



## **Core Interventions**

**Eliminating Disparities in Viral Suppression Rates  
Ryan White HIV/AIDS Program (RWHAP)-Funded Clinics Due to**

**Housing Instability and Homelessness**

**6.9.2020**

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## Dimension: Housing

### This Intervention is Linked to the Following Secondary Drivers:

- Welcoming and judgement-free clinic environment to clients experiencing housing insecurity
- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems
- Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support

**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 ambivalence. 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.<sup>1</sup>

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.

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

In one study<sup>2</sup> 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<sup>3</sup> 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 likelihood of Motivational Interviewing use. The findings contributed 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 Interviewing, 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 take hold?
  - 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 this training?
- 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.

<sup>2</sup> 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 Randomized Trial of Training Clinicians in Screening and Motivational Interviewing. *PLoS one*, 10(9), e0137581. <https://doi.org/10.1371/journal.pone.0137581>

<sup>3</sup> Ledesma, Lucy, "Implementation of Motivational Interviewing in a Multidisciplinary HIV Clinic in an Academic 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 \(MIKAT\)](#)<sup>4</sup>

## 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)

<sup>4</sup> 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](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 Randomized 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](https://nanopdf.com/download/motivational-interviewing-quiz-oklahoma-state-university_pdf)

<b>Dimension: Housing</b>	<b>The Undetectables Program</b>
<b>This Intervention is Linked to the Following Secondary Driver:</b> <ul style="list-style-type: none"><li>• Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support</li></ul>	
<b>Level of Evidence:</b> 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.

## 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 ( $\leq 50$  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 Undetectables 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](https://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](http://www.housingworks.org) and the Undetectables Program Site <https://liveundetectable.org>



<b>Dimension: Housing</b>	<b>Use of Peer Navigators</b>
<b>The Intervention Links to the Following Secondary Drivers:</b> <ul style="list-style-type: none"><li>• Welcoming and judgement-free clinic environment</li><li>• Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support</li><li>• Effective clinic flow to care and support clients</li></ul>	
<b>Level of Evidence:</b> A reasonably well-defined Intervention (numerous models) with an evidence-base	

## 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 accept/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 a 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.

<b>Dimension: Housing</b>	<b>Trauma-Informed Approaches: Improving Care for People with HIV</b>
<b>This Intervention is Linked to the Following Secondary Drivers:</b> <ul style="list-style-type: none"><li>• Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support</li><li>• Customized care plan for all clients experiencing substance use issues and/or mental health concerns</li></ul>	
<b>Level of Evidence:</b> Well-Defined Interventions with an evidence-base	

### 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 be 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: Housing

### This Intervention Links to the Following Secondary Drivers:

- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems
- Strategies to address additional barriers, such as food security, legal support, etc.

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 experiencing homelessness 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 Navigator documents 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, Strategies and 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 Resources Checklist
- % 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.

<b>Dimension: Housing</b>	<b>Uber Health (or similar) Transportation Services</b>
<b>This Intervention is Linked to the Following Secondary Drivers:</b> <ul style="list-style-type: none"><li>• Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems</li><li>• Strategies to address additional barriers, such as food security, legal support, etc.</li></ul>	
<b>Level of Evidence:</b> Well-Defined Interventions with an evidence-base	

## Summary:

A number of studies<sup>5</sup> 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 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 service)
- 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, reason for 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 patient up
- The passenger is picked up and dropped off as scheduled

<sup>5</sup> 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>

<b>Dimension: Housing</b>	<b>Optimal Linkage and Referral (Active Referral Intervention)</b>
<b>This Intervention is Lined to the Following Secondary Drivers:</b> <ul style="list-style-type: none"><li>Processes in place for making customized referrals (after vetting potential referrals), following-up on referrals and ensuring successful linkages</li><li>Housing service providers are integrated into the HIV care team and participate in case conferences</li></ul>	
<b>Level of Evidence:</b> Well-Defined Interventions with an evidence-base	

## 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<sup>6</sup> 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<sup>7</sup> 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

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

<sup>7</sup> 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
<b>Psychosocial</b>	
Low self-efficacy <sup>19</sup>	Strength-based case management
Health illiteracy <sup>19</sup>	HIV counseling and education, appropriate and varied educational materials
Concerns for confidentiality <sup>20</sup>	Explain and post confidentiality protections, provide private spaces for triage and examination
Concerns for stigma <sup>21</sup>	Nonjudgmental and inclusive approach and clinic environment
Language barriers <sup>19,22</sup>	Access to translation services through staff on site or by phone
Cultural barriers <sup>16,22</sup>	Cultural competency training, hiring cultural concordant staff
Substance use <sup>23</sup>	Screening for, and access or referrals to, substance-abuse programs
Mental illness <sup>16</sup>	Screening for, and access or referrals to, mental health services
Isolation <sup>20</sup>	Peer patient navigation, support group, case management
<b>Socioeconomic</b>	
Homeless <sup>17</sup>	Access to HIV/AIDS housing resources
Poverty <sup>16,17</sup>	Access to jobs training, social security disability benefits, or poverty reduction programs.
Lack of transportation <sup>18</sup>	Providing HIV care appointments at locations convenient to the patient; directly providing transportation assistance
Lack of insurance <sup>16,18</sup>	Providing health insurance enrollment service at the clinic or referrals to such
Health care system Complexity of health care systems <sup>17,18</sup>	Colocating HIV care and STD clinics; strong referral or linkage systems
Complexity of insurance systems <sup>18,19</sup>	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>

<b>Dimension: Housing</b>	<b>Training on Continuous Improvement</b>
<b>This Intervention is Linked to the Following Secondary Drivers:</b> <ul style="list-style-type: none"><li>• Procedures to review housing and health outcomes data and take improvement actions if indicated</li><li>• Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems</li><li>• Client-centered and client-driven support systems in place to provide individual and peer-to-peer group support</li></ul>	
<b>Level of Evidence:</b> Well-Defined Interventions with an evidence-base	

## 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](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](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*. 2<sup>nd</sup> Edition, Jones & Bartlett Learning, Burlington, MA, 2019.
2. Langlely, J. et al. *The Improvement Guide*. 2<sup>nd</sup> 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 Propositions of 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: Housing

### This Interventions Links to the Following Secondary Drivers:

- Ongoing engagement with care team helps ensure clients are comfortable discussing housing status
- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems
- Customized care plan for all clients experiencing housing instability

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 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 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<sup>8</sup> 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

<sup>8</sup> 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: Housing

### This Intervention is Linked to the Following Secondary Drivers:

- Welcoming and judgement-free clinic environment to clients experiencing housing insecurity
- Ongoing engagement with care team helps ensure clients are comfortable discussing housing status
- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems

**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 there are numerous clinics that 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 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 long wait)
- 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 to make 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 Milieu Manager](#)

## 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 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.