	May 21, 2020 June 2, 2020 June 24, 2020 July 7, 2020
Virtual meeting with the social worker	July 20, 2020
Completion of section three of the DNP paper	July 20, 2020
Formal letter of support	July 20, 2020

Appendix B

Table 2

DNP Project Timeline Fall 2020

Planned	Met
Biweekly meeting with Dr. Tillman	August 10, 2020 August 19, 2020 August 25, 2020 September 1, 2020 September 15, 2020 October 6, 2020 November 3, 2020
Biweekly email with project team	August 10, 2020 September 3, 2020 September 30, 2020 October 15, 2020 October 22, 2020 November 2, 2020
Team meeting on-site for project engagement	August 19, 2020 August 26, 2020 September 2, 2020 September 8, 2020 September 16, 2020 September 23, 2020 September 30, 2020 October 7, 2020 October 14, 2020 October 21, 2020 October 28, 2020 November 4, 2020
Project implementation	September 8, 2020-November 4, 2020
Weekly clinic data collection	September 8, 2020 September 16, 2020 September 23, 2020 September 30, 2020 October 7, 2020 October 14, 2020 October 21, 2020 October 28, 2020

Appendix C**Table 3*****DNP Project Timeline Spring 2021***

Planned	Met
Synthesis of the qualitative and quantitative evaluation result	January 31, 2021
Recommendation for the organization and next steps and final poster presentation	April 5 th , 2021
Dissemination of the project	March 29, 2021
Final DNP Paper submission	April 21, 2021

Appendix D

Table 4

DNP Essentials Mapping

	Competency/Description	Demonstration of Knowledge
Essential I Scientific Underpinning for Practice	<p>Competency – Analyzes and uses information to develop practice</p> <p>Competency -Integrates knowledge from humanities and science into context of nursing</p> <p>Competency -Translates research to improve practice</p> <p>Competency -Integrates research, theory, and practice to develop new approaches toward improved practice and outcomes</p>	<ol style="list-style-type: none"> 1. Completed literature review of practices and frameworks to support need for DNP project ideas. 2. Completed research of improving health equality and equity by way of health insurance and eligibility of patients living with HIV/AIDs. 3. Completed DNP case simulations. 4. Reviewed the literature to support development of the PICO question. 5. Reviewed and applied the 2019 Wake County Community Health Needs Assessment towards the project development.
Essential II Organizational & Systems Leadership for Quality Improvement & Systems Thinking	<p>Competency –Develops and evaluates practice based on science and integrates policy and humanities</p> <p>Competency –Assumes and ensures accountability for quality care and patient safety</p> <p>Competency -Demonstrates critical and reflective thinking</p> <p>Competency -Advocates for improved quality, access, and cost of health care; monitors costs and budgets</p> <p>Competency -Develops and implements innovations incorporating principles of change</p> <p>Competency - Effectively communicates practice knowledge in writing and orally to improve quality</p> <p>Competency - Develops and evaluates strategies to manage ethical dilemmas in patient care and within health care delivery systems</p>	<ol style="list-style-type: none"> 1. Development of project needs with project partner and team. 2. Applied for IRB and was waived due to the nature of the project goal. 3. Reviewed library resources for literature search strategies and development of a literature matrix. 4. Completed CITI modules which provided insight of ethical considerations during project development and implementation. 5. Edited and completed the DNP paper for submission to The Scholarship. Successful virtual presentation of the DNP project poster at ECU CON Poster Presentations.

<p>Essential III <i>Clinical Scholarship & Analytical Methods for Evidence-Based Practice</i></p>	<p>Competency - Critically analyzes literature to determine best practices Competency - Implements evaluation processes to measure process and patient outcomes Competency - Designs and implements quality improvement strategies to promote safety, efficiency, and equitable quality care for patients Competency - Applies knowledge to develop practice guidelines Competency - Uses informatics to identify, analyze, and predict best practice and patient outcomes Competency - Collaborate in research and disseminate findings</p>	<ol style="list-style-type: none"> 1. Analysis of CMS regarding healthcare basics and ACA training. 2. Critically analyzed research regarding community outreach and education of Ryan White benefits and health insurance the needs of vulnerable populations. 3. Review behavioral health organizational strategies to improve health insurance opportunities in special populations. 4. The PDSA framework was chosen for the project and utilized for implementation and evaluation. 5. Collaborate with project team and faculty to disseminate findings and make recommendations for future efforts.
<p>Essential IV <i>Information Systems – Technology & Patient Care Technology for the Improvement & Transformation of Health Care</i></p>	<p>Competency - Design/select and utilize software to analyze practice and consumer information systems that can improve the delivery & quality of care Competency - Analyze and operationalize patient care technologies Competency - Evaluate technology regarding ethics, efficiency and accuracy Competency - Evaluates systems of care using health information technologies</p>	<ol style="list-style-type: none"> 1. Attended DNP project orientation and reviewed applicable modules and content within the DNP project book to analyze project information and context. 2. Reviewed the literature for ethical consideration for a vulnerable population. 3. Developed a referral process for patient identification of benefit eligibility and on-site enrollment. 4. Utilized YouTube for marketplace enrollment education and guidance. 5. Evaluated the current workflow process at the project site for process improvement.
<p>Essential V <i>Health Care Policy of</i></p>	<p>Competency- Analyzes health policy from the perspective of patients, nursing and other stakeholders</p>	<ol style="list-style-type: none"> 1. Analyzed health policy for Ryan White federally funded benefits and legal assistance

Advocacy in Health Care	<p>Competency – Provides leadership in developing and implementing health policy</p> <p>Competency –Influences policymakers, formally and informally, in local and global settings</p> <p>Competency – Educates stakeholders regarding policy</p> <p>Competency – Advocates for nursing within the policy arena</p> <p>Competency- Participates in policy agendas that assist with finance, regulation and health care delivery</p> <p>Competency – Advocates for equitable and ethical health care</p>	<p>with marketplace enrollment.</p> <ol style="list-style-type: none"> 2. Completed an implementation worksheet and plan. 3. I was a leader in support of behavioral change and process improvement in the clinic. 4. Educated clinic staff of literature support towards the project aim. 5. Advocated for clinic process improvement and increased staff collaborative effort towards patient outreach and support.
Essential VI Interprofessional Collaboration for Improving Patient & Population Health Outcomes	<p>Competency- Uses effective collaboration and communication to develop and implement practice, policy, standards of care, and scholarship</p> <p>Competency – Provide leadership to interprofessional care teams</p> <p>Competency – Consult intraprofessionally and interprofessionally to develop systems of care in complex settings</p>	<ol style="list-style-type: none"> 1. Completed on-site engagement and collaborative effort towards the development of a workflow change and standard of patient outreach and care. 2. Self and peer-review to consult and provide feedback towards system change and development. 3. Participated in peer group meetings to consult on poster design and presentation. 4. Development of a navigator role and script for the project team.
Essential VII Clinical Prevention & Population Health for Improving the Nation’s Health	<p>Competency- Integrates epidemiology, biostatistics, and data to facilitate individual and population health care delivery</p> <p>Competency – Synthesizes information & cultural competency to develop & use health promotion/disease prevention strategies to address gaps in care</p> <p>Competency – Evaluates and implements change strategies of models of health care delivery to improve quality and address diversity</p>	<ol style="list-style-type: none"> 1. Integrated population health care delivery by way of a process improvement to support patient education of health insurance benefits and enrollment. 2. Reviewed literature and resources focused on health promotion and specialty care needs of the HIV/AIDs population.

<p>Essential VIII Advanced Nursing Practice</p>	<p>Competency- Melds diversity & cultural sensitivity to conduct systematic assessment of health parameters in varied settings Competency – Design, implement & evaluate nursing interventions to promote quality Competency – Develop & maintain patient relationships Competency –Demonstrate advanced clinical judgment and systematic thoughts to improve patient outcomes Competency – Mentor and support fellow nurses Competency- Provide support for individuals and systems experiencing change and transitions Competency –Use systems analysis to evaluate practice efficiency, care delivery, fiscal responsibility, ethical responsibility, and quality outcomes measures</p>	<p>3. Completed research of funding sources for the clinic. 4. Addressed gaps in care by incorporating the National HIV/AIDs Strategy, Healthy People 2020, and the Triple Aim.</p> <hr/> <p>1. Designed, implemented, and evaluated a DNP project by improving a workflow process and developing an on-site navigator role. 2. Monitored implementation by way of a PDSA framework to make adjustments and improvement to interventions and strategies. 3. Developed a trusting relationship with the project team and patients. 4. Demonstrated clinical judgment of project needs and improving patient outcomes. 5. Mentored other nurses by peer-review of DNP posters and papers. Provided team support and collaboration. 6. Analyzed quality outcomes by way of result evaluation and comparison.</p>
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