Resources

This pocket guide is part of the *Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond* resources from the Integrating HIV Innovative Practices (IHIP) Project.

Systems Linkages and Access to Care for Populations at High Risk of HIV Infection (System Linkages) Initiative
hab.hrsa.gov/abouthab/special/systemslinkages.html

Electronic Networks of Care Initiative
hab.hrsa.gov/abouthab/special/electronicnetworksofcare.html

LaPHIE Overview
www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/data_committee_resources/louisiana_guide.pdf

LaPHIE Presentation
careacttarget.org/sites/default/files/rw2010/papers/I-21A.pdf

Legal and Ethical Aspects of Louisiana Public Health Information Exchange (LaPHIE). **"Using Technology to Improve Health Outcomes."** What's Going on @ SPNS.
www.researchgate.net/publication/266900599_Legal_and_ethical_aspects_of_Louisiana_Public_Health_Information_Exchange_LaPHIE

"Sustainability Results in Better Care for More People." What's Going on @ SPNS.
hab.hrsa.gov/sites/default/files/hab/About/Parts/cyberspnssustainability.pdf

CDC Effective Interventions: Louisiana Public Health Information Exchange (LaPHIE)
effectiveinterventions.cdc.gov/docs/default-source/data-to-care-d2c/LaPHIE_Program_Description_12_10_13.pdf?sfvrsn=0

Magnus M, Herwehe J, Murtaza-Rossini M, et al. **Linking and Retaining HIV Patients in Care: The Importance of Provider Attitudes and Behaviors.** *AIDS Patient Care and STDS.* 2013; 27(5): 297–303.
www.ncbi.nlm.nih.gov/pubmed/23651107

Herwehe J, Wilbright W, Abrams A, et al. **Implementation of an Innovative, Integrated Electronic Medical Record (EMR) and Public Health Information Exchange for HIV/AIDS.** *J Am Med Inform Assoc.* 2012;19(3): 448–452.
www.ncbi.nlm.nih.gov/pubmed/22037891

Improving Linkage to Care:

Increasing Coordination and Communication for Newly Diagnosed and Lost-to-Care HIV+ Individuals

Highlights from the Special Projects of National Significance (SPNS) Program

POCKET GUIDE

This pocket guide contains highlights from: Louisiana Public Health Information Exchange (LaPHIE) at the Louisiana State University, and the Virginia Department of Health Active Referral Intervention.

Improving linkage to and retention in HIV care are associated with multiple barriers, particularly for hard-to-reach populations. The goal of this pocket guide is to provide a condensed reference tool for HIV provider organizations working to facilitate client referrals to HIV care and/or to engage those lost to follow-up.

HRSA Health Resources & Services Administration
U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
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Virginia Department of Health Active Referral Intervention

INTERVENTION OBJECTIVES

The objectives of the Active Referral Intervention were to establish linkage to care after HIV diagnosis, and to provide linkage to HIV-positive clients who are newly diagnosed, have not accessed care, or have fallen out of care.

Key Considerations for Replication

- **Disease intervention specialists (DIS)** are responsible for facilitating active referral. Their role includes (but is not limited to): following up on priority clients, providing referrals, and following up on active linkage to care.
- A **DIS supervisor** provides direct oversight of DIS compliance with protocol. This role can be filled by a variety of staff types, including: an STD nurse, a nurse manager, or STD Surveillance Operations & Data Administration (SODA) field operations manager.
- A **regional "champion"** is needed to address referral and linkage to care issues, as well as identify any overlaps or opportunities for synergy across other interventions.
- A **clear understanding of state-level DIS** roles will facilitate intervention replication.
- **Staff turnover**, including at community-based organizations, may necessitate ongoing trainings.
- Active referral requires **access to data on reportable new HIV cases**, which may be difficult to collect (e.g., due to incomplete reporting or provider reluctance to release data to program staff).
- Processes for **documenting client follow-up** is needed to ensure successful linkage to care.

Unmet Needs in Linkage and Retention in Care

- While approximately 87% of PLWH in the U.S. have been diagnosed and are aware of their infection:[1,2]
  - » 74.5% of diagnosed PLWH age 13 and older are linked to care within 1 month following an HIV diagnosis;
  - » 56.6% are retained in care; and
  - » 54.7% are virally suppressed.
- Linking newly diagnosed PLWH to HIV care, and retaining individuals in care, are critical to achieving viral suppression and improving health outcomes.
- PLWH can face a variety of barriers to care, including emotional barriers (stigma, fear of treatment effects), structural barriers (socioeconomic limitations, housing instability, low access to transportation), and co-occurring conditions (substance use, mental health issues).[3,4]

Utilization of existing reporting practices and/or health information technology (HIT) can enhance efforts to rapidly and efficiently link newly diagnosed PLWH into care, or re-establish care for those lost to follow-up.

[1]Centers for Disease Control and Prevention (CDC). Today's HIV/AIDS Epidemic. Fact Sheet. July 2015. Available at: www.cdc.gov/nchhstp/newsroom/docs/factsheets/todaysepidemic-508.pdf.

[2] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. HIV Surveillance Supplemental Report 2016;21(No.4). www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf Accessed September 16, 2016

[3] Mayer KH. Introduction: Linkage, Engagement, and Retention in HIV Care: Essential for Optimal Individual- and Community-Level Outcomes in the Era of Highly Active Antiretroviral Therapy. *Clin Infect Dis*. 2011;52(suppl 2):S205–S207.

[4] Yehia BR, Stewart L, Momplaisir F, Mody A, Holtzman CW, Jacobs LM, Hines J, Mounzer K, Glanz K, Metlay JP, Shea JA. Barriers and facilitators to patient reten-tion in HIV care. *BMC Infect Dis*. 2015 Jun 28;15:246.

Louisiana State University (LSU) Louisiana Public Health Information Exchange (LaPHIE)

INTERVENTION OBJECTIVES

The objectives of the Louisiana Public Health Information Exchange (LaPHIE) intervention were to facilitate a bidirectional information exchange between hospital system records and surveillance data to identify and link out-of-care HIV-positive clients back to care and treatment.

The LaPHIE dataset contains the records of persons diagnosed with HIV who appear to be out-of-care, defined as no record of CD4 or viral load in the last 9 months. The Office of Public Health database interfaces with the LSU hospital client registration and EMR systems. When individuals enter the LSU hospital system (ER, clinic, or otherwise) the system compares those clients against the out-of-care list. When an exact match is made, a message is sent in real-time to the EMR and an alert is visible to nurses and physicians who are in a position to take action.

Key Considerations for Replication

- An **IT manager** will be needed to oversee the development of data systems, troubleshoot issues, and provide technical assistance as needed.
- A **surveillance manager** is needed to lead the surveillance, prevention, and care programs, conduct data entry and analysis, and input on the datasets and alert systems.
- Program staff should have **experience with and understanding of surveillance data** and quality assurance strategies, as well as knowledge of the existing EMR and health information technology systems.
- **Access to timely and accurate surveillance data,** either directly or through a collaborator, is required.
- Clinicians receiving alerts may not be experienced with HIV care; thus, **training and education** may be needed.
- **Privacy and security issues** should be considered during early stages to ensure adherence to institutional, state, and federal policies.