

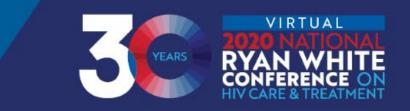
## Linkage to Care for Retention and Prevention in a Large Urban Care Setting

#### Tara Hixson M.Ed Linkage to Care Coordinator

EIS Primary Care Clinic and Denver Public Health

Denver Health and Hospital Authority





• Presenters have no financial interest to disclose





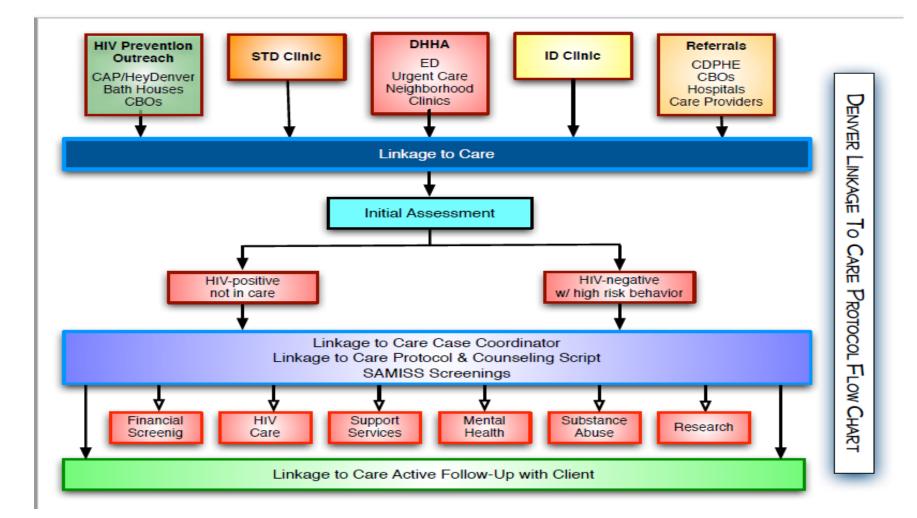
• Define the Linkage to Care Program at Denver Health/Denver Public Health

• Explain key changes made to the program to improve access to care and engagement for PLWH

• Describe program steps for LTC for PrEP and nPEP

### Linkage to Care Model





### **Referring Partners**



- Denver Metro Health Clinic
- Outreach Testing through Denver Public Health
- DHHA (Hospital, ER, Urgent Care, DPH Clinics and FQHCs)
- CBOs (Harm Reduction Action Center, Hey Denver ...)
- ASOs
- Bath Houses
- Planned Parenthood
- Metro Area Hospitals and ERs

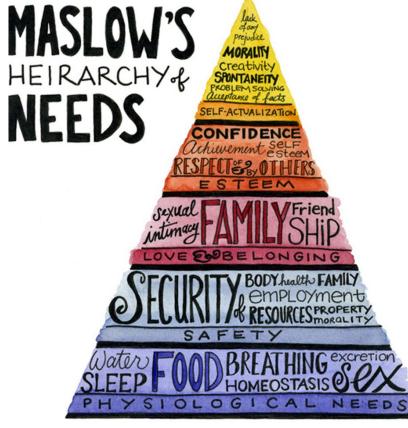
### Linkage to Care Process





# Helping PWH overcome barriers to care





VIRTUAL

### Linkage to Care 2019



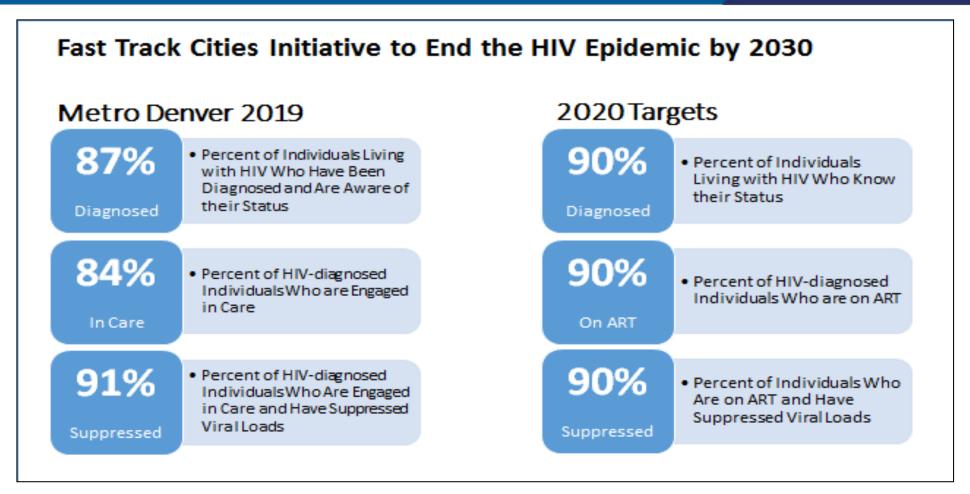
In 2019, 279 persons referred to LTC at Denver Public Health

- -149 were re-identified PLWH
- -130 were newly diagnosed persons
- -Median Time to linkage for 2019 = 11 days (>90 days) 120 (< 90 days)

Delays in linkage: Insurance / SDAP Enrollment/ Lack of Stable Housing/ Stigma/SUD/Mental Health

### LTC and 90/90/90









- FAST Rapid ART
- Expedited Enrollment Services
- Co-located Health Access Insurance Navigation
- Specialized workflows for those with additional barriers
- COVID workflows

### FAST Rapid ART Pilot



#### **FAST Program Patient Flow**



#### Linkage visit #1

Post test counseling
Obtain labs for HIV confirmatory testing

•Introduce FAST Program

•Discuss Insurance/SDAP

#### Provider Visit #1

•Rule out OIs •Order intake Labs\*

#### FAST Intake Visit

Linkage Visit #2
 Disclose results
 Facilitate partner services
 Continue insurance
 enrollment processes
 Schedule appt with

continuity provider

- Provider visit #2
- H&P
- Order labs (if not completed)
- Order 1mo supply meds
- Offer DOT

#### Follow-up Plan

- Linked by 2 weeks → f/u w continuity provider
- Linked by 1 mo → f/u continuity provider
- If not Linked f/u Visits w FAST Provider:
  - 2 wk f/u
  - Q 1 mo f/u PRN



We have enrolled 22 people into the FAST Pilot since starting in 2019

- 19 were uninsured
- 17 identified as Latinx
- 2 identified as Black
- Median time to ART start was 6 days
- Median time to linkage to continuity care 39 days
- ALL were virally suppressed at 2 week follow-up

### Denver Metro Clinic PrEP



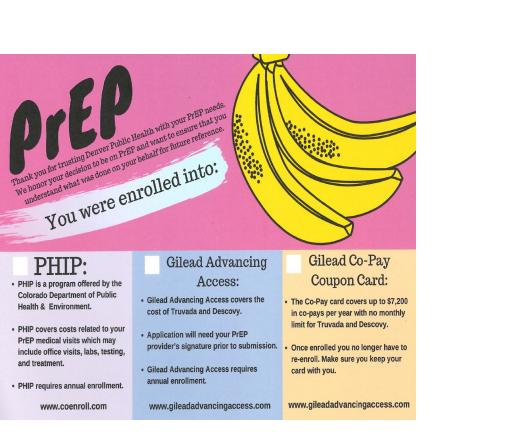
- 1,394 PrEP Starts since 2018
- 569 PrEP Starts 2019
- 231 PrEP Starts in 2020
- 367 TelePrEP visits since 3/17/2020

### **PrEP** Navigation



#### **PrEP Navigation** Assessment/ Schedule PrEP **Renewal of PrEP Referral** Follow Up Provider/Labs Pharmacy & Screening Appointment Patient Appointment Pick-Up for PEP Assistance (Insurance/Provider Assessment) Programs

### **PrEP Financial Assistance**



All assistance programs require that you provide proof of income. Proof of income was submitted during your enrollment visit by your PrEP Navigator. You will need to submit your own proof of income for PHIP and/or Gilead yearly re-enrollments.

Submit all that applies

### **Proof of Income Includes:**

- Last two pay stubs from employer
- Letter from employer that includes employers contact info and dollar amount the employee is paid
- Award Letter (i.e. SSI, SSDI)

Call a H

with

30

- PHIP Self Employment Worksheet (PHIP only)
- PHIP Statement of Support (PHIP only)

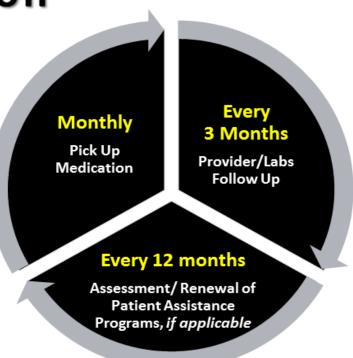
|                | PHIP              | 2        |
|----------------|-------------------|----------|
| PrEP Navigator | Enrollment Dates: |          |
| any questions: | Gilead            | DENVER   |
| corry 4        | Enrollment Dates: |          |
| 03-602-3652    | ID:Bin:           |          |
| 03-002-2024    | PCN: Group:       | <u> </u> |
|                |                   |          |

VIRTUAL

### **PrEP** Retention



### **PrEP** Retention



What are some common barriers?

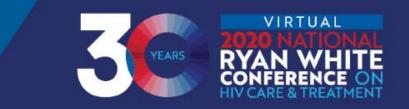
What retention data should be considered?

### Opportunities



- Expansion of FAST (Rapid ART re-start for PWH and out of care)
- Walk-in model
- Co-located SW and BH Counseling in DMHC
- Increased collaboration with community partners
- Data and staffing resources to support PrEP Retention
  - Outpatient clinics
  - Patient Navigation





- Specialized LTC support can help close gaps in care and retention, by reducing barriers to care for PLWH
- Building community trust and partnerships is key to a successful linkage program
- LTC programs and counselors are well suited to provide support for HIV Prevention as well as treatment
- QI should be built into your work

### Acknowledgements



- DHHA HIV Primary Care Clinic Team
- Denver Metro Health Clinic Team
- Nathan Gibson LTC
- Alex Delgado BSW/LTC
- MaShawn Moore LTC
- Julia Wiese LCSW
- Oluyomi Obafemi MD
- Karen Wendel MD



# Thank You for Your Time!

Tara Hixson M.Ed EIS Primary Care Clinic Denver Health and Hospital Authority