

Promoting Linkages to Care for Newly Diagnosed HIV + Persons in Racial and Ethnic Communities

Ken Malone

HIV Testing Project Coordinator

Harris County Hospital District

August 25, 2010

Ryan White Grantees Meeting

Disclosure

- The author has no financial interest or other conflicts of interest to disclose
- Funding for this project is supported by grant number 5U62PS000775-02 from the Centers for Disease Control and Prevention through a collaboration with the Houston Department of Health and Human Services

Learning Objectives

1. By the end of this session, participants will be able to identify best practices and successful models that can be used to create and/or expand HIV testing and linkage-to-care services between hospital emergency and public health departments and Ryan White Program-funded HIV care providers serving members of minority communities.
2. By the end of this session, participants will be able to describe where and how members of racial and ethnic minority communities get tested for HIV, identify the barriers that newly diagnosed HIV-positive members of minority groups face accessing and engaging in HIV care, and explain the consequences of missed opportunities for HIV testing in nontraditional settings for health outcomes.
3. By the end of this session, participants will be able to identify collaborative approaches that intra-organizational and inter-organizational HIV testing and linkage-to-care initiatives have used to plan and coordinate their efforts and to address the system-, community-, organizational-, clinician-, and client-level barriers for implementing or expanding linkage-to-care programs for newly diagnosed HIV-positive members of racial and ethnical minority groups.

Ben Taub General Hospital



Key Elements of the RUSH Program (Routine Universal Screening for HIV)

- Routine HIV testing is Opt-Out
 - No additional consent is needed
 - Inform patients that they will be tested, unless they opt out
- Routine testing of patients aged 16-64
- Conventional blood test is utilized
- Only patients receiving a blood draw are screened
- Dedicated Service Linkage Workers to follow-up with positive patients and linkage to care
- Link to City of Houston DIS Workers

What Defines Service Linkage

- Patient is seen in the hospital or clinic setting
- Patients receive post-test counseling and has their needs assessed
- Appointments are made for eligibility, screening and doctor
- Patient's status is monitored to insure that appointments are kept

Barriers to Linkage to Care

- Denial of disease and stigma
- Breakdown in relationships
- Loss of family support and social support
- Substance abuse
- Depression and other mental illnesses
- Other responsibilities – work, children, etc
- Fear of family disclosure

Routine Universal Screening for HIV (RUSH) Program

Ben Taub General Hospital

August 04, 2008 – July 15, 2010

■ Total Tests	61,320
■ New Positives	331
■ Prevalence	0.54%
■ Previous Positives	911
■ Overall Prevalence	1.49%
■ Total Positives	1242
■ New +s linked to care	276 or 83%

Challenges

- Staff and provider buy-in
- Data Issues—collection, assimilation, and analysis
- Lack of cost effectiveness data
- Communications with the laboratory
- Economic conditions
- EC environment

Lessons Learned

- Training is continuous
- Keeping up with the changing times
- Culture Change of an existing department
- Building a network of colleagues that do the same thing
- Provider/patient relationships vary
- Promote your successes

Illinois Department of Public Health

Referring HIV positive ex-offenders to care services

IDOC Background

- Number of Inmates 2009 – 45,529
- Number of employees – 11,000
- Budget - \$1.2b
- Total Correctional Facilities – 36
 - Includes 8 adult transitional centers – ATC
 - Largest facility – Stateville w/3,404 inmates
- Recidivism rate 2009 – 51.3%

IDOC Background

- Nationally recognized programs:
 - **Sheridan National Model Drug Prison and Reentry Program**
 - **National Model Meth Prison and Reentry Program**



HIV and Prison Population

- U.S. Department of Justice reports an estimated 2% of State prisoners nationwide are HIV+.
- IDPH AIDS surveillance and IDOC statistics reveal an estimated 6% of IDOC's population is HIV positive.
- IDOC reports an estimated 69% of inmates have not received an HIV test prior to release.
- AIDS Foundation of Chicago estimates that the prevalence of HIV/AIDS in correctional settings is 14 times greater than in the general population.

Referral process in Illinois

- Begins 6 months prior to release and at each facility.
 - Each facility holds a summit (health fair).
 - Each HIV positive offender completes a needs assessment
- At time of discharge:
 - Offenders information packet
 - www.HIVCareConnect.com
 - ADAP Application
 - Sign medical releases etc.

Referral process in Illinois Continued

- IDOC and offender complete Transitional Tracking Referral form (TTR)
- Referral made to Care Connect Regional Office or CORE Center in Chicago.
 - Spreadsheet tracking
 - Phone call or fax TTR form
- If offender refuses services, must sign denial form
- Offender given 1 month supply of medication with script for 2 additional weeks.



HIV Care Connect Regions



Ongoing Support www.summitofhope.org



20 Years of Leadership
A LEGACY OF CARE



20th RYAN WHITE ALL GRANTEE MEETING AND 10TH ANNUAL CLINICAL CONFERENCE

HIVCareConnect.com



Extending your ability to help people with HIV

See reverse side and visit www.hivcareconnect.com to learn more.



Illinois HIV Care Connect

Illinois HIV Care Connect is a collaborative effort to increase the number of people who are receiving HIV care and treatment in Illinois. This effort is a partnership between the Illinois Department of Public Health, the Illinois State Board of Health, and the Illinois State Board of Education.

Who can participate?

Illinois HIV Care Connect is open to all Illinois residents who are 18 years of age or older and are currently receiving HIV care and treatment. This includes people who are currently receiving HIV care and treatment in Illinois, as well as people who are currently receiving HIV care and treatment in another state but who are currently residing in Illinois.

How to apply:

For more information, visit www.hivcareconnect.com or call 1-800-458-5234.



Illinois HIV Care Connect

Illinois HIV Care Connect is a collaborative effort to increase the number of people who are receiving HIV care and treatment in Illinois. This effort is a partnership between the Illinois Department of Public Health, the Illinois State Board of Health, and the Illinois State Board of Education.

Who can participate?

Illinois HIV Care Connect is open to all Illinois residents who are 18 years of age or older and are currently receiving HIV care and treatment. This includes people who are currently receiving HIV care and treatment in Illinois, as well as people who are currently receiving HIV care and treatment in another state but who are currently residing in Illinois.

How to apply:

For more information, visit www.hivcareconnect.com or call 1-800-458-5234.



Extending your ability to help people with HIV

Illinois HIV Care Connect is a collaborative effort to increase the number of people who are receiving HIV care and treatment in Illinois. This effort is a partnership between the Illinois Department of Public Health, the Illinois State Board of Health, and the Illinois State Board of Education.

Who can participate?

Illinois HIV Care Connect is open to all Illinois residents who are 18 years of age or older and are currently receiving HIV care and treatment. This includes people who are currently receiving HIV care and treatment in Illinois, as well as people who are currently receiving HIV care and treatment in another state but who are currently residing in Illinois.

How to apply:

For more information, visit www.hivcareconnect.com or call 1-800-458-5234.




Illinois HIV Care Connect

Illinois HIV Care Connect is a collaborative effort to increase the number of people who are receiving HIV care and treatment in Illinois. This effort is a partnership between the Illinois Department of Public Health, the Illinois State Board of Health, and the Illinois State Board of Education.

Who can participate?

Illinois HIV Care Connect is open to all Illinois residents who are 18 years of age or older and are currently receiving HIV care and treatment. This includes people who are currently receiving HIV care and treatment in Illinois, as well as people who are currently receiving HIV care and treatment in another state but who are currently residing in Illinois.

How to apply:

For more information, visit www.hivcareconnect.com or call 1-800-458-5234.





Promoting Linkages to Care for Newly Diagnosed HIV + Persons in Racial and Ethnic Communities



Amber Rossman

Manager of HIV Case Management Programs

Kansas City Free Health Clinic

August 25, 2010

Ryan White Grantees Meeting

Disclosure

- The author has no financial interest or other conflicts of interest to disclose
- Funding for this project was initially funded through ARTAS II by the Centers for Disease Control and Prevention and was further supported by Ryan White Treatment Modernization Act through subcontract through the Kansas City Health Department and Missouri Department of Health and Senior Services

Promoting Linkages to HIV Care for Newly Diagnosed HIV Positive Persons in Racial and Ethnic Communities

2010 Ryan white Grantee Meeting and 13th Annual Clinical Conference

Panel Member: Amber Rossman, LMSW
Manager of HIV Case Management Programs
Kansas City Free Health Clinic
3515 Broadway ~ Kansas City, MO 64111
amberr@kcfree.org ~ www.kcfree.org

Craw, J., Gardner, L (2010), Rossman, A., et al. **Structural factors and Best Practices in Implementing a Linkage to HIV Care Program Using the ARTAS Model.** *BMC Health Services Research*, *manuscript accepted Aug 2010; pending publication date*.

Craw, J., Gardner, L., et al. **Brief Strengths Based Case Management Promotes Entry Into HIV Medical Care: Results of the Antiretroviral Treatment Access Study II (ARTAS II).** *JAIDS / J Acquir. Immune Defic Syndr* 2008; 47:597-606.

Dietz CA, Ablah E, Reznik DA, Robbins DK. **Patients' Attitudes About Rapid Oral HIV Screening in an Urban, Free Dental Clinic.** *AIDS Patient Care.* 2008; 22(3):20-212.

Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs. *Federal Interagency HIV/AIDS Case Management Work Group: US Department of Health and Human Services (CDC & HRSA) publication.* August 2008.



Routine Testing & Linkage to Care

two major initiatives combined

Linkage to Care:

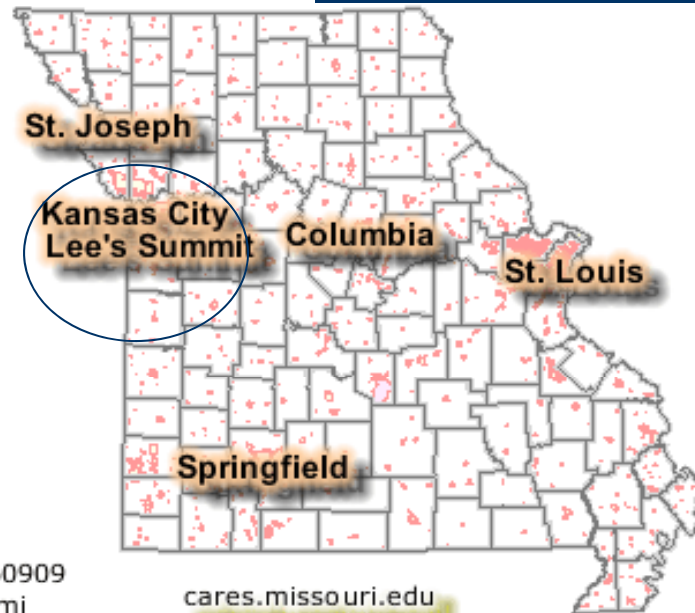
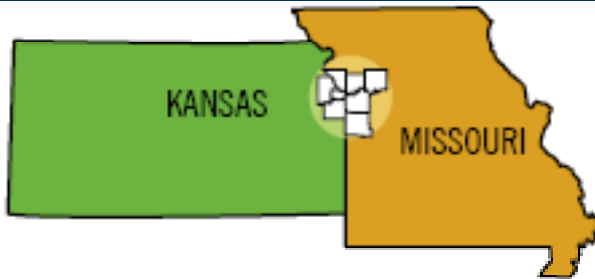
- Demonstration Project with ARTAS II, funded by Centers for Disease Control and Prevention
- 2005 – demonstration project studies begin
- 2008-2010 – funding continuation through City/State health department collaborations, subcontracted funding by HIV AIDS Bureau

Routine Testing:

- Technical Assistance from HIV AIDS Bureau
- March 2007- First Site visit by TA providers
- Clinic developed implementation plan and continues through 2010

Project Area

Kansas City Free Health Clinic



Kansas City Project Area includes:

- 11 counties in MO
- 3 counties in KS

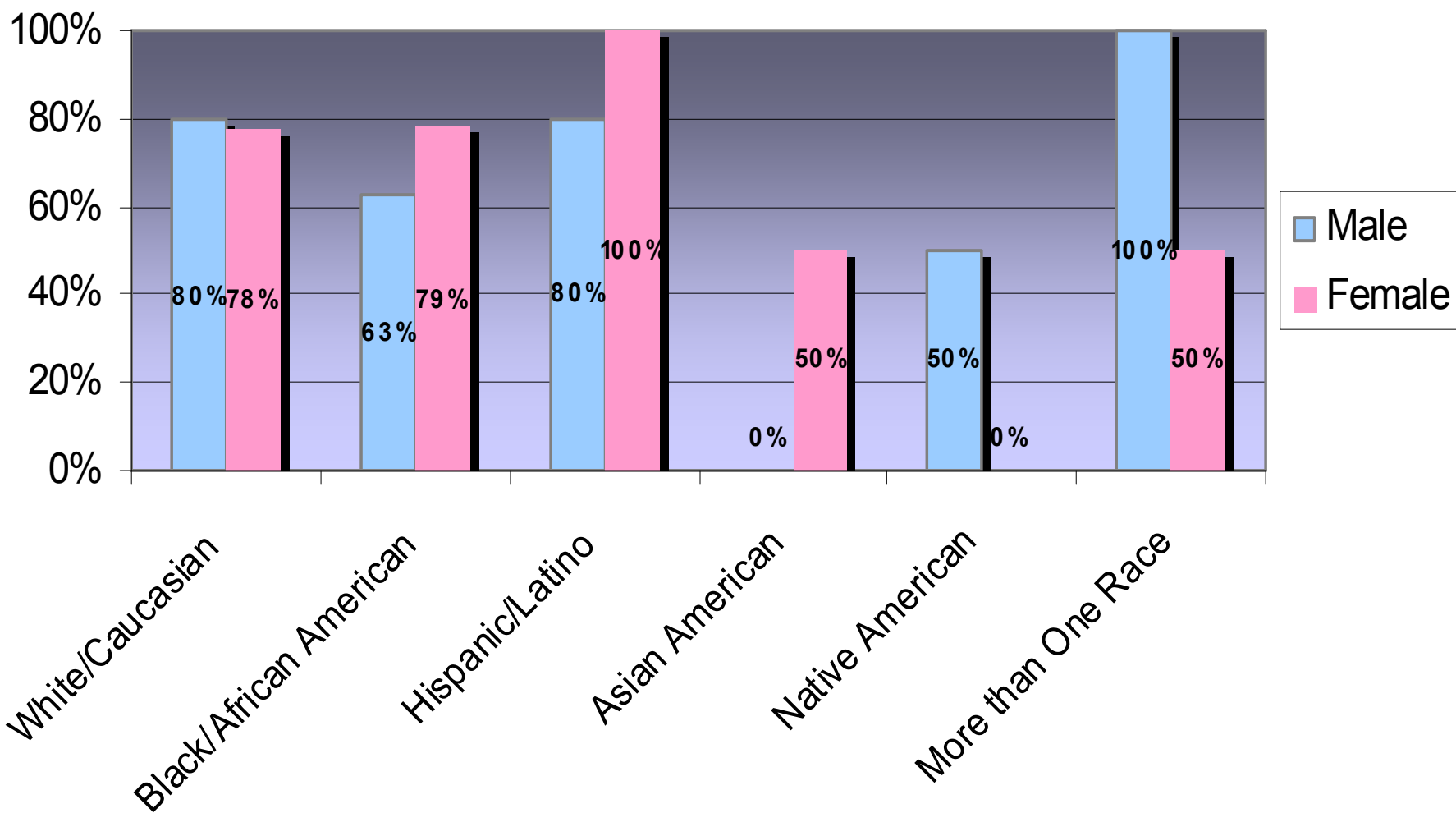
Most referrals from the following Health Depts:

- Kansas City Health Dept.
- Missouri Dept of Health and Senior Services
- Wyandotte Co. Health Dept.

Routine/Opt Out HIV Testing

- Free Health Clinic: Dental Clinic
- Free Health Clinic: General Medicine/STD Clinics
- Indigent Care Hospital: Emergency Department
- ***Future: Expanding to New Collaborations in Testing?***
 - Other outpatient public health clinics
 - Sexual and reproductive health care providers (i.e. *Planned Parenthood*)
 - Other Emergency Departments

Percent of Respondents Reporting Willingness to Take a Free, Rapid HIV Screening Test during a Dental Visit, by Ethnicity/Race and Gender



Testing in Dental: Results Reporting

- 73% (n=103) would be willing to be tested (p<0.001)
- 62% (n=100,) reported *It Does Not Matter* who provided HIV Screening test results to them (p=0.01)
 - Excluding “Doesn’t Matter”
 - 37% My Dentist
 - 24% Personal Physician
 - 3% Dental Assistant/Hygienist
 - 11% Counselor
 - 13% Letter
 - 13% Other

*In this pilot study, the majority of dental clinic patients responded favorably to the offer of a free, rapid oral HIV screening test.

**Participant demographics closely match the demographics of the dental clinic.

Testing in Dental: Expected Conclusions...

Not Found!

These conclusions were assumed by providers but **NOT** found in this pilot survey:

- Fear of Self-Awareness of HIV result? *NOPE*
- Fears or Issues of Consent/Confidentiality? *NOT HERE*
- Fear of being treated differently? *NO SIR*
- Fear of Dentist/Hygienist Knowing Results *OR* providing the results? – *NOT REALLY*
- Time constraints? – *NONE*
- Fear of HIV test accuracy? – *NOT SO MUCH*
- Dental pain is a barrier to testing? - *NADA*

Linkage to Care Case Management Program Purpose and Problem Overview

- 40-60% of newly diagnosed HIV+ not in care
- Late diagnosis is frequent
- Passive referrals less effective
- Missed opportunities for earlier care, interventions
- Complexity of patients lives = barriers to care

96% in the KC site study had no personal help with their HIV diagnosis and care.

- 62% would depend solely on an HIV professional
- 34% perceived they would have no help

Linkage to Care Activities

90 Day, Intensive Intervention:

- Health Literacy, Disease & Treatment 101
- Identify patient strengths that facilitate care
- Identify barriers to care
- Set goals for HIV tx
- Negotiate complicated care system
- Attend appointments; debrief with patient; identify long term payer source
- “Graduated Disengagement” & “Active Handoff”

Newly Diagnosed HIV+ Person

BARRIERS TO CARE

Personal Barrier:

Addictions
Behavioral Health
Lifestyle/Culture
Health literacy
Poverty

System Barrier:

Complicated systems
Availability
Costs

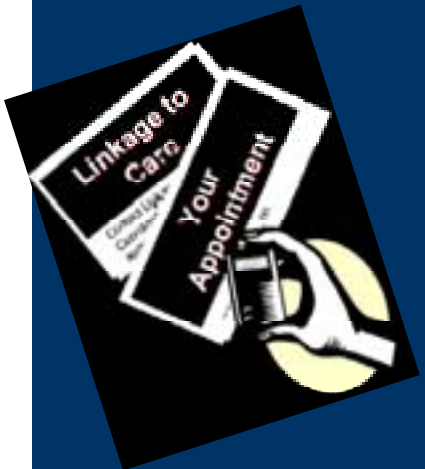
LINKAGE:

Access to Medical Care



ENGAGEMENT:

Long term engagement in medical care



HIV Diagnosis

Page Linkage to Care – *20m response*

Initial Response – meet with patient and diagnosing provider

Intervention - Enrollment or Referrals

Linkage to Care - 90 Day, intensive intervention of LTC Case Management (continuation w/ referral to CM services)

87% COMPLETE:

Graduate to long term HIV Case Management Services, continue engagement in care

8% COMPLETE:

Graduate to self-sufficiency, continued HIV care with own resources

5% NOT COMPLETE:

Lost to Care, Unable to Contact, Disengaged from Program; cont'd attempts re-engagement

84% of graduates still in care after 12 months.

- ### Referring Sites
- Hospitals
 - Health Depts (KC, Jx, Jo, Wy, MO)
 - Publicly Funded Testing Sites
 - Free Clinic (KCFHC)
 - Med Offices/Other
 - Self Referral

Lessons Learned in Linkage to Care

Results from ARTAS-II indicated that 79% of all participants visited an HIV clinician at least once within the first six months (Craw, et al., 2008)

- *Linkage to Care programs – state health department grantees or CBOs with existing strong testing, care and case management programs*
- *Sources of referrals of HIV-infected persons to the Linkage to Care program*
- *Marketing the benefits of the Linkage to Care program*
- *Partnerships with HIV primary medical care providers*

Lessons Learned in Linkage to Care



- *Transportation for the linkage coordinator: the advantage of being mobile*
- *Disengagement process: transitioning clients from ARTAS linkage case management to long-term case management*
- *The “active hand-off”: a model for facilitating the transition to long-term case management*
- *Distinguishing ARTAS linkage case management from long-term case management*
- *Supervision of the linkage coordinators*

Lytt Gardner, Ph.D., Jason Crow, M.P.H. Lessons Learned from Implementing a Linkage to HIV Care Program using the ARTAS Model.

Amber Rossman, LMSW

Manager of HIV Case Management Programs

Kansas City Free Health Clinic

3515 Broadway

Kansas City, MO 64111

amberr@kcfree.org

www.kcfree.org



Linkages to Care for HIV + Persons Leaving NYC Jails



Alison O. Jordan, LCSW

Executive Director, Transitional Health Care
Coordination

New York City Department of Health and
Mental Hygiene

August 25, 2010

Ryan White All Grantee Meeting

Disclosure

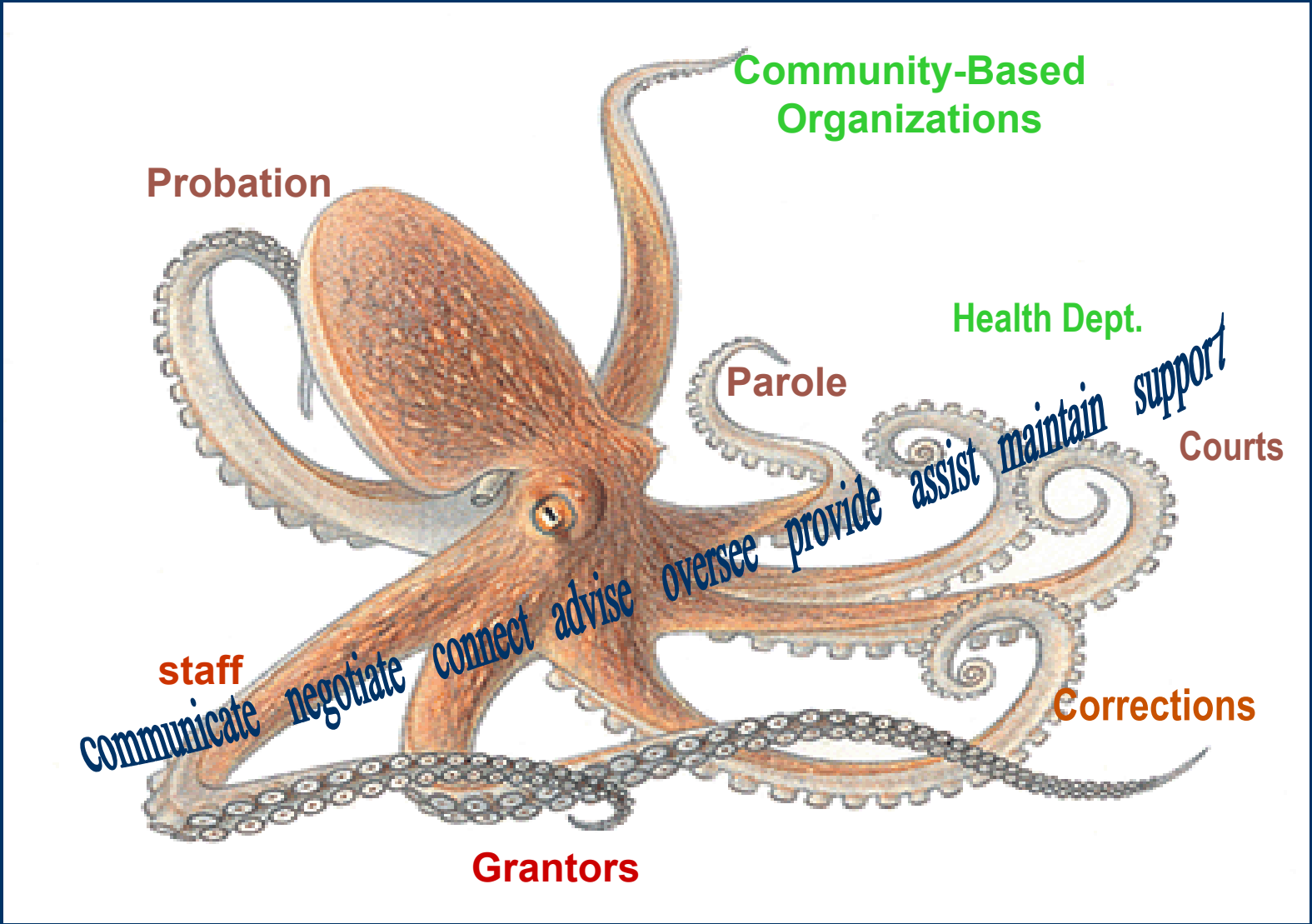
- Alison O. Jordan has no financial interest or other conflicts of interest to disclose
- Funding for this project is made available by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), Special Projects of National Significance (SPNS) Program [HRSA-07-031] Enhancing Linkages to HIV Primary Care In Jail Settings (Sites) 2007-2011, and the Centers for Disease Control and Prevention.

RIKERS ISLAND, NY



NYC Jail Health

- High risk of HIV infection (2006 blinded serosurvey)
 - 4.7% (4.1% - 5.3%) in males
 - 9.7% (8.3% - 11.1%) in females
- Over 70% released to the community return to the areas of greatest health disparities
- Women are twice as sick as male counterparts



Discharge Planning

- Engage client
- Conduct assessment
- Screen for Benefits
- Arrange discharge medications
- Coordinate post-release plan
- Facilitate continuity of care
 - Aftercare letters / transfer medical information
 - Make appointments / walk-in arrangements
 - Arrange transportation / accompaniment

Post-release Plan

- Housing
- Treatment (Substance Abuse / Mental Health)
- Primary Care
- Specialty Care
- Social Services
- Transitional Case Management



Supported Transitions

- Case conferencing prerelease
- Court advocacy and Alternatives to Incarceration (ATI)
- Community case manager
- Accompaniment / transport
- Patient Navigator / Care Coordinator

What a Team!



Contact us

- Alison O. Jordan, NYC

ajordan@health.nyc.gov

917-748-6145