Core Interventions

Eliminating Disparities in Viral Suppression Rates

Ryan White HIV/AIDS Program (RWHAP)-Funded Clinics Due to

Age

6.9.2020

Table of Contents

Dimension: Age

This Intervention is Lined to the Following Secondary Drivers:

- Process for engaging clients to take advantage of linkages and promote offered age-related services
- Processes in place for making customized referrals (after vetting potential referrals), following-up on referrals, and ensuring successful linkages
- Geriatric and pediatric health providers are integrated into the HIV care team and participate in case conferences

Level of Evidence: Well-Defined Interventions with an evidence-base

Optimal Linkage and Referral (Active Referral Intervention)

Summary:

Active Referral involves successful linkage of people with HIV to primary care as well as other services and supports. This may include newly diagnosed individuals, persons previously diagnosed who have never been linked to care, or persons who have fallen out of care and are being re-linked.

Core Components

Active Referral[6] addresses several key areas that have been found to improve linkage and re-engagement in care, including:

- removal of structural barriers
- increased social support services
- use of peers, client navigation, and care coordination
- a culturally responsive approach
- appointment scheduling and follow up
- timely and active referrals post-diagnosis
- integrated one-stop-shop care delivery

One study[7] looked at 16 barriers to successful linkages and proposed evidence-informed methods for mitigating their effects. One strategy associated with increased linkage to care is active referral. Many studies have shown that referral by a tester who makes the treatment appointment or accompanies the patient to an appointment increases the likelihood of linkage, compared with passive referral (e.g., only

[6] Active Referral Intervention. (2017, June). Retrieved May 17, 2020, from https://targethiv.org/sites/default/files/file-upload/resources/ihip-linkage-to-Care-Active-Referral-Case-Study-and-Intervention.pdf

[7] Carter, M. W., Wu, H., Cohen, S., Hightow-Weidman, L., Lecher, S. L., & Peters, P. J. (2016). Linkage and Referral to HIV and Other Medical and Social Services: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs. *Sexually transmitted diseases*, *43*(2

Suppl 1), S76–S82. https://doi.org/10.1097/OLQ.0000000000000290

providing written material).

The table below outlines the barriers and potential strategies for mitigating them.

TABLE 1.

Common Barriers to Linking or Retaining HIV-Infected Patients in HIV Medical Care

Barriers (Reference Number)	Examples of Potential Means of Mitigating Barriers
Psychosocial	
Low self-efficacy[19]	Strength-based case management
Health illiteracy[19]	HIV counseling and education, appropriate and varied educational materials
Concerns for confidentiality[20]	Explain and post confidentiality protections, provide private spaces for triage and examination
Concerns for stigma[21]	Nonjudgmental and inclusive approach and clinic environment
Language barriers[19,22]	Access to translation services through staff on site or by phone
Cultural barriers[16,22]	Cultural competency training, hiring cultural concordant staif
Substance use[23]	Screening for, and access or referrals to, substance-abuse programs
Mental illness[16]	Screening for, and access or referrals to, mental health services
Isolation[20]	Peer patient navigation, support group, case management
Socioeconomic	
Homeless[17]	Access to HIV/AIDS housing resources
Poverty[16,17]	Access to jobs training, social security disability benefits, or poverty reduction programs.
Lack of transportation[18]	Providing HIV care appointments at locations convenient to the patient; directly providing transportation assistance
Lack of insurance[16,18]	Providing health insurance enrollment service at the clinic or referrals to such
Health care system Complexity of health care systems[17,18]	Colocating HIV care and STD clinics; strong referral or linkage systems
Complexity of insurance systems[18,19]	Providing health insurance enrollment service at the clinic or referrals to such; ongoing support and education for using benefits

Tips and Tricks:

- Active referral programs often include peer navigators.
- While formal linkage and referral agreements between providers may be useful, they cannot replace active referrals.
- Implementing a successful active referral system at an HIV clinic takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- HRSA HIV/AIDS Bureau (HAB) - **Active Referral Intervention: Case Study, Overview, and Replication Tips**

- **Linkage and Referral to HIV and Other Medical and Social Services:** A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs

- Target HIV's **Using Community Health Workers to Improve Linkage and Retention in Care**

Suggested Measures:

Process Measures

- Number of referrals made
- % of referrals made that result in a successful linkage
- % of patients who agree or strongly agree that (Name of Clinic) provides culturally responsive referrals
- % of patients who agree or strongly agree that (Name of Clinic) provides active follow up to help ensure that referrals are successful and meet my unique needs

Outcome Measures

- % of patients that report successful linkages with improved viral suppression rates within 6 months
- % of patients that report successful linkages that achieve viral suppression (Percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

1. Active Referral Intervention. (2017, June). Retrieved May 17, 2020, from https://targethiv.org/sites/default/files/file-upload/resources/ihip-linkage-to-Care-Active-Referral-Case-Study-and-Intervention.pdf
2. Carter, M. W., Wu, H., Cohen, S., Hightow-Weidman, L., Lecher, S. L., & Peters, P. J. (2016). Linkage and Referral to HIV and Other Medical and Social Services: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs. *Sexually transmitted diseases*, *43*(2 Suppl 1), S76–S82. https://doi.org/10.1097/OLQ.0000000000000290

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Judgement-free clinic environment to welcome and serve clients of all ages
- Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support
- Effective clinic flow to care and support clients with age-related issues, ie..transitioning adolescent/adult care, referral tracking

Level of Evidence: Well-Defined Interventions with an evidence-base

Staff Training on Motivational Interviewing Skills, Strategies, and Tools

Summary:

Motivational interviewing is a client-centered, directive therapeutic style to enhance readiness for change by helping clients explore and resolve am- bivalence. An evolution of Rogers's person-centered counseling approach, Motivational Interviewing elicits the client's own motivations for change.

Core Components

Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.[1]

The approach upholds four principles:

1. Expressing empathy and avoiding arguing
2. Developing discrepancy
3. Rolling with resistance
4. Supporting self-efficacy (client's belief s/he can successfully make a change)

Training on Motivational Interviewing

While using the full range of Motivational Interviewing strategies, methods and tools requires intensive training and practice, all clinic staff interacting with patients can benefit from a relatively brief training to learn and implement a smaller, core set of Motivational Interviewing strategies.

[1] Miller, W. R., & Rollnick, S. (2013). *Applications of motivational interviewing. Motivational interviewing: Helping people change (3rd edition).* Guilford Press.

In one study[2] involving a clinic serving adolescents, 9 hours of foundational motivational interviewing training for clinicians, and 3 hours of foundational Motivational Interviewing training for other staff, improved patient outcomes.

Another study's[3] findings suggest that a two-day introductory course is effective in improving Motivational Interviewing knowledge, perception of the effectiveness of Motivational Interviewing, perception of behavior change, and the likelihood of Motivational Interviewing use. The findings contributed to sustainability recommendations to use Motivational Interviewing to promote ART adherence within a clinic setting.

It is critical to ensure that the clinic receives the right training(s), with the right dosage and the right trainer(s) for their specific context and planned use of Motivational Interviewing. Before holding a training on Motivational Interview, consider the following:

- What are we trying to accomplish (what are we hoping to improve by offering training for Motivational Interviewing? What are our desired results)?
- Who needs to be trained and for what specific purposes?
- How will we follow-up on this training and help staff embed what they have learned into their daily work?
- What changes at the clinic/organization are needed for Motivational Interviewing to takehold?
    - Changes to organization/clinic culture?
    - Changes to workflow?
    - Changes to documents (intake forms, screening tools, etc.)?
- Who will be the clinic "champion" to help ensure that patients benefit from thistraining?
- How will we know (measure) if Motivational Interviewing training has achieved its desired result(s)?

Embedding Motivational Interviewing strategies, methods, and tools in a Ryan White Clinic

Many people think of Motivational Interviewing as a tool of clinicians. In addition, clinics can embed the core principles of Motivational Interviewing into all aspects of its work, including but not limited to:

- Intake, including intake form and how questions are asked
- The work of Peer Navigators, especially around engaging new patients and re-engaging patients who have disengaged
- Primary Care Provider conversations about ART and ART Adherence
- Patient reports, questionnaires, and surveys

Training can help clinic staff understand Motivational Interviewing and help them see the benefits of this approach. But for Motivational Interviewing strategies, methods, and tools to fully take hold, the clinic/organization needs to cultivate a culture where this approach can thrive, provide ongoing training and support on the use of Motivational Interviewing and redesign its workflow and documents to fully align with this approach to care.

[2] Sanci, L., Chondros, P., Sawyer, S., Pirkis, J., Ozer, E., Hegarty, K., Yang, F., Grabsch, B., Shiell, A., Cahill, H., Ambresin, A. E., Patterson, E., & Patton, G. (2015). Responding to Young People's Health Risks in Primary Care: A Cluster RandoMotivational Interviewingsed Trial of Training Clinicians in Screening and Motivational Interviewing. *PloS one*, *10*(9), e0137581. https://doi.org/10.1371/journal.pone.0137581

[3] Ledesma, Lucy, "Implementation of Motivational Interviewing in a Multidisciplinary HIV Clinic in an AcadeMotivational Interviewingc Medical Setting"(2015).Doctoral Dissertations. Paper 29. https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1028&context=dissertations

Tips and Tricks:

- While it may be helpful to have one or more experts on Motivational Interviewing, the clinic should consider providing foundational training on Motivational Interviewing to all staff who come in contact with patients. The amount (dosage) of training can vary based upon the position from 1-2 hours on up.
- It may be useful to design training and follow-up related to specific improvement work at the clinic. For example, if the clinic wants to improve how it has open and honest conversations about substance use, it might offer a general foundational training in Motivational Interviewing, followed by a working session on how clinic staff can embed what they have learned into their conversations with patients and their screening for substance use.

Additional Resources (Existing Guides, Case Studies, etc.):

□ HRSA HIV/AIDS Bureau (HAB) **Innovative Models of Care: Motivational Interviewing**

- NMAC's **Motivational Interviewing and HIV: A Guide for Navigators**
- SAMHSA/HRSA Center for Integrated Health Solutions' **Motivational Interviewing** (2016)
- SAMHSA/HRSA Center for Integrated Health Solutions' **Motivational Interviewing for Better Health Outcomes** (2011)

□ **Motivational Interviewing Knowledge and Attitudes Test (MIKAT)**[4]

Suggested Measures:

Process Measures

- % of clinic staffed trained (annually)
- % of clinic staff who are able to achieve a perfect score on the MIKAT (see above) or similar test of knowledge of Motivational Interviewing
- % of clinic staff that agree or strongly agree with the statement "I am able to apply the principles of Motivational Interviewing in my daily work"
- % of clinic staff that agree or strongly agree with the statement "the clinic makes it easy for me to apply Motivational Interviewing in my daily work"
- % of clinic staff that agree or strongly agree with the statement "our use of Motivational Interviewing translates into better health outcomes for patients."

Outcome Measures

- % of patients that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that achieve viral suppression (Percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

[4] Leffingwell, T. R. (2006). Motivational Interviewing Knowledge and Attitudes Test (MIKAT) for evaluation of training outcomes. https://nanopdf.com/download/motivational-interviewing-quiz-oklahoma-state-university_pdf

Citations and Acknowledgements:

1. Miller, W. R., & Rollnick, S. (2013). *Applications of motivational interviewing. Motivational interviewing: Helping people change (3rd edition).* Guilford Press.
2. Sanci, L., Chondros, P., Sawyer, S., Pirkis, J., Ozer, E., Hegarty, K., Yang, F., Grabsch, B., Shiell, A., Cahill, H., Ambresin, A. E., Patterson, E., & Patton, G. (2015). Responding to Young People's Health Risks in Primary Care: A Cluster RandoMotivational Interviewingsed Trial of Training Clinicians in Screening and Motivational Interviewing. *PloS one*, *10*(9), e0137581. https://doi.org/10.1371/journal.pone.0137581
3. Ledesma, Lucy, "Implementation of Motivational Interviewing in a Multidisciplinary HIV Clinic in an Academic Motivational Interviewing Medical Setting"(2015).Doctoral Dissertations. Paper 29. https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1028&context=dissertations
4. Leffingwell, T. R. (2006). Motivational Interviewing Knowledge and Attitudes Test (MIKAT) for evaluation of training outcomes. https://nanopdf.com/download/motivational-interviewing-quiz-oklahoma-state-university_pdf

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Procedures to review various age groups and health outcomes data to make improvement actions if indicated

Indicator definitions are well established to track health outcomes for clients according to age group, including co-morbidities

Level of Evidence: Well-Defined Interventions with an evidence-base

Training on Continuous Improvement

Summary:

Organizational leaders frequently make bold statements about their commitment to quality and its components (e.g., safety, efficiency, effectiveness, value and listening to their customer). However, the real test of whether an organization is making quality improvement its north star is how well it has prepared its leaders and staff to apply quality concepts, methods and tools to daily work. Building capacity and capability for continuous improvement, therefore, is a fundamental building block of this journey.

Core Components

Building capacity and capability for continuous improvement requires the following set of interrelated and mutually supported components:

- Building a cascading system of learning that involves everyone, and we do mean everyone, in the organization.
- Developing a group of internal quality experts who can teach the concepts, methods and tools of QI.
- Developing Quality Improvement Coaches who can support improvement teams
- Developing a core curriculum of programs focused on QI and its various dimensions.
- QI learning sessions should be of varying length and be designed around multi-trait and multi-method principles of adult learning.
- Create an evaluation process to continuously gather participant experiences with the learning sessions.

Tips and Tricks:

- Don't plan to send all staff to a day or week of "training" and expect to see significant results in outcomes. Learning is a journey not a one-off training course.

- If your organization has multiple sites or clinics, take the QI workshops out to the sites rather than expecting the sites to all come to the corporate offices.
- Work to build internal expertise with QI rather than always bringing in consultants to deliver QI training sessions.
- Remember that the staff is responsible for the actual delivery of services, but management is responsible for quality. Quality is not a department!

Additional Resources (Existing Guides, Case Studies, etc.):

- Lloyd, R. "Quality is Not a Department" IHI blog posting, November 2018. http://www.ihi.org/resources/Pages/ImprovementStories/ImprovementTipQualityIsNotaDepartment.aspx
- Lloyd, R. "Standardize Before you Improve" IHI blog posting, July 3, 2018. http://www.ihi.org/communities/blogs/standardize-before-you-improve
- Lloyd, R. "What Health Care Can Learn from Making Motorcycles" IHI blog Friday, February 8, 2019 http://www.ihi.org/communities/blogs/what-health-care-can-learn-from-making-motorcycles
- Lloyd, R. "Building Capacity and Capability" *Healthcare Executive*, May/June 2018.
- IHI Whiteboard Videos on the Science of Improvement http://www.ihi.org/education/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx
- IHI On-Demand Videos on the Science of Improvement
  - Deming's System of Profound Knowledge and the Model for Improvement http://www.ihi.org/education/WebTraining/OnDemand/ImprovementModelIntro/Pages/default.aspx
  - Data Collection and Understanding Variation http://www.ihi.org/education/WebTraining/OnDemand/DataCollection_Variation/Pages/default.aspx
  - Using Run and Control Charts http://www.ihi.org/education/WebTraining/OnDemand/Run_ControlCharts/Pages/default.aspx

Suggested Measures:

Process Measures

- % of leaders, managers and staff completing QI workshops (stratified by type of program offered)
- % of leaders, managers and staff using QI concepts methods and tools in daily work
- # of hours spent in QI workshops (stratified by job category)
- Amount of money spent on QI workshops

Outcome Measures

- # of QI Expert in the organization (aka Improvement Advisors)
- # of Improvement Coaches
- # of QI teams working on improvement projects

- % of QI teams achieving their stated aims
- Estimated resources (e.g., time, work hours dollars)
- % of participants in QI sessions stating that the program will help them improve work processes and outcomes

Citations and Acknowledgements:

1. Lloyd, R. Quality health Care: A Guide to Developing and Using Indicators. 2nd Edition, Jones & Bartlett Learning, Burlington, MA, 2019.
2. Langley, J. et al. The Improvement Guide. 2nd Edition, Jossey-Bass Publisher, 2009.
3. Lloyd, R. *Building Capacity and Capability for Improvement: embedding Quality improvement skills in NHS Providers*. NHS Improvement, Publication code: IG 36/17, September 2017.
4. Furnival J, Boaden R, Walshe K (2017), *Conceptualizing and assessing improvement capability: a review. International Journal for Quality in Health Care 1-8*. Available from: https://doi.org/10.1093/intqhc/mzx088 [accessed 3 August 2017]
5. Perla R, Provost L and Parry G "Seven Propositionsof the Science of Improvement: Exploring Foundations" *Quality Management in Health Care*, 22(3) 2013: 170–186.
6. Berwick D The "Science of Improvement" *Journal of American Medical Association,* 12 March 2008 299 (10).
7. Deming WE. *The New Economics*, 2nd edition, Cambridge: The MIT Press, 1994.

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- **Judgement-free clinic environment to welcome and serve clients of all ages**
- **Client-centered and client-driven support systems in place to provide individuals and peer-to-peer group support**
- **Strategies for addressing additional barriers, such as food security, legal support, housing, etc.**

Level of Evidence: Well-Defined Interventions with an evidence-base

Trauma-Informed Approaches: Improving Care for People with HIV

Summary:

According to NASTAD's Trauma-Informed Approaches Toolkit (see link below), being trauma-informed is an approach to administering services in HIV care that acknowledges that traumas may have occurred or may be active in clients' lives, and that those traumas can manifest physically, mentally, and/or behaviorally.

Core Components

SAMHSA offers 6 key principles of a trauma-informed approach:

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

NASTAD's Trauma-Informed Approaches Toolkit, discusses and provides guidance on the following components of integrated trauma informed approaches to care:

- Recognition & Awareness
- Foundational Knowledge
- Agency Readiness
- Process & Infrastructure
- Gather Information & Identify Opportunities
- Prioritize & Create a Work Plan
- Implement & Monitor
- Celebrate & Maintain

Tips and Tricks:

- □ While foundational knowledge can often to obtained through effective training, ensuring that a clinic uses trauma-informed approaches in every aspect of its work, requires changes to culture, processes and systems.
- Implementing effective trauma-informed approaches takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- NASTAD's **Trauma-Informed Approaches Toolkit**
- SAMHSA's **Trauma-Informed Approach: Improving Care for People Living with HIV Curriculum Trainer's Manual**
- SAMHSA's **Concept of Trauma and Guidance to a Trauma Informed Approach**
- **Attitudes Related to Trauma Informed Care (ARTIC) Scale**

Suggested Measures:

Process Measures

- % of staff who receive ongoing training on trauma-informed approaches
- Results on the ARTIC Scale or other validated tool to measure the use of trauma-informed approaches
- % of patients who agree or strongly agree with the statement "(Name of Clinic) helps me understand and address trauma"

Outcome Measures

- % of patients that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

1. Sales, J. M., Swartzendruber, A., & Phillips, A. L. (2016). Trauma-Informed HIV Prevention and Treatment. *Current HIV/AIDS reports*, *13*(6), 374–382. https://doi.org/10.1007/s11904-016-0337-5
2. Nightingale, V. R., Sher, T. G., Mattson, M., Thilges, S., & Hansen, N. B. (2011). The effects of traumatic stressors and HIV-related trauma symptoms on health and health related quality of life. *AIDS and behavior*, *15*(8), 1870–1878. https://doi.org/10.1007/s10461-011-9980-4
3. Baker, C. N., Brown, S. M., Wilcox, P. D., Overstreet, S., & Arora, P. (2016). Development and psychometric evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale. *School*

Mental Health: A Multidisciplinary Research and Practice Journal, 8(1), 61–76. https://doi.org/10.1007/s12310-015-9161-0

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Strategies to address additional barriers, such as food security, legal support, housing, etc.
- Processes in place for making customized referrals (after vetting potential referrals), following-up on referrals, and ensuring successful linkages
- Customized care plans for clients experiencing Age-related concerns and/or co-morbidities

Level of Evidence: Well-Defined Interventions with an evidence-base

Uber Health (or similar) Transportation Services

Summary:

A number of studies[5] have demonstrated that the lack of access to transportation has been consistently associated with sub-optimal ART adherence. Uber Health and similar medical transportation services can be an effective strategy for patients experiencing transportation barriers.

Core Components

Whether Uber Health or a similar service, the core components are:

Setting Up and Managing Medical Transportation Using Uber Health or Similar Service

- Create an online account for your clinic (Uber Health or other services)
- Train clinic staff on how to use the service including the workflow, paperwork, billing codes, and any approvals required
- Use a tracking sheet to document client identifiers, date of service, provider name, the reason for the ride, cost, etc.
- Use a survey for patients (users and non-users) and clinic staff to determine the level of satisfaction and improve how the clinic provides transportation services

Setting Up a Ride for a Patient

- Clinic staff use the Uber Health dashboard (or similar) to book a ride on-demand or for a future appointment for a patient
- The trip details are given to the passenger (patient) by a text message or a call at the time the ride is booked
- Trip details are confirmed once again when a driver is on the way to pick the patientup

- The passenger is picked up and dropped off as scheduled

[5] Cornelius, T., Jones, M., Merly, C., Welles, B., Kalichman, M. O., & Kalichman, S. C. (2017). Impact of food, housing, and transportation insecurity on ART adherence: a hierarchical resources approach. *AIDS care*, *29*(4), 449–457. https://doi.org/10.1080/09540121.2016.1258451

Tips and Tricks:

- It is important to consider patient needs and preferences for pick-up and drop-off locations and potential stigma when planning rides for patients (e.g. a client experiencing homelessness may not want to use a shelter as their pick-up location). Consult with each patient before scheduling the ride to make sure you are meeting their needs and preferences.
- Older adults, adults with vision issues and others may require additional assistance or alternatives.
- Implementing an effective Medical Transportation Program takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- □ ECHO Collaborative Video Presentation: **Transportation Services**
- □ **Uber Health Website**
- □ ECHO Collaborative Video Presentation: **SafeRide: Using Medical Transportation Services to Improve Access to HIV Care**
- □ **LYFT for Healthcare Website**
- Texas Department of Health and Human Services' **Medical Transportation Service Standards**

Suggested Measures:

Process Measures

- % of patients screened for transportation barriers
- % of patients with transportation barriers who are offered Medical Transportation Services
- % of patients offered Medical Transportation Services who utilize it
- % of patients using Medical Transportation Services that agree or strongly agree with the statement "Medical transportation services have helped me to improve my overall health."
- % of clinical staff that agree or strong agree with the statement "Medical transportation services are an effective strategy for improving the health of patients with transportation barriers.

Outcome Measures

- % of patients using medical transportation services that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients using medical transportation services that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

Cornelius, T., Jones, M., Merly, C., Welles, B., Kalichman, M. O., & Kalichman, S. C. (2017). Impact of food, housing, and transportation insecurity on ART adherence: a hierarchical resources approach. *AIDS care*, *29*(4), 449–457. https://doi.org/10.1080/09540121.2016.1258451

Dimension: Age

The Intervention Links to the Following Secondary Drivers:

- Judgement-free clinic environment to welcome and serve clients of all ages
- Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support
- Effective clinic flow to care and support clients with age-related issues, ie.. transitioning adolescent/adult care, referral tracking

Level of Evidence: A reasonably well-defined Intervention (numerous models) with an evidence-based

Use of Peer Navigators

Summary:

Peer navigator services are often useful for new patients, patients who have inconsistent engagement and patients who have disengaged. Several organizations participating in the ECHO Collaborative as well as several controlled studies have showed the efficacy of peer navigators, particularly around engagement and re-engagement.

Core Components

While there is significant evidence indicating the effectiveness of peer navigators in certain roles, the exact roles of peer navigators and the specific models used, vary. Many potential roles including:

- Community outreach to bring newly diagnosed and out-of-care clients to services
- Weekly/regular calls to check-in with patients and reminder calls for upcoming appointments
- Accompanying clients to appointments related to their overall care
- Coordinating and assisting with successful linkage and referral to other services and supports including assistance with transportation
- Treatment adherence education and support
- Having peer navigators conduct targeted outreach to patients who have disengaged from care.
- Having peer navigators serve as Waiting Room Milieu Managers (see separate write-up of this intervention)

Several potential models – see Additional Resources below.

Tips and Tricks:

- It appears that peer navigator programs are most successful when their roles are fully integrated into the clinic's care team
- Most models stress the importance of ongoing training, supervision and ongoing support of peers.
- Implementing an effective Peer Navigator program takes time, testing and refining before going to

scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

□ U.S. Health Resources and Services Administration (HRSA) - **Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates**

- HRSA's Target HIV - **Building Blocks to Peer Program Success: Toolkit for Developing HIV Peer Programs**
- AIDS United's **Best Practices for Integrating Peer Navigators into HIV Models of Care**
- ECHO Collaborative Video Presentation **– Peer Programs: A Community Health Worker Program**

Suggested Measures:

Process Measures

- % of patients offered to be linked to a peer navigator
- % of patients offered a peer navigator who accepts/use peer navigation services

Outcome Measures

- % of patients that have a peer navigator that agree or strongly agree that their peer navigator helps them achieve their HIV treatment and other life goals
  - Overall patient population
  - Segmented by race, gender identity, housing status, substance use status, and other relevant sub-populations
- % of patients that have peer navigators with improved viral suppression rates within 6 months
- % of patients with peer navigator that achieve viral suppression (percentage of patients with an HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Balancing Measures

- Comparison of improvement of viral suppression and achieving viral suppression (see outcome measures above) between patients with a peer navigator and patients that do not have a peer navigator.

Citations and Acknowledgements:

1. Melanie A. Thompson, Michael J. Mugavero, K. Rivet Amico, Victoria A. Cargill, Larry W. Chang, Robert Gross, Catherine Orrell, Frederick L. Altice, David R. Bangsberg, John G. Bartlett, Curt G. Beckwith, Nadia Dowshen, Christopher M. Gordon, Tim Horn, Princy Kumar, James D. Scott, Michael J. Stirratt, Robert H. Remien, Jane M. Simoni, and Jean B. Nachega. Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV:

Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel. Annals of Internal Medicine 2012 156:11, 817-833
2. Bradford, J. B., Coleman, S., & Cunningham, W. (2007). HIV System Navigation: an emerging model to improve HIV care access. *AIDS patient care and STDs*, *21 Suppl 1*, S49–S58. https://doi.org/10.1089/apc.2007.9987
3. AIDS United. Best Practices for Integrating Peer Navigators into HIV Models of Care. Washington, DC. 2015.

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Judgement-free clinic environment to welcome and serve clients of all ages
- Strategies to address additional barriers, such as food security, legal support, housing, etc.

Level of Evidence: Good idea worthy of testing

Waiting Room Milieu Manager

Summary:

Using a Milieu Manager to manage the waiting area, welcome people, help manage the atmosphere of the waiting room, act as liaison between patient and clinic staff, and help people feel comfortable.

Core Components

While numerous clinics use a Milieu Manager or similar position in their waiting rooms, this is not yet a well-defined intervention with well-defined components. In theory, an effective Waiting Room Milieu Manager strategy would include:

- Trained peers are used as Milieu Managers when feasible
- A job description clearly outlining the specific role, duties, and tasks of the Milieu Manager
- Milieu Manager role's position as part of the overall clinic team is clearly articulated and understood by all staff
- Specific duties and tasks might include:
  - Welcoming each patient as they enter the clinic, ensuring they understand how to sign-in and answering any immediate questions
  - Helping all first-time patients understand what the first visit will entail and preparing them to see their primary care provider and other members of the care team
  - Assisting patients with answering questions on any requested paperwork/forms
  - Helping administer questionnaires/surveys to better understand patient experiences and improve services (before and/or after a visit with primary care provider)
  - Providing educational material, including decision aids in the patient's preferred language
  - Monitoring the environment of the waiting room to help ensure that all patients feel safe and welcome
  - Encouraging patients to write down any questions or items they want to cover with the provider in advance of the visit
  - Acting as a peer health coach

  - Relating the needs of patients to clinic staff
  - Providing patient triage services for other members of the clinic team
  - Providing status updates to patients (especially if there has been a longwait)
  - Otherwise helping to ensure that the patient feels comfortable and prepared for their visit
- A simple and effective way to track the extent to which the Milieu Manager is:
  - Making clients feel welcomed (patient survey)
  - Preparing clients for their visits (patient survey)
  - Making the visit with the provider(s) more productive (provider survey)

Tips and Tricks:

- There are other potential names for this position, including Waiting Room Concierge and Waiting Room Manager
- Making effective use of a Milieu Manager takes time, testing and refining before going to scale, using continuous improvement methods.
- Ongoing, brief surveys of patients can help you determine if you are on the right track and can provide specific ideas for improvement
- The Boston Health Care for the Homeless Program has successfully used Milieu Managers tomake the waiting room (and sometimes some fairly substantial waits to see a provider) more welcoming and comfortable.

Additional Resources (Existing Guides, Case Studies, etc.):

- **Center for Care Innovations: Create a Waiting Room Concierge**
- **The Waiting Room "Wait": From Annoyance to Opportunity**
- Boston Health Care for the Homeless - **Sample Job Description for the MilieuManager**

Suggested Measures:

Process Measures

- % of patients who answer with a "yes" to the following question "Did you interact with/talk with a Milieu Manager during your most recent visit to the clinic?"
- % of patients that complete brief survey related to the effectiveness of the Milieu Manager (can be integrated into a large survey)

Outcome Measures

- **%** of patients that agree or strongly agree that the "[name of clinic] Milieu Manager (or similar) makes me makes me feel comfortable"
  - Overall patient population
  - Segmented by race, gender identity, housing status, substance use status and other relevant sub-populations
- **%** of patients that agree or strongly agree that the "[name of clinic] Milieu Manager (or similar)makes

me makes me feel better prepared for my visit"
    - Overall patient population
    - Segmented by race, gender identity, housing status, substance use status and other relevant sub-populations
- **%** of providers/clinic staff that agree or strongly agree that the "[name of clinic] Milieu Manager (or similar) makes the visit more productive"
- % of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year

Citations and Acknowledgements:

To come as this intervention develops an evidence base.

Dimension: Age

This Interventions Links to the Following Secondary Drivers:

- Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support
- Strategies to address additional barriers, such as food security, legal support, housing, etc.
- Customized care plan for clients experiencing Age-related concerns and/or co-morbidities

Level of Evidence: Good idea worthy of testing

Walk-In Availability and Open Access to Care

Summary:

Walk-in availability of and open access to Ryan White HIV/AIDS Program-funded clinics allow clients to come for services at a time that is convenient for them and be seen by appropriate providers within a reasonable period during normal business hours.

Core Components

Walk-in availability and open access are often cited as powerful strategies for reducing barriers to care and retention to care. But little has been written to help guide busy Ryan White HIV/AIDS Program-funded clinics to implement these and similar practices. An effective walk-in availability and open access strategy would like to include the following:

- Regular communication with patients about walk-in availability and open access options (including explicit mention of these during each visit and in written communications)
- Setting an aim for being able to see any/all walk-in patients within 30 minutes of arrival using an operational definition of being seen by a member of the clinic's care team within 30 minutes of a patient signing in.
- Developing workflows, systems, and processes to see walk-in patients within 30 minutes of arrival:
  - Continually understanding the characteristics of walk-in patients to better meet their needs and preferences.
  - Continually understanding walk-in numbers at the clinic (this can be done by plotting the daily number of walk-ins to the clinic and then finding the median, high and low numbers of walk-ins over the previous 2-4 week period)
  - Continually understanding the "surge" times for walk-in clinics (this can be done by plotting the times of walk-ins to the clinic and then finding the peak and low times for walk-ins over

the previous 2-4 week period)

- Designing a system with patients and front-line staff to accommodate the anticipated number of walk-in patients including during “surge” times

Developing and continually refining the theory for how the clinic can

accommodate walk-ins in the form of a Driver Diagram
- Developing a workflow (including staff roles/responsibilities) that aligns with the aim, driver diagrams anticipated number of walk-ins and surge times
- Ensuring that all staff understand the current workflow, systems and processes for achieving the goal of seeing all walk-ins within 20 minutes of arrival
- Putting in place a system that any staff can use to call for additional support if they are having trouble meeting the walk-in aim
- Using continuous improvement methods to track progress toward achieving the aim, using data to improve the processes and continually updating the system based on changes to walk-in data and/or surge times.

Tips and Tricks:

- Implementing an effective and efficient walk-in availability system takes time, testing and refining before going to scale, using continuous improvement methods.
- Keeping a work board up at the clinic that monitors the "wait time" for the previous day and run charts for the current period can be useful and, if done correctly, motivating to clinic staff.
- The **Max Clinic** in Seattle, Washington[8] offered walk-in access to primary care five afternoons per week and walk-in access to case management services 5 full days a week

Additional Resources (Existing Guides, Case Studies, etc.):

- To come as resources become available

Suggested Measures:

Process Measures

- % of walk-in patients seen within 20 minutes (using the operational definition)

Outcome Measures

- % of walk-in patients that achieve viral suppression within 4 months (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Balancing Measure

- Comparison of wait times for scheduled patient visits and walk-ins

[8] Dombrowski, J. C., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., & Golden, M. R. (2018). The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington. *AIDS patient care and STDs*, *32*(4), 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5905858/

Citations and Acknowledgements:

Dombrowski, J. C., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., & Golden, M. R. (2018). The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington. *AIDS patient care and STDs*, *32*(4), 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5905858/

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Effective clinic flow to care and support clients with Age-related issues, i.e., transitioning adolescent/adult care, referral tracking
- Customized care plan for clients experiencing Age-related concerns and/or co-morbidities
- Strategies to address additional barriers, such as food security, legal support, housing, etc.
- Geriatric and pediatric health providers are integrated into the HIV care team and participate in case conferences

Level of Evidence: Good idea worthy of testing

Case Conferencing to Support ART Adherence

Summary:

Case conferencing allows a multi-disciplinary team to review patients (either select patients or all patients), understand their challenges and assets, and develop customized strategies to stay in ongoing HIV care and improve viral suppression rates.

Core Components

Case Conferencing is frequently cited as an important component of an effective Ryan White HIV/AIDS Program-funded clinic and several evidence-based practices list case conferencing as a core component. Despite this, case conferencing itself is often not well-defined. While the core components of a successful case conferencing strategy targeted to reach viral suppression, are not fully defined, the following components were identified in the CQII Initiative as useful:

- Regularly scheduled
- Triage and selection process to prioritize (not spontaneous or everyone)
- Standard format for presenting (often using a standard form)
- Didactic at the beginning
- Structured presentation
- Questions/consultation
- Development of a strategy/next steps
- Strategy and next steps are documented in the patient's record
- Patient record records the extent to which strategy and next steps are implemented and the apparent result(s) of these
- Subsequent case conferences for the same patient review strategies and next steps developed previously, document what did (and did not) work, and a revised strategy and nextsteps.

- The staff both consult and present their own cases
- Diversity of positions and roles within the room (including case management, peers, pharmacy, etc.)

- Includes outside providers, when appropriate and feasible; the client's right to privacy and confidentiality in contacts with other providers is maintained
- Frequency depends on the organization and its culture
- 3-4 cases per Case Conferencing Session
- Case Conferencing session is not longer than one hour

Tips and Tricks:

- To be sustainable, case conferencing needs to fit within the workflow of the clinic and be valued by participating staff as a great use of their time.
- Effective case conferencing takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- **Targeted Team Discussions for Viral Load Suppression - I**n this video, Margaret Haffey presents on a quality improvement project implemented by Boston Medical Center that used targeted team discussions to improve viral load suppression. The steps they took, including tools used to assess viral load suppression and changes to their team meetings, are covered in this presentation.

- **New York State Department of Health HIV Case Coordination and Case Conferencing Strategies**

- **Sample Case Conferencing Form (NY State Department of Health)**

Suggested Measures:

Process Measures

- % of case conferences presented using the standard format and standard form
- % patients who have not achieved viral suppression after 6 months who are reviewed at a case conference
- % of patient with case conferences that have strategy and next steps detailed in the patient record
- % of patient with case conferences that document the extent to which strategies and next steps have been implemented
- % of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year

Outcome Measures

- % of patients who receive case conferences that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Balancing Measure

- Comparison of viral suppression rates of patients who receive case conferences (6 months post-case conference) with patients who do not receive case conference

Citations and Acknowledgements:

To come as this idea is tested and develops an evidence base.

Dimension: Age	The Undectables Program
This Intervention is Linked to the Following Secondary Driver: • Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support • Strategies to address additional barriers, such as food security, legal support, housing, etc.	
Level of Evidence: Well-Defined Interventions with an evidence-base	

Summary:

A stepped approach to ART adherence for people with HIV who have mental health issues, substance use issues and/or are experiencing homelessness or age related challenges.

Core Components

The Undetectables Program as originally implemented by Housing Works and evaluated by Housing Works and the University of Pennsylvania consisted of the following core components:

- Stepped approach to ART adherence
- Individual-level ART adherence planning and support
  - Case conferences among client, health providers & case manager
  - Motivational interviewing & assistance to meet subsistence needs
  - Behavioral health assessment/referral
- $100 gift card incentive for quarterly lab result showing undetectable viral load (≤50 copies/ml), up to 4 per year
- Cognitive behavioral therapy (CBT) adherence support groups
- Adherence devices such as pill-boxing and text or other daily medication reminders
- Directly observed ART therapy (DOT) –formal and informal

Since the successful pilot, Undetectable Projects have been successfully implemented in more than a dozen locations.

Tips and Tricks:

- Organizations interested in starting an Undetectables Program can receive the following support from Housing Works:
  - **Comprehensive technical assistance** to guide agencies through adopting the Undetectables program, from exploring the model to assessing organizational readiness to training staff at all levels.

- **An Undetectables Program Guide** to support full program implementation. Resources include training slides, reference materials, step-by-step instructions, sample forms and policies and marketing materials.

- Implementing an effective Undectables Program takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- Housing Works' Undetectables Program Site - **LiveUndetectable.org**
- **Housing Works' Presentation on the Undetectables Project**
- **"The Undetectables" & "PrEP Heroes" HIV Suppression Campaigns**

Suggested Measures:

Process Measures

- % of patients living with HIV who have mental health issues, substance use issues and/or experiencing homelessness and housing stability that are referred to an Undetectables Program
- % of patients referred to an Undetectables Program who successfully enter a program
- % of patients participating in an Undetectables Program that agree or strongly agree with the statement "My Undetectables Program has helped me to achieve my HIV viral suppression goals.
- % of patients participating in an Undetectables Program that agree or strongly agree with the statement "My Undetectables Program has helped me to achieve other life goals.

Outcome Measures

- % of patients participating in an Undetectables Program with improved viral suppression rates within 6 months
- % of patients participating in an Undetectables Program that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

Housing Works www.housingworks.org and the Undetectables Program Site https://liveundetectable.org

Dimension: Age

This Intervention Links to the Following Secondary Drivers:

- Effective clinic flow to care and support clients with Age-related issues, ie., transitioning adolescent/adult care, referral tracking
- Strategies to address additional barriers, such as food security, legal support, housing, etc.
- Process for engaging clients to take advantage of linkages and promote offered age-related services

Level of Evidence: Well-Defined Interventions with an evidence-base

Patient Navigator Model (SPNS Project)

Summary:

This model, tested and evaluated as part of a Special Projects for National Significance (SPNS) project, is a time-limited (generally 12 months) service delivery process that helps people with HIV (PWH) to obtain timely HIV-related care to optimize their health.

The target populations are:

1. Newly diagnosed PWH
2. PWH who have fallen out of care for six months or longer
3. PWH who have never received care;
4. PWH who are at risk of being lost-to-care.

It may be particularly useful to patients with substance use issues and who require more intensive supports.

Core Components

The model includes 5 Steps:

1. **Client Referred to Patient Navigation Services -** After a positive test result, the client is referred to VDH's Patient Navigation intervention via a Disease Intervention Specialist (DIS) or to another community partner. During this step, the client completes a Coordination of Care and Services Agreement (CCSA), which provides his or her consent to receive Patient Navigation services and share information with designated providers.

2. **Client Intake** - The Patient Navigator conducts an assessment of the client's barriers to accessing and staying in care. The assessment is not limited to one interaction; a full assessment may take weeks or even months. During this step, the Patient Navigator and client work hand-in-hand to develop a linkage-to-care plan, which addresses the client's barriers to care and strategies to address these barriers.

3. **Routine Client Encounters** - Once connected to care, the Patient Navigator and client work together

on a retention plan, which outlines challenges or barriers that have been resolved and outstanding challenges that require continued attention. During these client encounters, the Patient Navigator may also identify other HIV infected individuals through HIV testing of clients' partners and contacts.

4. **Client Transition** - The Patient Navigator performs an assessment of the client's readiness for transition out of the Patient Navigation program at least every six months. When the client is determined to be successfully engaged in care, the client is transitioned out of the Patient Navigation intervention into community care—such as case management services—or into self-managed care.

5. **Client Discharged** - The Patient Navigatordocuments the client's transition plans when discharging him or her from care and that the transition has occurred. Although the intervention is designed to result in self-management, clients may be re-enrolled based on new or changing needs. Re-enrolled clients would need to go through the same referral and initial assessment process and would be required to sign a new CCSA form.

Tips and Tricks:

- While this model can utilize trained peer navigators, it should not be confused with a Peer Navigation. See also the intervention titled "**Use of Peer Navigators**".
- This model includes using Motivational Interviewing strategies, methods and tools. See also the Intervention titled "**Staff Training on Using Basic Motivational Interviewing Skills, Strategiesand Tools**".

Additional Resources (Existing Guides, Case Studies, etc.):

- **SPNS Project Patient Navigation Intervention Fact Sheet**
- **Intervention Guide—SPNS Demonstration Model on Patient Navigation Intervention**

Suggested Measures:

Process Measures

- The extent to which the Clinic has the resources included in the Toolkits ResourcesChecklist
- % of clinic staff who agree or strongly agree that the use of the Patient Navigator Model has resulted in better health outcomes for their patients.

Outcome Measures

- % of patients that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Improving Health Outcomes: Moving Patients Along the HIV Care Continuum Intervention Guide: SPNS Demonstration Model on Patient Navigation Intervention. Rockville, Maryland: U.S. Department of Health and Human Services, 2018.

Dimension: Age	Patient Self Care Plans
This Intervention is Linked to the Following Secondary Drivers: • Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support • Customized care plan for clients experiencing Age-related concerns and/or co-morbidities	
Level of Evidence: Good idea worthy of testing	

Summary:

A Patient Self Care Plan is a patient-centered planning technique that recognizes a patient's own strengths, assets and networks as part of their overall care plan.

Core Components

A Strategy for Using a Patient Self Care Plan might contain the following elements:

- Training for relevant staff on the purpose and use of the Patient Self Care Plan and how to support patients in developing their own
- Developing a brief patient self-assessment form and a brief patient Self Care plan form with clinic patients and utilizing the resources provided below.
  - A brief, user-friendly patient self-assessment might
    - include: A survey of the patient's own assets
    - An understanding of their family and social networks
    - An understanding of what (in their words) is important to them and could include prompts such as "favorite quotes", etc.
    - Areas in which they would like to include (include in their Self Care Plan)
  - A brief, user-friendly patient care form might include:
    - Patient goals (in their own words)
    - What they can do to help achieve their goals
    - Who they can call on (support system) to help them achieve their goals
    - How they will know if their plan is working or starting to work
- A simple and effective way to track the extent to which developing a Patient Self Care Plan:
  - Is viewed as useful by patients
  - Makes patients feel more involved in their own care
  - Results in better patient outcomes
- The patients' goals and strategies in their Self Care Plan can be used to motivate patients, to re-energize them when they are feeling down, and to help ensure that the care provided meets the patient's needs
- The plan can be reviewed and updated with the patient at regular intervals (e.g. every six months)

Tips and Tricks:

- Making effective use of Patient Self Care Plans takes time, testing, refining and ability to continually monitor and improve
- Ongoing, brief surveys of patients can help you determine if you are on the right track and can provide specific ideas for improvement
- Patient Self Care Plans can help build deeper, more authentic relationships between patient and provider.
- Ursuline Sisters HIV/AIDs ministry uses a Self Care plan that allows a patient to develop a detailed plan for what they will do (or not do) during specific situations and to practice regular Self Care.

Additional Resources (Existing Guides, Case Studies, etc.):

- **Common Elements in Self-Management of HIV**
- **Institute for Healthcare Improvement: HIV Self-Management and Adherence**
- Ursuline Sisters HIV/AIDs Ministry uses an assessment adapted from the following: Saakvitne, K. W., & Pearlman, L. A. (1996). Transforming the pain: A workbook on vicarious traumatization. New York: W.W. Norton & Company.

Suggested Measures:

Process Measures

- % of patients that complete brief survey related to their use of the Patient Self Care Plan (can be integrated into a large survey)

Outcome Measures

- **%** of patients that agree or strongly agree that "The Patient Self Care Plan is useful"
  - Overall patient population
  - Segmented by race, gender identity, housing status, substance use status and other relevant sub-populations
- **%** of patients that agree or strongly agree that "The Patient Self Care Plan allows me to be more involved in my HIV Treatment"
  - Overall patient population
  - Segmented by race, gender identity, housing status, substance use status and other relevant sub-populations
- % of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year

Citations and Acknowledgements:

Age– Core Interventions: Eliminating Viral Suppression Disparities

To come as this idea is tested and develops an evidence base.

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Customized care plan for clients experiencing Age-related concern and/or co-morbidities
- Process for engaging clients to take advantage of linkages and promote offered age-related services
- Judgement-free clinic environment to welcome and serve clients of all ages
- The care team understands the signs of potential complication/barrier due to Age concerns

Level of Evidence: Well-Defined Interventions with an evidence-base

U=U Education Initiatives

Summary:

The science[7] has confirmed that as a person living with HIV continues to use ART as prescribed gets to undetectable they can no longer sexually transmit the virus to other people or, more simply put, Undetectable = Untransmittable or U=U. Communicating this to patients can help motivate ART adherence, reduce stigma and improve their wellbeing.

Core Components

Various U=U educational initiatives or communication campaigns are sharing the U=U message, including customized and targeted strategies for specific subpopulations of people with HIV.

The **Prevention Access Campaign** summarizes the message as follows:

The U=U message is an unprecedented opportunity to transform the lives of millions of people with and affected by HIV and to radically transform the field:

- Well-being of people with HIV: Transforms the social, sexual, and reproductive lives of people with HIV by freeing them from the shame and fear of sexual transmission to their partners.
- HIV stigma: Dismantles the HIV stigma that has been destroying lives and impeding progress in the field since the beginning of the epidemic.
- Treatment goals: Reduces the anxiety associated with testing and encourages people with HIV to stay on treatment to stay healthy and prevent transmissions to their partners.
- Universal access: Offers a critical public health argument in advocacy for universal access to treatment, care, and diagnostics to save lives and prevent new transmissions, bringing us closer to ending the epidemic.

[7] Eisinger, R. W., Dieffenbach, C. W., & Fauci, A. S. (2019). HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. *JAMA*, *321*(5), 451–452. https://doi.org/10.1001/jama.2018.21167

Tips and Tricks:

- While generalized messaging about U=U is helpful, some people with HIV will need customized messaging to understand and process what U=U means for them and their lives.
- U=U messaging needs to go beyond posters in the clinic, to messaging that is shared consistently and accurately by providers with every patient and that is embedded into the workflow of the clinic.
- Initial conversations on U=U should include a discussion of what the message means to the patient and how they live their lives to both increase motivation for ART adherence and decrease stigma.

Additional Resources (Existing Guides, Case Studies, etc.):

- The Prevention Access Campaign provides a full range of resources on **U=U Communications Strategies for Providers**
- ECHO Collaborative Video Presentation: **Communicating U = U**
- British HIV Association (BHIVA) Presentation: **Do You Speak U = U?**

Suggested Measures:

Process Measures

- % of patients that are provided the U=U message by a provider
- % of patients who can articulate the U=U message in a way that is accurate and meaningful to them
- % of patients who agree or strongly agree with the statement "U=U motivates me to take my medication as prescribed."

Outcome Measures

- % of patients that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

1. Eisinger, R. W., Dieffenbach, C. W., & Fauci, A. S. (2019). HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. *JAMA*, *321*(5), 451–452. https://doi.org/10.1001/jama.2018.21167
2. Rendina, H. J., & Parsons, J. T. (2018). Factors associated with perceived accuracy of the Undetectable = Untransmittable slogan among men who have sex with men: Implications for messaging scale-up and implementation. *Journal of the International AIDS Society*, *21*(1), e25055. https://doi.org/10.1002/jia2.25055

Dimension: Age

This Intervention is Linked to the Following Secondary Driver:

- Effective clinic flow to care and support clients with Age-related issues, i.e., transitioning adolescent/adult care, referral tracking
- The care team understands the signs of a potential complication/barrier due to Age concerns
- Geriatric and pediatric health providers are integrated into the HIV care team and participate in case conferences

Level of Evidence: Well-Defined Interventions with an evidence-base

Collaborative Care Model

Summary:

The integration of physical and mental health care is an important component in effective patient care for patients with co-morbid conditions. The Collaborative Care Model offers an evidence-based[2] approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor patients' progress.

Core Components

According to the American Psychiatric Association, the Collaborative Care Model consists of 5 key elements:

1. **Patient-Centered Team Care -** Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

2. **Population-Based Care -** Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving, and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

3. **Measurement-Based Treatment to Target -** Each patient's treatment plan clearly articulates personal goals and clinical outcomes and is routinely measured by evidence-based tools. Treatments are actively changed if patients are not showing improvement as expected until the clinical goals are achieved.

4. **Evidence-Based Care -** Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. The Collaborative Care Model (CoCM) has a substantial evidence base for its effectiveness, one of the few integrated care models that do.

[2] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews*, *10*, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

5. **Accountable Care -** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Tips and Tricks:

- In addition to detailed implementation guide, the American Psychiatric Association offers guidance on billing and payment structures to make use of this model sustainable for clinics (see Additional Resources section below).
- Successful implementation of the Collaborative Care Model takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- American Psychiatric Association's **Collaborative Care Model Resources**. Among other relevant materials, this site offers:
  - Access to training, including online training
  - A step-by-step Implementation Guide
  - Draft Job Descriptions
  - Examples across different healthcare settings
  - Billing and Payment Models

- McMaster University's **Identifying and Assessing the Core Components of Collaborative Care** offers guidance on how to assess fidelity to the model.

- AIMS Center's **Checklist of Collaborative Care Principles and Components**

Suggested Measures:

Process Measures

- The extent to which the clinic implements the Collaborative Care Model in accordance with the AIMS Center's Checklist of Collaborative Care Principles
- % of patients for whom Collaborative Care is indicated that receive Collaborative Care

Outcome Measures

- % of patients that receive Collaborative Care that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that receive Collaborative Care that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews*, *10*, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

Dimension: Age

This Intervention is Linked to the Following Secondary Drivers:

- Judgement-free clinic environment to welcome and serve clients of all ages
- Process for engaging clients to take advantages of linkages and promote offered age-related services
- Customized care plan for clients experiencing Age-related concerns and/or co-morbidities

Level of Evidence: Well-Defined Interventions with emerging evidence- base

Tele-Health to increase ART Adherence

Summary:

There is emerging evidence (see Citations section) that telehealth with patients can help address several barriers to care, improve health outcomes and can help improve ART adherence. There is also evidence to recommend the addition of tele-mental health for patients with a mental health issue.

Core Components

The American Medical Association outlines twelve steps in developing an effective telehealth practice:

1. Identifying a Need
2. Forming the Team
3. Defining Success
4. Evaluating the Vendor
5. Making the Case
6. Contracting
7. Designing the Workflow
8. Preparing the Care Team
9. Partnering with the Patient
10. Implementing
11. Evaluating Success
12. Scaling

In terms of telehealth to improve ART adherence, there are several models that appear to be effective including:

- Telehealth between a primary care provider and a patient to discuss medication and ART Adherence and/or other health concerns
- Tele-mental health between a therapist and a patient in which counseling and/or therapy is provided virtually and could include a discussion related to addressing barriers to ART adherence
- Telehealth between a primary care provider and an HIV (or other specialist) to have a rapid consult and receive expert advice.

Tips and Tricks:

- The Lallie Kemp Medical Center has found that providing patients with a mental health issue with a referral for psychiatry telehealth appointments the same day as their HIV clinic appointments is an effective and efficient way to refer patients to mental health telehealth services.
- Telehealth is not a one-size-fits-all intervention and it is helpful to design the clinic's program with providers, front-line staff and patients to make sure it meets their needs
- It is important to add an Equity Lens when developing a telehealth program to identify who might be left out or have barriers to accessing telehealth and developing strategies to remove or mitigate these barriers.
- Developing an effective telehealth program takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- HRSA's **Guide to Expanding HIV Care Through Telehealth**
- American Medical Association's **Telehealth Implementation Play Book**

□ **U.S. Department of Health and Human Services website on Telehealth**

- Institute for Healthcare Improvement's **Recommendations for Designing High Quality Telehealth**
- Institute for Healthcare Improvement's **Virtual Learning Hour Special Series: Telemedicine: COVID-19 and Beyond**
- American Psychiatric Association and American Telemedicine's **Best Practices in Telemental Health**
- Rural Health Information Hub's **Telehealth and Use of Technology to Improve Access to Care for People with HIV/AIDS**
- AHRQ's **Sample Telehealth Consent Form**

Suggested Measures:

Process Measures

- % of patients offered telehealth services and supports
- % of patients offered telehealth services and supports that participate in telehealth
- % of clinic staff that agree or strongly agree to the statement "Telehealth improves health outcomes for our clinic's patients"
- % of patients participating in telehealth that agree to the statement "telehealth has helped to improve my health".

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Outcome Measures

- % of patients participating in telehealth that have not yet achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients participating in telehealth that achieve viral suppression (percentage of patients with an HIV viral load less than 200 copies/ml at last viral load test during the measurement year)