Using the Learning Collaborative Model to Craft and Test Systems-Level Linkage to Care Interventions

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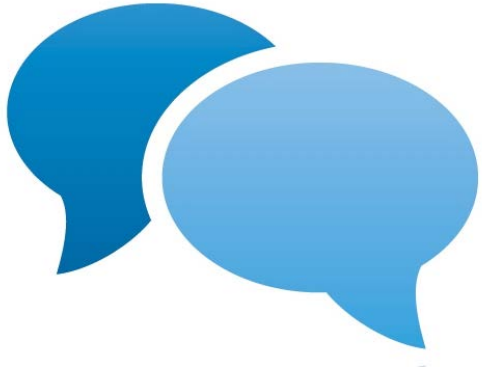
WELCOME

Agenda

- Introductions & Overview
- Overview of each Project/Intervention
  - SPNS initiative & Use of Learning Collaborative
  - MA: Acuity Scale
  - NY: Peer Support
  - VA: Care Coordination
- Facilitated Discussion
  - Buy-in & Engagement
  - Resources & Infrastructure
  - Evaluation & Data
  - Lessons Learned
- Question & Answers



SPNS Systems Linkages and Access to Care Initiative

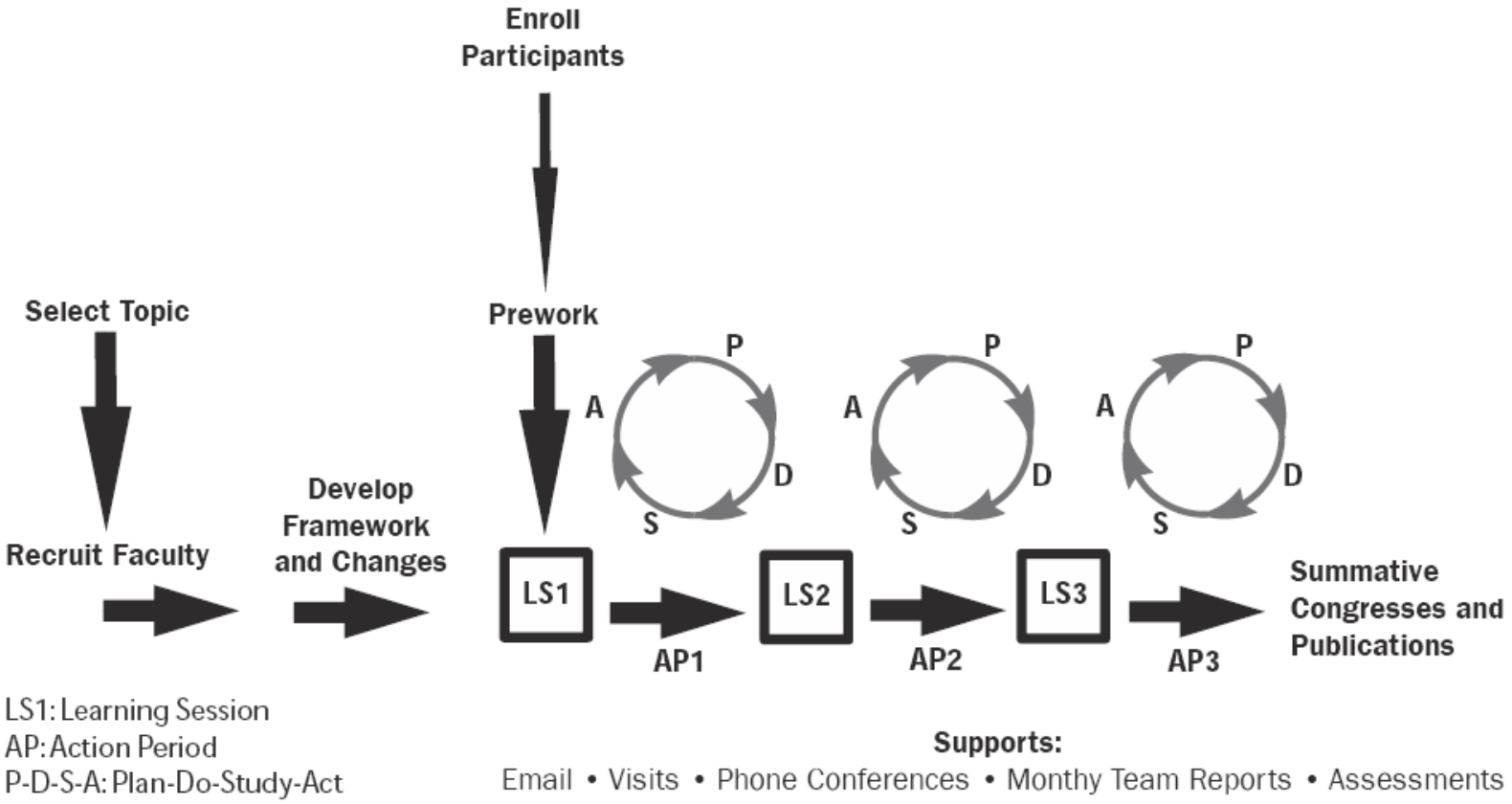
- Purpose:
  - Establish effective & sustainable sustainable systems linkages to maximize existing HIV counseling and testing, surveillance, prevention and treatment resources within their States
- Goal of Linkages
  - Demonstrate improvement in access to and retention in high quality, competent HIV care and services for hard-to-reach populations
- Six States: LA, MA, NY, OH, VA & WI

Approach

- 2 year Learning Collaborative Phase
  - Pilot test and select ideal systems linkage interventions
  - Build capacity for implementation
  - Forge relationships
  - Refine policies & procedures & data systems
  - Train-the-trainer model

- 2 year (+ 1 yr) Implementation & Evaluation Phase
  - Wider-scale test of systems linkage interventions
  - Evaluation

Collaborative Learning Model



At end of 2 years…

Set of ideal end products to be in place after Initiative's 1st two years:

1. Limited menu of systems linkages interventions
   - PDSA cycles will be used to test out acceptability & feasibility of potential linkage interventions for wide-scale implementation
2. Systems of measurement
   - Existing data systems will be &/or new systems developed modified to measure outcomes & monitor how people move through testing & care systems
   - Interventions are expected to cut across traditional funding streams & data monitoring systems

At end of 2 years…(cont.)

3. Involvement of key decision makers
   - Identify & involve key personnel involved in setting policies & funding for testing & care services
   - Identify key data & findings that would sustain linkage interventions

4. Change management & evaluation expertise
   - Build capacity at the local level in skills related to change management and use of data to guide implementation of new service models

Partnership

- UCSF Evaluation & TA Center
- State Department of Health

MA Department of Public Health

Strategic Peer Enhanced Care and Treatment Retention Model

Development of an acuity based system to support retention in care for HIV+ individuals

Sophie Lewis

MA Department of Public Health

Bureau of Infectious Disease and Laboratory Sciences

Background

- In 2012 MA Department of Public Health (MDPH) introduced a draft acuity tool as part of SPECTRuM
- Goal of SPECTRuM was to expand access and improve retention in care for HIV+ individuals who had fallen out of care or were struggling with retention in care
- SPECTRuM service was short-term intensive linkage to care provided by a peer/nurse team
- Acuity tool developed to assist sites with identifying high need individuals for referral to service

Acuity Tool Development

- October 2012: Introduced tool at Learning Collaborative
- October 2012 – April 2013: Provided site specific and group TA on tool
  - Developed individual patient service plan tool linked to acuity
- April 2013: Debriefed successes and challenges at Learning Collaborative
- Revised tool based on feedback from sites

Tool Specifics

Medical Case Mgmt Levels

- Intensive
- Moderate
- Basic
- Self-management

Areas of Functioning

- Care adherence
- Medication adherence
- Current health status
- Health literacy
- Insurance status
- Housing
- Mental health
- Substance use

Development continued

- April 2013 – June 2014: Sites used the revised tool
- June 2014: Sites presented case studies at Learning Collaborative focused on the transition process out of SPECTRuM
- Case studies included acuity score at enrollment, and indicators for readiness to transition (including acuity)

Statewide Expansion

- June 2014 – October 2014: Expanded tool to include more comprehensive areas of functioning
  - Partnered with city health department and BU School of Public Health
- October 2014: Statewide meeting for MCM funded sites to introduce tool
- November 2014 – April 2015: Piloted tool with 38 agencies (and 761 clients)
- May 2015 – October 2015: Evaluated the pilot results
  - Compared tool to assessments, re-assessments, and service plans
  - Interviewed agency staff

Final Acuity Tool

Medical Case Management Levels

- Intensive need
- Moderate need
- Basic need
- Self-management

Areas of Functioning

- HIV care adherence
- Current HIV health status
- Other non-HIV related medical issues
- Medication adherence
- Health insurance/HDAP
- Sexual and reproductive health
- Current mental health status
- Current substance use
- Support systems & relationships
- Current legal status
- Current income/personal finance
- Transportation
- Nutrition

Acuity Tool: Sample Page

Area of Functioning: Adherence to Medical Care				Acuity Score:	
				Dates of Last 2 HIV Appointments:	dd/mm/yyyy
					dd/mm/yyyy
Intensive Need (3)	**Moderate Need (2)**	**Basic Need (1)**		**Self Management (0)**	
Has missed 2 or more consecutive HIV medical appointments in the last 6 months	Has missed 1 or 2 (non-consecutive) HIV medical appointments in the last 6 months but has been seen by member of HIV medical team	Has attended HIV medical appointments in the last 6 months as indicated by HIV medical provider, but has missed 1 appointment in the last 12 months		Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider	
Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability	Requests accompaniments to medical appointments from MCM or other member of the care team	Needs assistance with making and keeping HIV medical appointments		Does not require any assistance or reminders to schedule or keep medical appointments	
Has not been seen by HIV medical team in the last 6 months	Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)				

Implementation

- As of July 1, 2016 All MCM funded agencies are required to use the tool at intake/enrollment and every six months for reassessment
- Tool includes place to track recent VL and last 2 HIV medical visits
- New service tier, Care Access, added for clients with very low level of acuity
  - Allows agencies to keep clients enrolled in medical case management but without some of the MCM requirements
  - Care Access clients must be reassessed every 6 months using acuity tool and re-enrolled in MCM as needed or requested

Next Steps

- Develop acuity tool companion guide based on feedback from agencies using the tool
- Develop new comprehensive assessment that corresponds with acuity tool
- Work with BU to develop project to assess clients who receive services at more than one MCM funded sites
- BU will review acuity and other tools to assess what services clients are receiving and what their acuity scores are at each agency

MDPH Acknowledgments

- Emily Levine, Service Quality Coordinator, Office of HIV/AIDS, Bureau of Infectious Disease and Laboratory Sciences, MDPH
- H. Dawn Fukuda, Director, Office of HIV/AIDS, Bureau of Infectious Disease and Laboratory Sciences, MDPH
- Linda Goldman, Director, Health Promotion & Disease Prevention, Office of HIV/AIDS, Bureau of Infectious Disease & Laboratory Sciences, MDPH
- HIV/STD Surveillance staff, Bureau of Infectious Disease and Laboratory Sciences, MDPH
- Serena Rajabiun, Melissa Hirschi, and Edith Ablavsky , BU School of Public Health, Center for Advancing Health Policy and Practice
- Kevin Cranston, Director, Bureau of Infectious Disease and Laboratory Sciences, MDPH

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Peer Support

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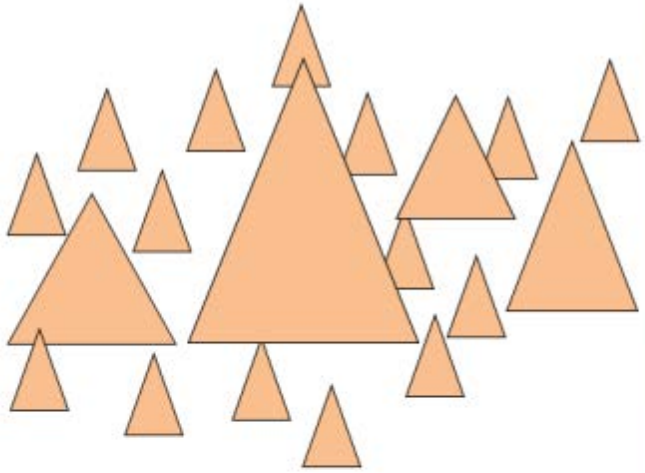
NY-LINKS
August, 2016

Peer Support

NYLinks Implementation Package



Peer Support

Brief Description—To have trained peers engage patients who are new to HIV care, or returning to HIV care at the organization, in order to establish a foundation and relationship that enables regular HIV medical care

Peer Support

Target Population—Newly HIV diagnosed (within the last 6 months) adult consumers, those transferring their HIV ambulatory care, or those returning to HIV care after going at least 6 months without receiving HIV medical care.

Peer Support: Core Elements

An accurate roster is developed based on target population

Eligible patients are offered the opportunity to enroll in intervention

Patient is paired with a peer who offers the following services

- Meet and greet patients
- Provide a tour of the facility
- Inform patients about available services and processes
- Introduce patients to appropriate staff

Core Elements (cont.)

- Provide educational and organizational materials and answer questions
- Provide reminder calls to patients and check in with patients to reduce barriers

The intervention is documented as delivered.

Peer Support

Adaptable Elements

- Peers can be volunteers or paid staff
- Peers can work with patients in more integrated ways
- Peers that are currently employees could be used as navigators.
- Additional elements may be added to the work of the peer—education, advocacy, emotional support, etc.
- The time period within which the peer needs to meet with the patient

Peer Support

Length of Time to be delivered—minimum of 6 months or until the patient decides s/he no longer wants or needs a peer

Resource requirements—Peers, Staff to supervise peers, recruitment and selection process, policies and procedures related to use of peers, time for training, time to initiate steps, time to develop and manage lists, training time for staff and peers, time needed for peers to meet with patients

Training needed—None required. Recommended trainings include: Motivational Interviewing, policies and procedures, confidentiality, disclosure, general HIV information, facility structure, adherence, safety protocols if any, data collection. The organization may have requirements around the use of peers or volunteers or for new staff. Staff who supervise peers may need training.

Peer Support

Fidelity

It is critically important to all interventions that fidelity to the intervention be measured. This allows us to determine the impact of the implementation process to the intervention results. Fidelity will be done by NY Links staff.

NY Tools

- Peer Support Readiness Checklist
- Peer Support Implementation Manual
- Data Collection Tool
- Process Measure Collection Tool
- Fidelity Assessment
- Implementation Group Webinars

Contact Information

- Steven Sawicki, NYSDOH, SPNS Lead steven.sawicki@health.ny.gov, 518-474-3813
- Website at New York Links
- Blog at Link and Retain Blog

Virginia Care Coordination: Services for Recently Released Persons living with HIV

Anne Rhodes, PhD
Virginia Department of Health
Division of Disease Prevention

Virginia: Care Coordination

- Ensures access to HIV/AIDS related medical care and medications access for inmates released from correctional facilities as they re-enter Virginia communities

- Statewide collaboration between the Virginia Department of Health (VHD), Virginia Aids Drug Assistance Program (ADAP), Virginia Department of Corrections (DOC), Virginia Local and Regional Jails (VLRJ), and Virginia Commonwealth University Health System (VCUHS).

Care Coordination Development

- **Prior to Care Coordination…**

Previously know as "Seamless Transition", a passive model relying upon referrals from VADOC.

- Provided medications only
- No follow-up
- No referral or medical appointment coordination
- No local or regional jail involvement
- No active data collection

- **With Care Coordination…**

Care Coordinator (CC) actively monitors medication pick up and medical appointment for 12 months. CC refers clients to case managers and community partners statewide, including DIS and patient navigators

CC utilizes additional tools to locate clients, including Accurint and the National Victim Notification Network (VINE).

CC Program Scope

- Facilitates access to 30-day supply of medications from ADAP Formulary regardless of income or insurance status
- Expedites enrollment into ADAP and facilitates enrollment into the Affordable Care Act
- Addresses barriers to care by providing statewide referral and linkages
- Coordinates first medication pick up and monitors all subsequent medication pick ups and medical appointments for 12 months
- Informs Community Based Partners when a client is falling out of Care and expedites clients to Lost to Care list

Care Coordination: Delivery of Services

•Care Coordination Resources

ADAP Director, VDH

Carrie Rhodes

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Website: Virginia Department of Health Care Coordination Services

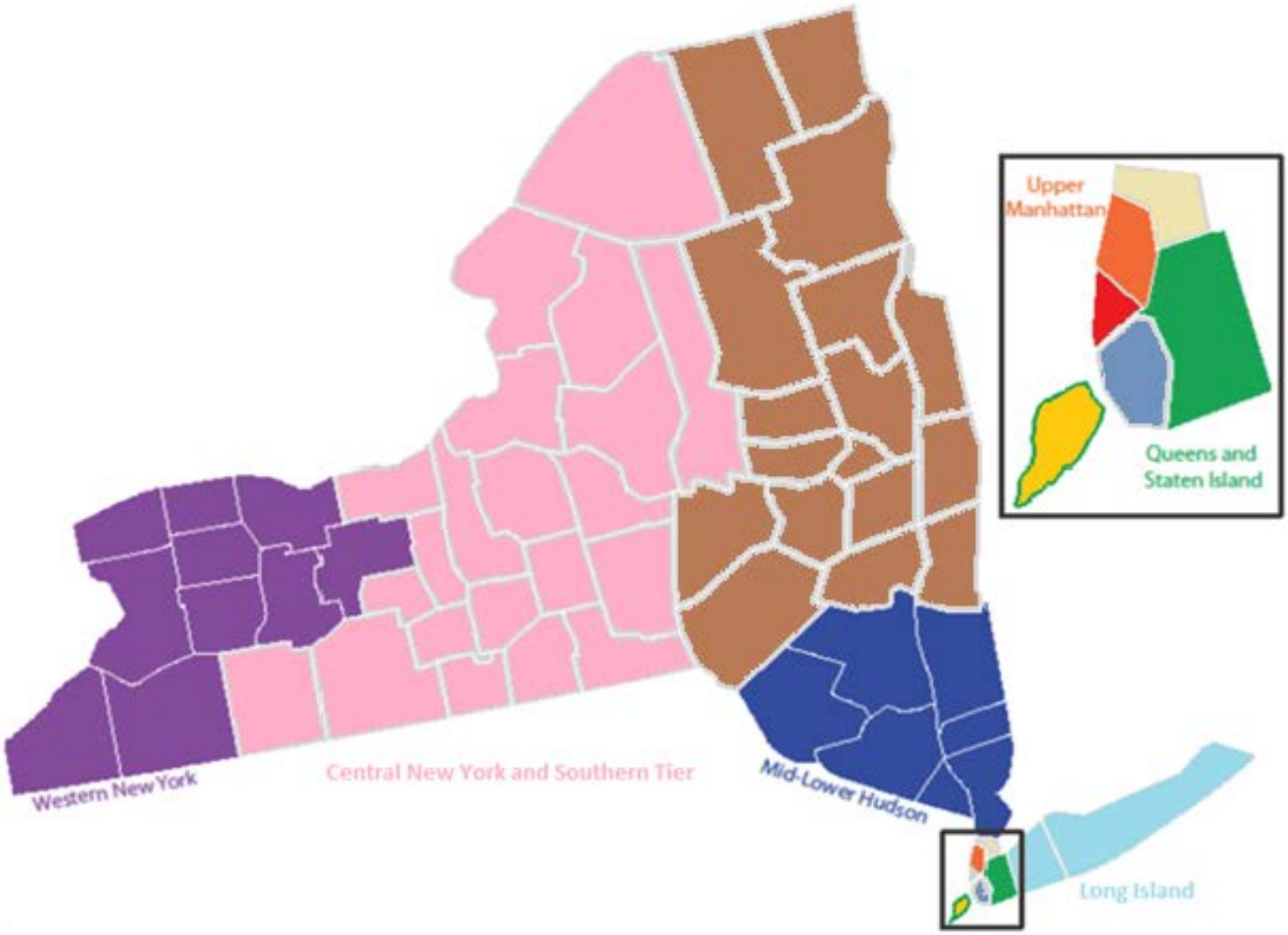
Buy-in & Engagement

VA Care Coordination Partners

VADOC	Local and Regional Jails	Community Partners	Correction Stakeholders
Headquarters Medical Unit Individual Facility Medical Units Re-Entry Specialists	Private Medical Contractor Leadership Individual Facility Medical Units Identify Large Jail Authorities	Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) Infectious Disease (ID)Clinics Case managers Community Based Organizations	Local Re Entry Council Committees Probation and Parole

Resources & Infrastructure

NY Learning Collaborative



Links

MA Resources:

Massachusetts Resources

NY Resources:

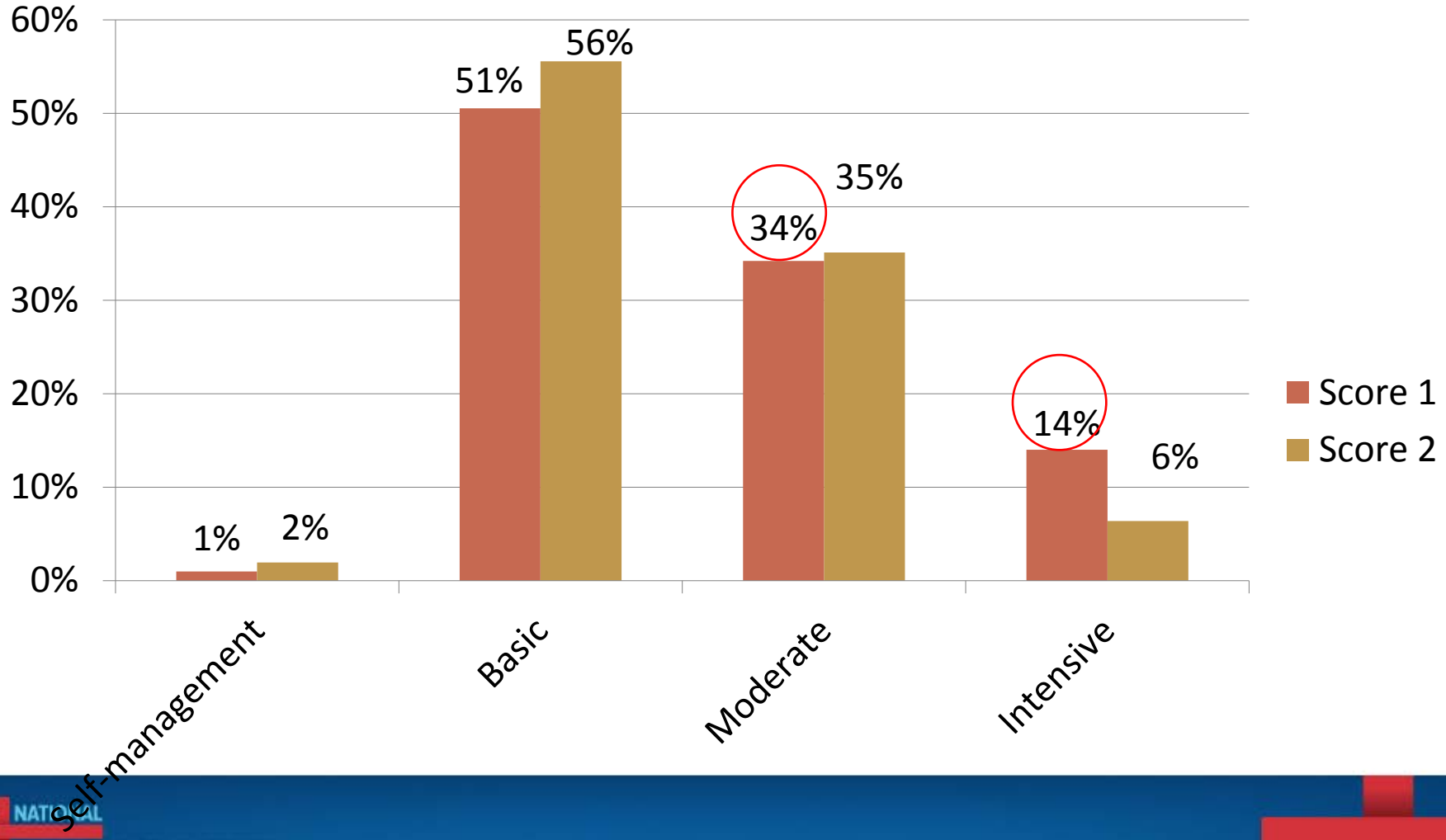
New York Resources

VA Resources:

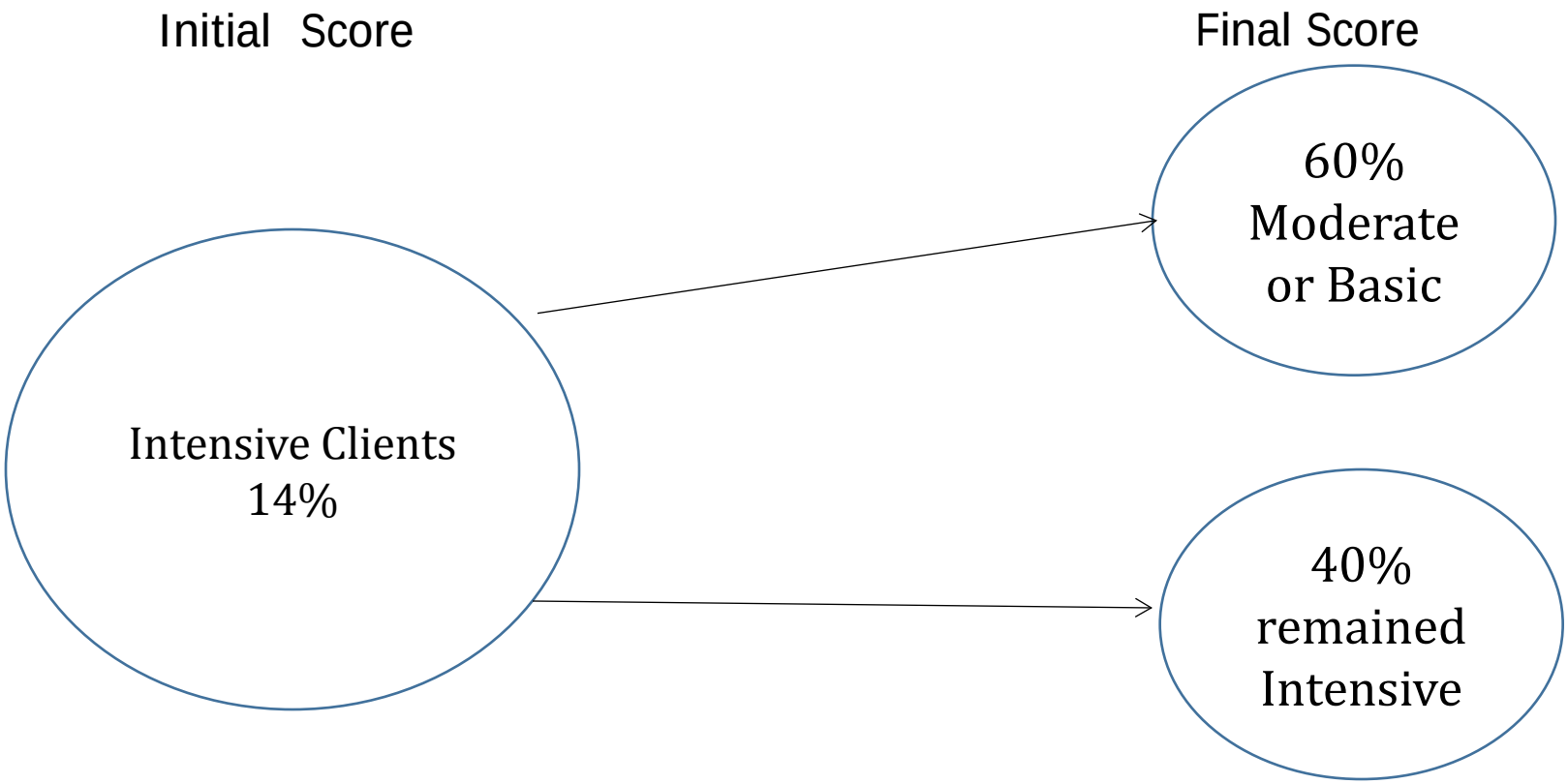
Virginia Resources

Evaluation & Data

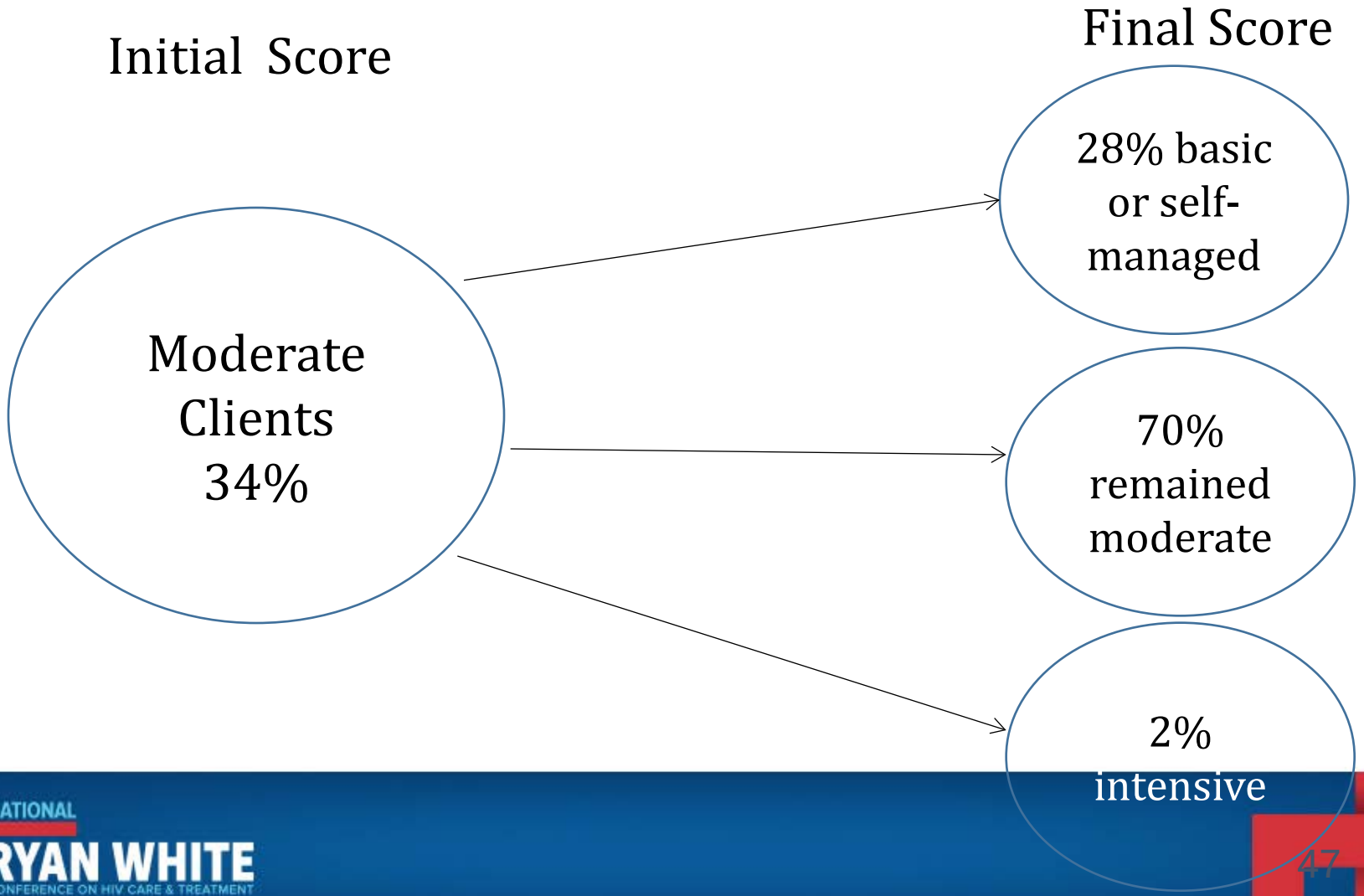
Acuity Tool Evaluation: Proportion of Client Initial & Final Score Groups (n=564)



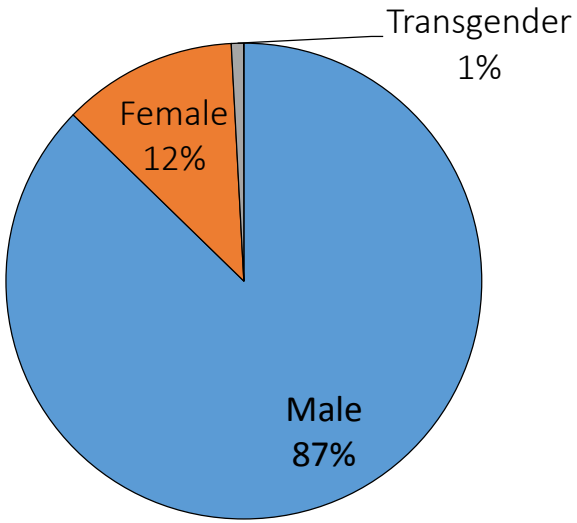
Acuity Tool Evaluation: Progress of Intensive Clients

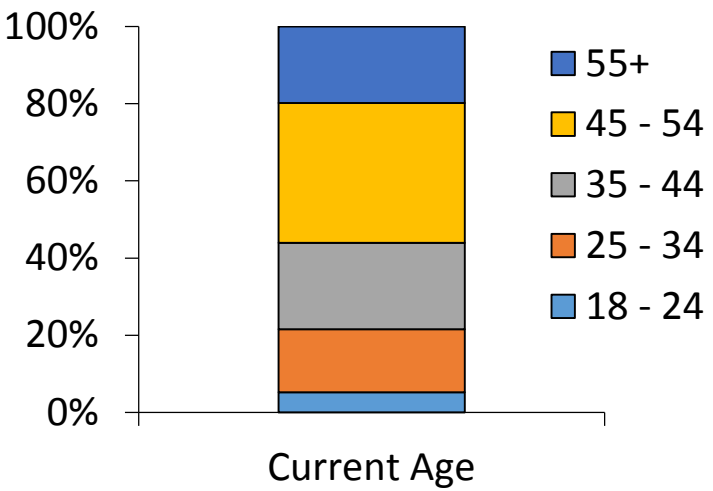


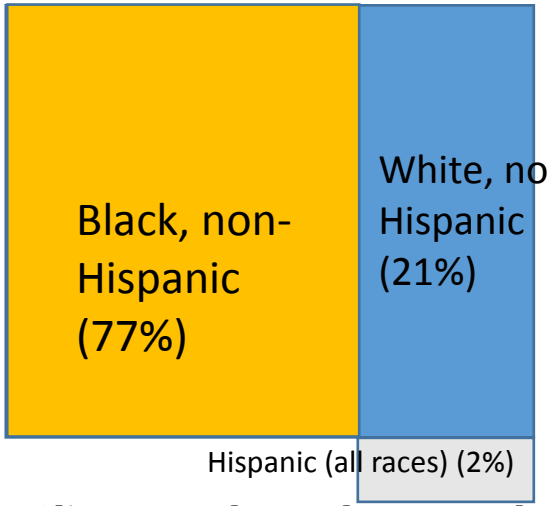
Acuity Tool Evaluation: Progress of Moderate Clients



Clients Enrolled in Care Coordination from January 1, 2015- December 31, 2015 (N=116)



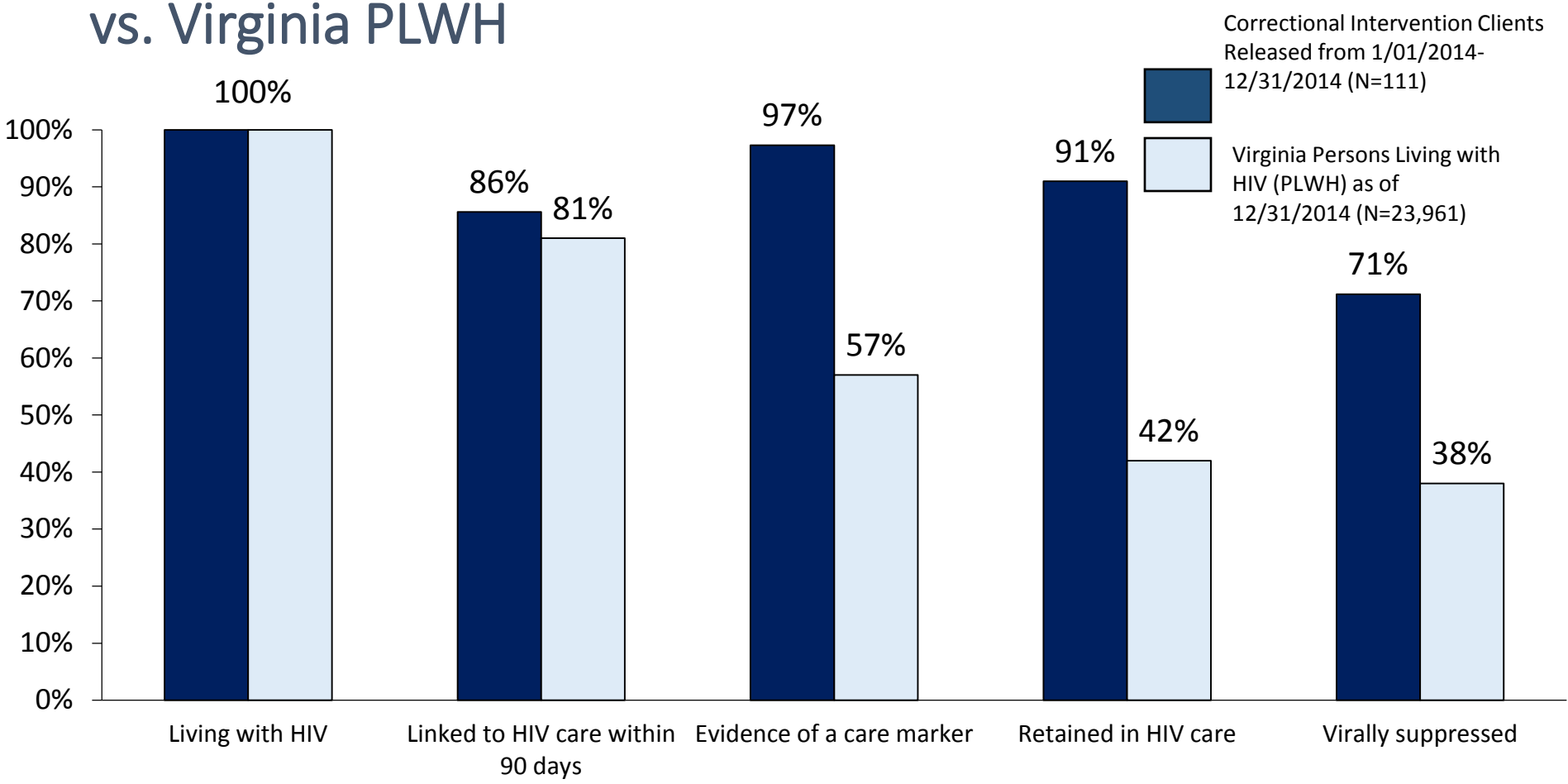




Transmission Risk	Percent (%)
Male-to-male sexual contact	34%
Injection drug use (IDU)	20%
MSM & IDU	9%
Heterosexual contact	11%
Pediatric	2%
No risk factor reported or identified	24%

***Clients are those who were released from a correctional facility from 1/1/2015 to 12/31/2015 and enrolled in the Care Coordination intervention during the same timeframe**

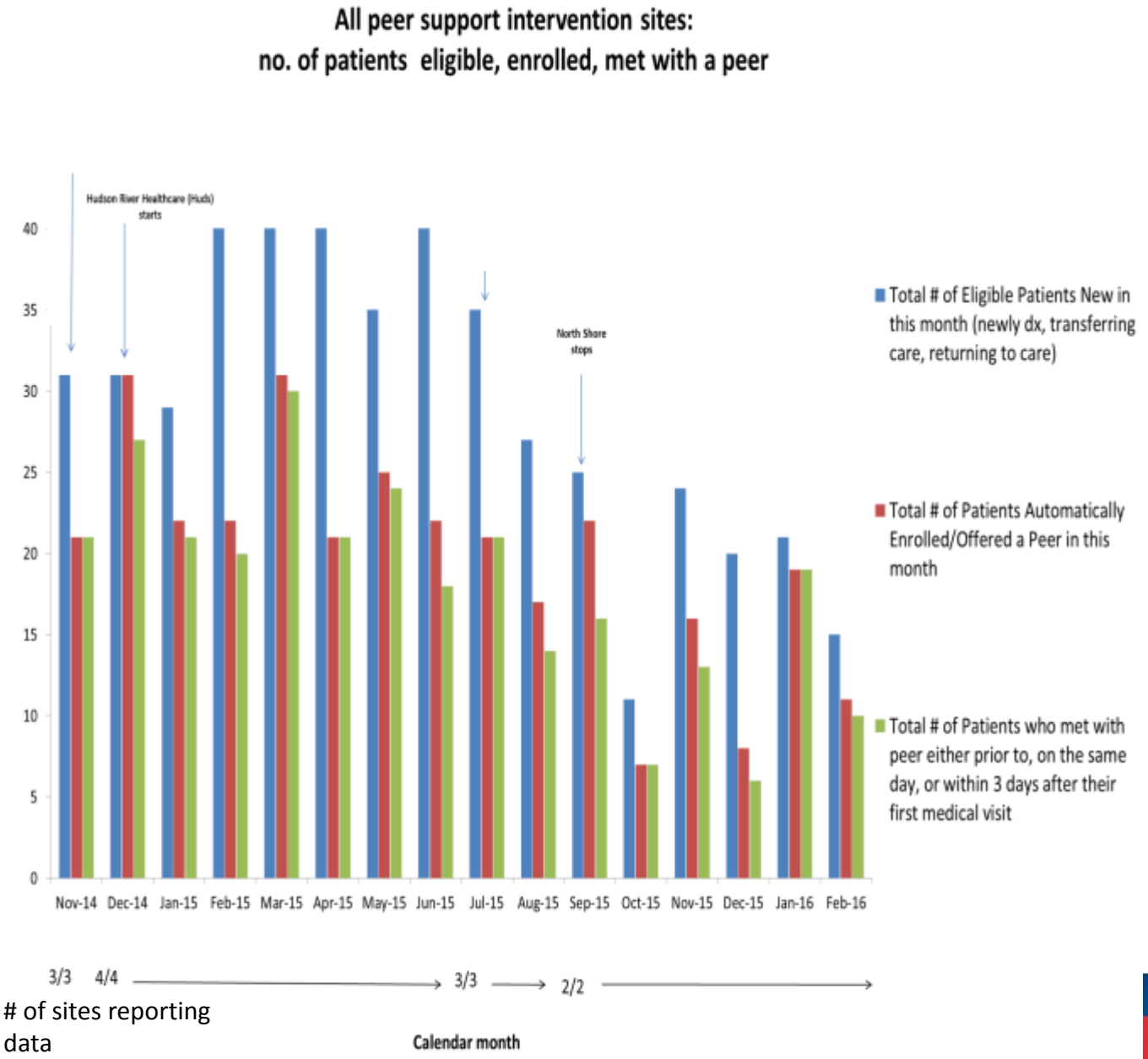
HIV Continuum of Care: Correctional Intervention Clients vs. Virginia PLWH

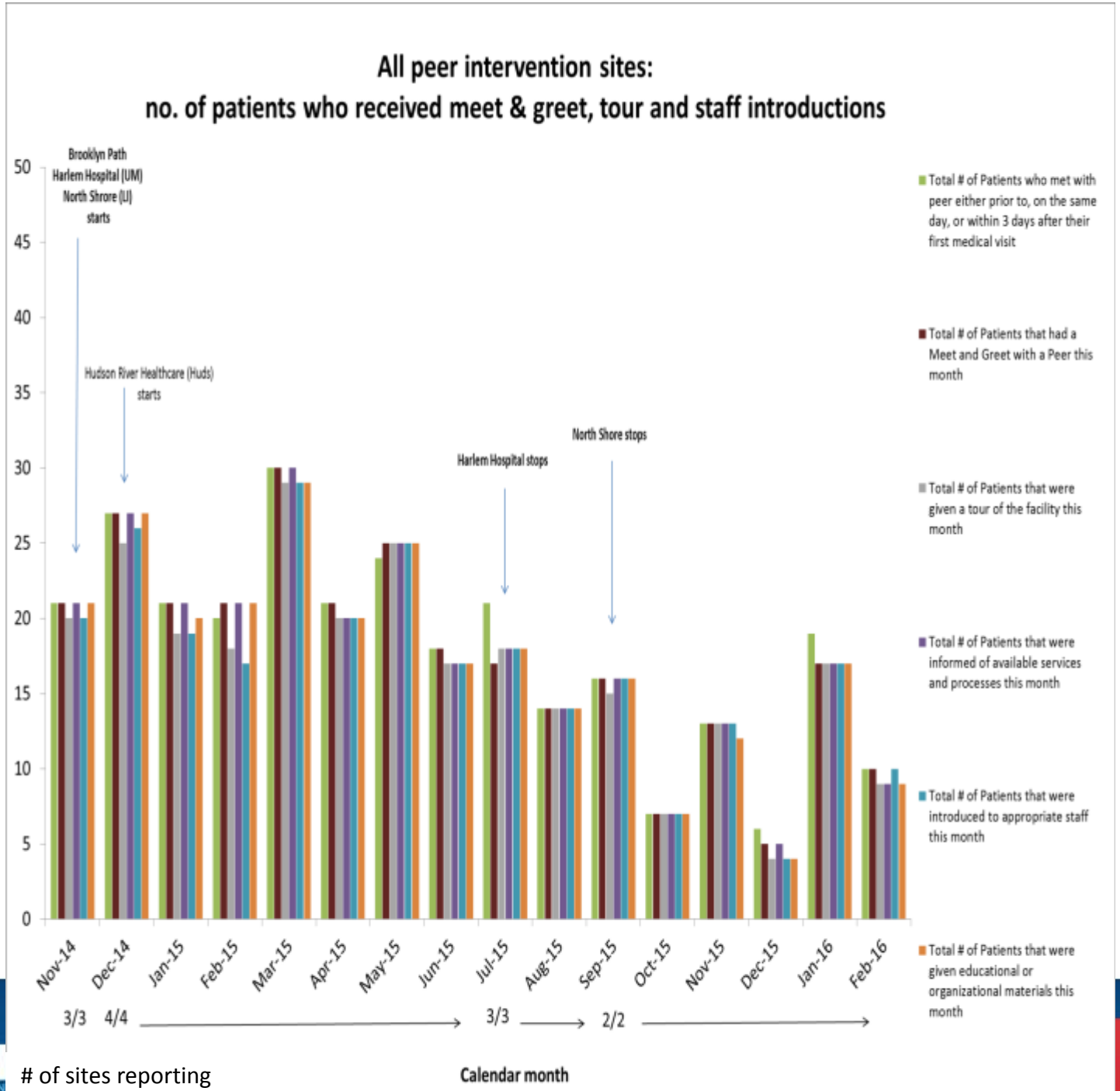


CHARLI and Care Coordination (Correctional Intervention Clients) HIV Continuum of Care (N=111)
Linked to HIV care: CHARLI/Care Coordination clients released from 1/01/2014-12/31/2014 who had a care marker within 90 days post-release
Evidence of a care marker: Evidence of care (CD4 or viral load lab, HIV medical care visit, or antiretroviral (ART) prescription) in the 12 months post-release
Retention and viral suppression: Measures based on 12 months post-release

Virginia's 2014 HIV Continuum of Care (N=23,961 as of 12/31/2014)
Linked to HIV care: Percent of persons newly diagnosed in Virginia in 2014 (N=924) who were linked to care within 90 days
Retention and viral suppression: Measures based on PLWH living in Virginia as of 12/31/2014 who were retained or virally suppressed in 2014

Peer Support





# of sites reporting data

Lessons Learned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&
A
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