![Center for Innovation and Engagement (CIE) logo]

TIPS FOR IMPLEMENTING THE CLINIC-BASED, SURVEILLANCE INFORMED (CBSI) INTERVENTION

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HIV treatment is crucial to improve the health of people with HIV and to prevent ongoing HIV transmission. Many people with HIV do not receive regular medical care, and it can be difficult for service providers to systematically identify people who have fallen out of care. HIV clinics can partner with health department HIV programs to identify individuals who have disengaged from HIV care and offer patients assistance with re-engagement in care. This partnership requires clinics to share information about patients that appear to be out of care and health departments to share information from the HIV case registry (surveillance) about whether those individuals are receiving care elsewhere or have left the area. Sharing clinical and public health data can increase the accuracy and efficiency of Data to Care (D2C) efforts, which use data to guide interventions to improve retention in care and viral suppression among people with HIV.

Relevant Statistics

- Among clients receiving Ryan White HIV/AIDS Program (RWHAP) services, approximately 88 percent are virally suppressed.[1]
- About 35 percent of people in the United States diagnosed with HIV did not receive any care in 2019.[2]
- An estimated 43 percent of new HIV transmissions are from people who are aware they have HIV but are not in care.[3]

A Summary of Implementation Phases

PHASE I: Identifying Clients Disengaged in Care

The first step to implementing the intervention is developing a relationship between the HIV clinic and the local or state health department. All health departments have an HIV case registry that contains identifying information about people with HIV who are living in the jurisdiction and the dates and results of their viral load tests. The Centers for Disease Control and Prevention (CDC) requires health departments to have a Data to Care strategy, which involves using HIV surveillance data to improve the HIV care continuum.[4] HIV clinics can generate a list of patients who have not visited the clinic during a specific period (e.g., the last year).[5] However, many of these patients are not out of care but have transferred their care or moved away.[6] Sharing clinic and health department data improves the accuracy of identifying out-of-care patients and saves time for clinic outreach staff.[5]

PHASE II: Electronic Medical Record (EMR) Review

Once a clinic has worked with the health department to generate a refined list of out-of-care patients, the next step is for an outreach worker to find and contact those patients. Outreach workers can review the medical records for current contact information and review the most recent notes to understand any circumstances that may indicate why the patient has not had a clinic visit. If the outreach worker can talk with a patient's case manager or medical providers, it can help to coordinate care. The outreach worker will discover new information about why patients have not been in the clinic during this process. This information may include if the patient has moved away, has died, is incarcerated, has been connected to care somewhere else, or has come back into care since the list was generated. Tracking this information in a database will allow the clinic to refine its registry of active patients, inform future outreach efforts, and evaluate the effectiveness of its outreach program.[5]

A Summary of Implementation Phases (*continued*)

PHASE III: Making Contact

After the outreach worker has reviewed the medical records and talked with case managers or providers, if applicable, the outreach worker should attempt to contact the patient by whatever means are appropriate locally. Usually, this includes phone calls or letters, but it will likely increase their success if the outreach worker can text patients. Some outreach workers go to the last known residence, but it is best to try to connect with them another way first. The outreach worker should have training and experience working with people with HIV who have complex barriers to care, such as homelessness or unstable housing, substance use, and mental health disorders. When the outreach worker successfully contacts a patient, they should identify who they are and why they are reaching the patient. Programs will differ in how the outreach workers approach their conversations, but all should strive to be supportive, non-judgemental, and patient-centered.

PHASE IV: Providing Re-Engagement Assistance

It is a critical success when the outreach worker has successfully contacted and connected with a disengaged patient. The outreach worker should work with each patient to determine strategies to assist the patient with re-engaging in care. Examples may include providing appointment reminders, making the patient an appointment, connecting them with support services, or working with the patient to address barriers such as transportation, child care needs, work schedules, and other issues. The goal of the outreach is to bring patients back into the clinic. This intervention may be more effective if the outreach workers have different options to offer the patient, such as a "red carpet" program for out-of-care patients. A "red carpet" program allows for quick scheduling, same-day appointments, or specialized care programs for people with complex barriers to care (e.g., low-barrier HIV care).

Conclusion

The CBSI intervention involves collaboration and information-sharing between clinics and health department HIV programs to effectively identify people with HIV who have disengaged from care and work to re-engage them in care. This type of intervention is a crucial first step for clinics to improve HIV care engagement in their patient populations. The model is flexible and can be paired with other services to help patients re-engage in HIV care and treatment.

Additional Resources

National Alliance of State and Territorial AIDS Directors (NASTAD). Data Points: A Health Department Roadmap for Enhancing Data to Care Programs

https://www.nastad.org/resource/data-points-health-department-roadmap-enhancing-data-care-programs

Center for Innovation and Engagement. CBSI Intervention Page

https://ciehealth.org/intervention/clinic-based-surveillance-informed/

Center for Innovation and Engagement. CBSI Technical Assistance

https://ciehealth.org/contact/

Center for Innovation and Engagement

About CIE

NASTAD's Center for Innovation and Engagement (CIE) is funded by HRSA's HIV/AIDS Bureau (HAB), RWHAP Part F, Special Projects of National Significance (SPNS), under a three-year initiative entitled Evidence-Informed Approaches to Improving Health Outcomes for People with HIV. The purpose of this initiative is to identify, catalog, disseminate, and support the replication of evidence-informed approaches and interventions to engage people with HIV who are not receiving HIV health care or who are at risk of not continuing to receive HIV health care. Learn more at **www.CIEhealth.org** and **www.TargetHIV.org/CIE**.

References

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[2] U.S. Department of Health and Human Services. (2021). Understanding the HIV Care Continuum. Retrieved July 28, 2021 from **https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum**

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