SPNS 101: SYSTEMS LINKAGES AND ACCESS TO CARE: A SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE INITIATIVE

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Learning Objectives

At the end of this activity, participants will be able:

1. To describe the different interventions implemented under the Systems Linkage Initiative
2. To identify the barriers and facilitators to implementing the interventions.
3. To evaluate the benefits provided by interventions used to facilitate engagement/re-engagement in HIV care.

Workshops Overview

Session 101 of a 3-part workshop on the Special Projects of National Significance's *"Systems Linkage and Access to Care for Populations at High Risk of HIV Infection Initiative"*

Session 101 features an initiative overview & case studies

Session 201 features presentations on state-level outcomes

Session 301 features presentations on cross-state outcomes

Initiative Description

In 2011, HRSA/SPNS launched the Systems Linkage and Access to Care Initiative.

Six State Departments of Public Health were funded to develop and implement testing, linkage & retention interventions.

Center for AIDS Prevention Studies, UCSF serves as the Evaluation and Technical Assistance Center (ETAC).

Initiative Design

Pilot Phase 2011- 2013

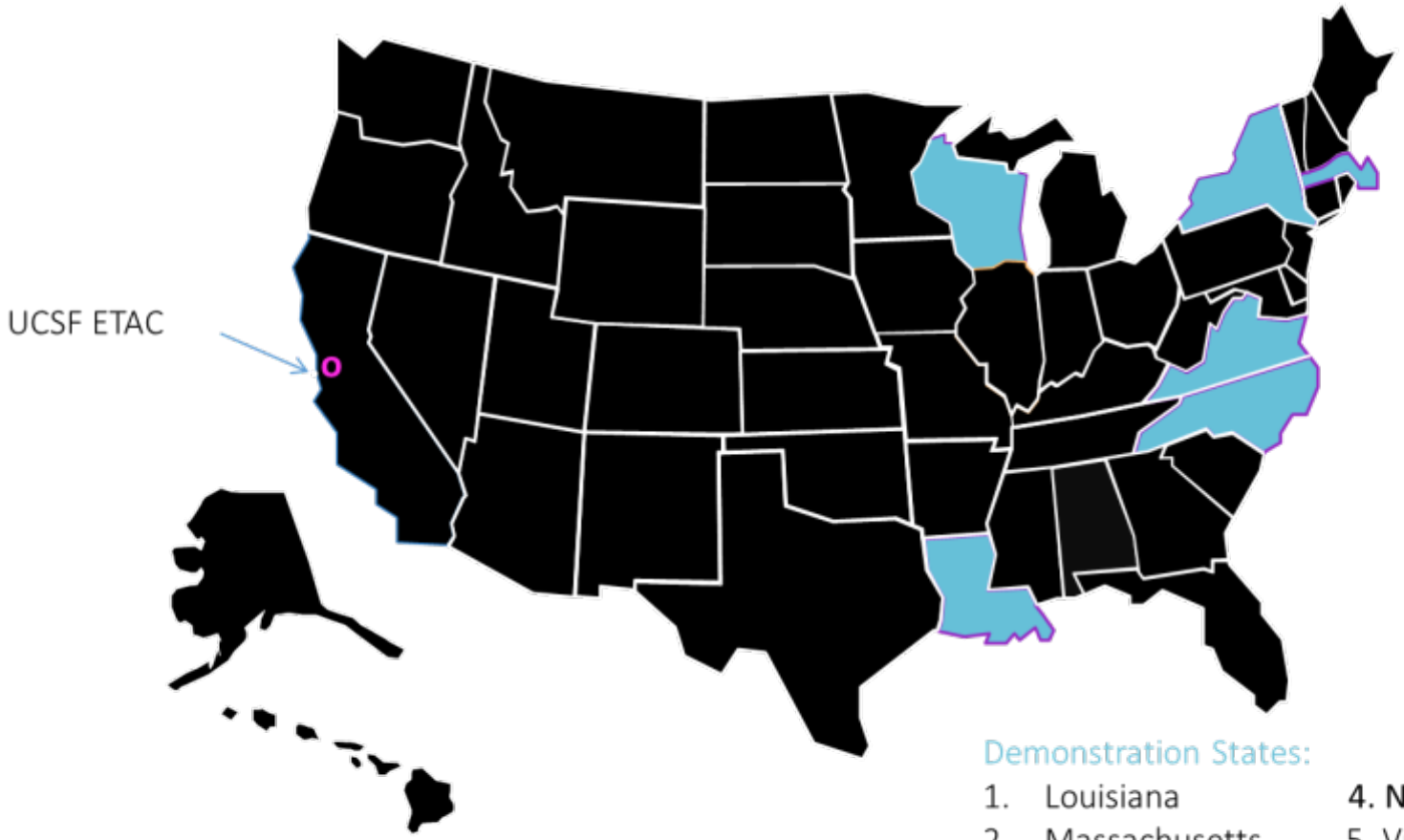
Grantees designed and piloted interventions in the first two years using the Institute for Healthcare Improvement's Collaborative Model.*

Implementation Phase 2013 - 2015

Interventions were refined and, in some cases, scaled up to statewide implementation in latter two years.

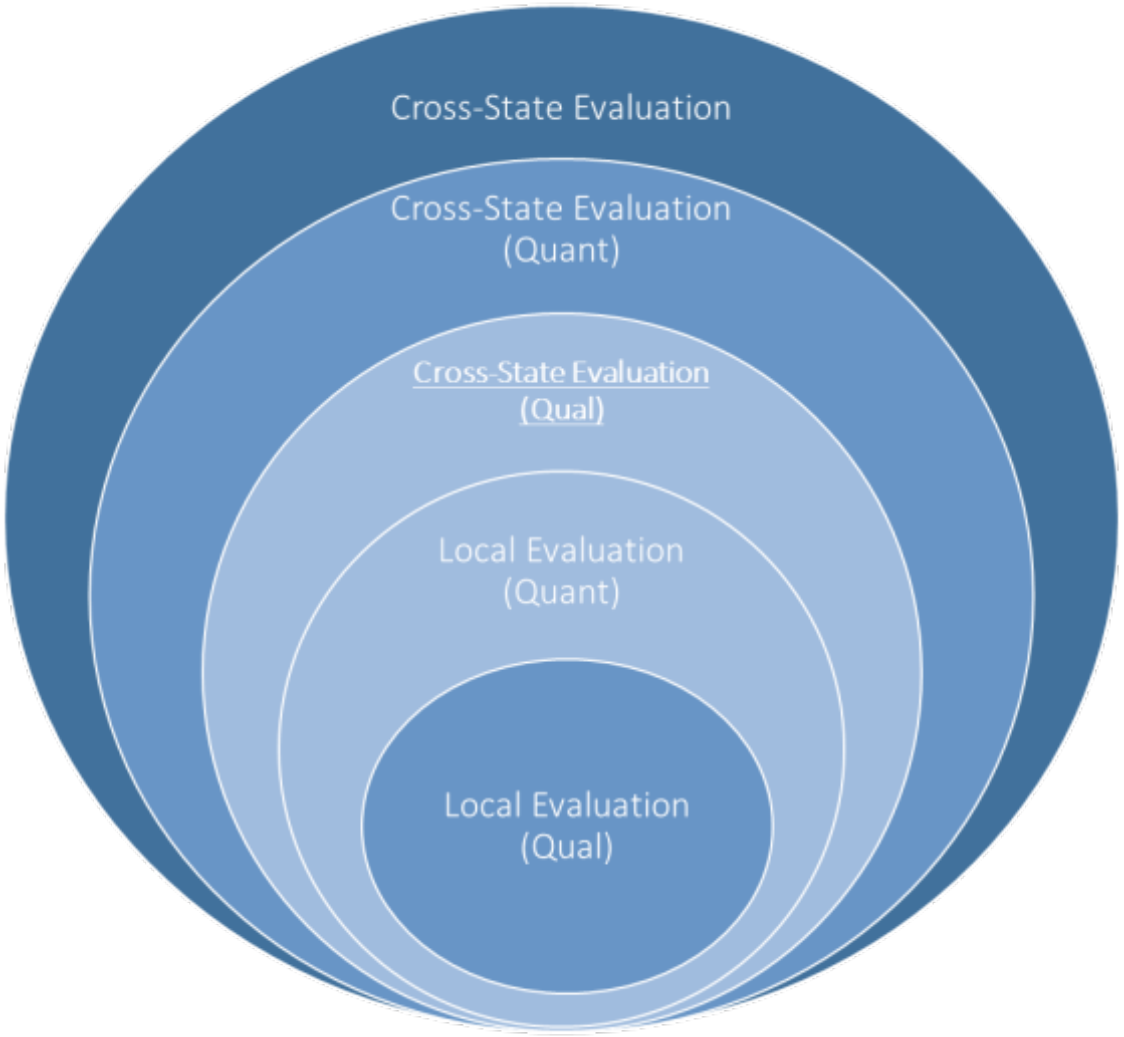
**The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003

Geographic Reach



Demonstration States:

1. Louisiana
2. Massachusetts
3. New York
4. North Carolina
5. Virginia
6. Wisconsin



Evaluating the Initiative

- States participate in cross-state and local evaluation activities

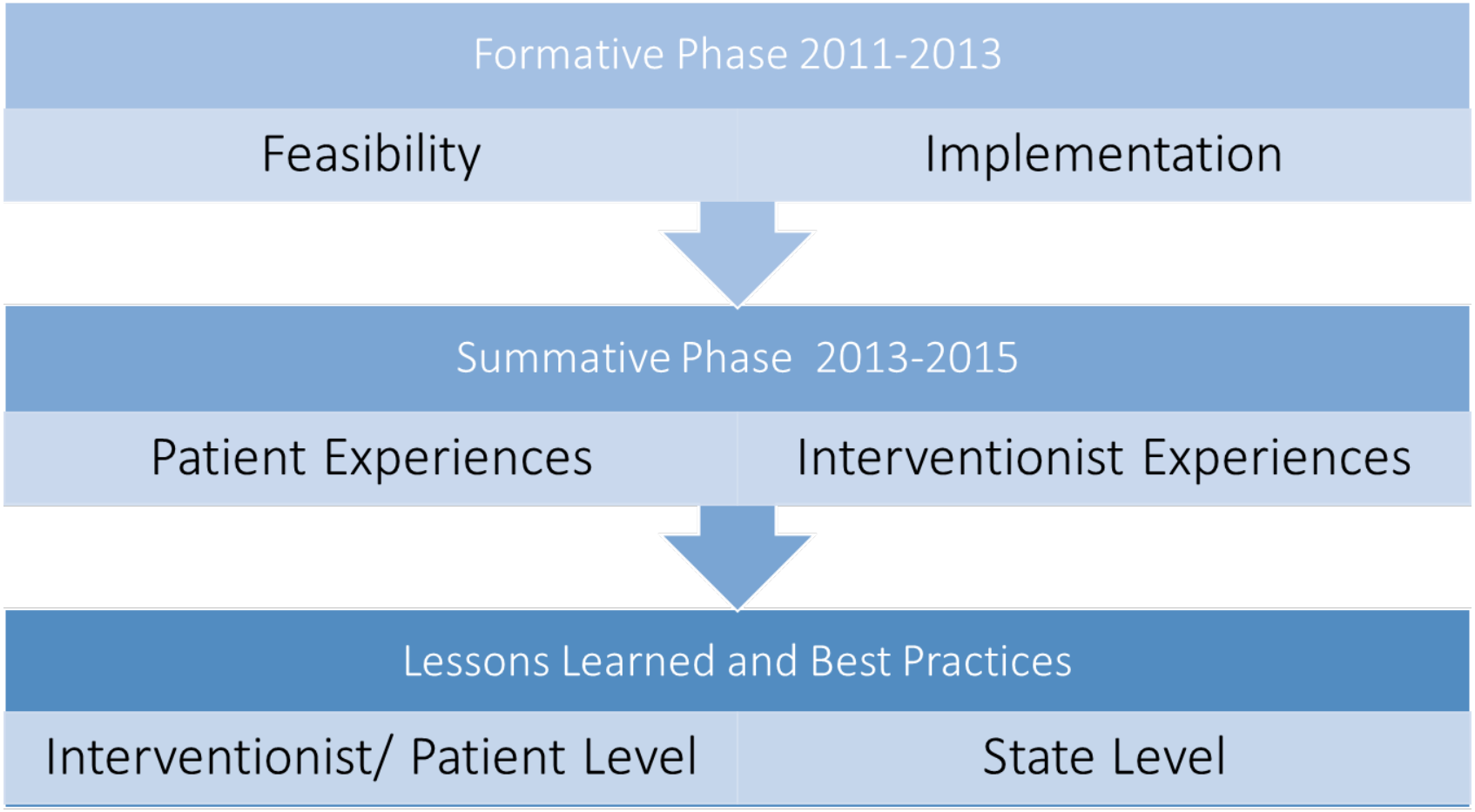
and

- Conduct a local quantitative evaluation; 5 of 6 local qualitative

UCSF Qualitative Inquiry

1. Are the interventions feasible to implement?
2. What are the barriers and facilitators to the implementation of the interventions?
3. How are the interventions working from the perspective of patients and the interventionists?
4. What are the key lessons learned & best practices associated with the interventions?

UCSF Qualitative Design



UCSF Qualitative Methods

- Review of secondary data
- Participant observation during “Learning Sessions”
- Key informant telephone interviews
- In-depth face-to-face interviews

Sample

Formative Phase:

- State health departments core team members
- Intervention collaborators
- People delivering interventions (Interventionists)

Summative Phase:

- Clients/Patients (*n* = 12 – 45 per state)
- Interventionists (*n* = 4-8 per state)

State	Informant Type	*n* =
Louisiana	Core team, 6 Collaborators , 6 Interventionists, 1	13
Massachusetts	Core team, 4 Collaborators, 7 Interventionists, 6	17
North Carolina	Core team, 4 Collaborators, 7 Interventionists, 2	13
New York	Core team, 2 Collaborators, 4	6
Virginia	Core team, 3 Collaborators , 3 Interventionists , 4	10
Wisconsin	Core team, 4 Collaborators, 3 Interventionists, 2	9
Totals	**Core team , 21** **Collaborators , 26** **Interventionists , 15**	**68**

Findings

- We identified 18 unique interventions across seven categories
  - Four focused on HIV testing and linkage category
  - Four on linkage category
  - Remaining 10 focused on the midpoints of the care continuum—retention and re-engagement efforts.
- We classified the projects along a continuum of intervention intensity from ‘light’ and ‘heavy.’

Testing and Linkage Interventions

Intervention Focus	State	Priority Population	Intervention Goal	Intervention Method	Interventionists
Test & Link	Louisiana	Incarcerated people entering jail	Administer opt-in HIV tests to increase status awareness and linkage to care	At in-take, inmates are offered HIV and syphilis testing via blood or rapid oral HIV test	HIV test counselor from a community-based organization
	North Carolina	Individuals who accompany HIV-positive clients attending clinical appointments	Provide free rapid HIV tests to individuals who accompany HIV-positive patients to appointments	During the medical visit, the accompanying individual is offered an HIV test onsite	Medical provider
	Wisconsin	Young people (age 29 and under) at risk for HIV	Enlist people living with HIV or at risk for HIV to serve as recruiters to encourage HIV testing to people in their social networks	Recruiters receive training on how to promote HIV testing and facilitate access to services	Community volunteers

Linkage Interventions

	n Goal	Intervention Method
Link		

Linkage & Re-Engagement Interventions

Intervention Focus	State	Priority Population	Intervention Goal	Intervention Method	Interventionists
Link/Re-Engage	Louisiana	Out of care HIV-positive individuals presenting for non-HIV related medical care	Identify out of care individuals and use the opportunity of a medical visit to engage them in care	Utilizes surveillance for an alert system that prompts providers to counsel patients to enter HIV care	Hospital medical provider
	Massachusetts	Newly diagnosed and out of care HIV-positive individuals	Provide intensive support focused on linkage and retention via care teams	Care teams provide enhanced medical case management, incl home visits up to 12 months	Nurse + HIV-positive Peer Team
	Massachusetts	Out of care HIV-positive patients	Generate clinic-specific lists of names of patients who have not had a CD_4 T-cell count or HIV viral load submitted to MHASP in more than 6 months.	Every month, MHASP distributes "line-lists" identifying of out-of-care individuals to participating clinics.	Massachusetts HIV/AIDS Surveillance Program (MHASP)
	New York	Newly diagnosed, transferring to new clinic, returning to care	Provide peer support and orientation to engage new clients in clinic services	Peer greets new client at first appointment and stays in touch via phone to give advice as needed	Peer Educator
	North Carolina	Newly diagnosed, at risk of falling out of care and out of care individuals	Link newly diagnosed who missed first appointment, retain those at risk of falling out of care and re-engage those out of care for 6 months or longer	Search throughout the state for individuals out of care and connect them to medical care via case management	State Bridge Counselor
	North Carolina	Newly diagnosed, at risk of falling out of care and out of care individuals	Retain those at risk of falling out of care and re-engage those out of care for 6 months or longer	EMR/CAREWare searches, phone calls, letters, internet searches, outreach to providers and pharmacies to locate out of care patients.	Regional Bridge Counselor
	Virginia	Newly diagnosed and out of care HIV-positive individuals	Link and retain out of care patients using motivational interviewing techniques	PN work with clients for 3-12 months to plan for retention in care.	Patient navigator (PN)
	Wisconsin	Newly diagnosed, out of care, recently released from correctional facility, at risk of falling out of care	Link individuals to HIV medical care through an intensive form of case management that addresses client barriers	LTCS works with client for a maximum of 9 months, with requirement to attend 3 care visits during time period	Linkage to care specialist (LTCS)

Retention Interventions

Intervention Focus	
	se manager
	Clinical and network staff

Intervention Intensity

Heavier touch:

- Client caseload is more manageable than a typical case manager e.g., maximum of 20 clients.
- Interventionists are encouraged to leave the office.
- Interventionists spend more time on behalf of or with clients than any one else in the clinic.

Lighter touch:

- Phone call to remind patient of upcoming appointments.
- Phone call to assist with appointment scheduling.

[The interventionist is] someone who will not drop the ball. . . If they don't answer the phone, then you figure out another way to find them. It's not traditional case management where you sit at your desk and hope you can reach them by phone. It's a whole different thing. – *Social worker*

Core Elements

1. Agreement that proactive and systematic outreach to patients newly diagnosed or out-of-care was necessary.
2. Determine mechanism to identify people never linked, out of care, not on medications and/or virally unsuppressed.
3. Refinement of list of identified people for accuracy, further information on whereabouts/status.
4. Hand-off information to interventionist to initiate next steps.

Table 2: Key Questions to Ask to Gather and Disseminate Essential Patient Information

Essential Questions	Systems Involved	People Involved
Who is out of care?	1. Surveillance 2. Electronic medical record (EMR)	3. SDoH staff 4. Clinic IT staff
Where/Why are they out of care?	2. Death records 3. Surveillance 4. Corrections 5. Hospital	6. Clinic staff 7. CBO staff 8. Corrections staff 9. Drug and alcohol treatment staff 10. Health department staff 11. Family/friends
What clinic info do we have?	1. Surveillance 2. EMR 3. Laboratory results 4. Pharmacy records 5. Regional Health Information Organization (RHIO)	6. SDoH staff 7. Clinic IT staff
What social info do we have	1. EMR	2. Clinic staff 3. CBO staff
When were they last seen?	1. Surveillance 2. EMR 3. Pharmacy 4. RHIO 5. Laboratory 6. ER/Hospital 7. CBO	8. Clinic staff 9. CBO staff 10. Drug and alcohol treatment staff 11. Corrections staff
Who is best suited to outreach to patient?	4. EMR	5. Clinic staff 6. CBO staff 7. Drug and alcohol treatment staff 8. Corrections staff

"…people on the edge of care need more attention and time…."

- Case manager

Implementation Facilitators

- Common agreement on the “problem”
- Clarity on the goals and clear vision of the intervention
- Skilled collaborators open to novelty
- Sufficient resources human & technological
- Use of the Collaborative Model

Shared Vision of Optimism

"People feel that we have the ability to begin to end the disease and saw this as a way to do that - if you are retaining patients and you're reducing viral loads, you're reducing incidents of HIV in your community; I think people were rallying around that message and continue to do so." *Collaborator*

Functional Collaboration

"From my standpoint this has been by far one of the most pleasant experiences that I've been involved in and I've been around a while. It just has all seemed so collaborative, non-threatening, people that are just so committed to a project and wanting to make it happen." *Collaborator*

Implementation Barriers

- Structural challenges
- Conceptual challenges
- Cross-organization collaboration challenges
- Interventionist-level challenges
- Patient-level challenges
- Collaborative Model

Structural Challenges

"… a [collaborative] project like this can only be successful if everyone is able to participate. And right now we just can't have that because of the way state government is working right now." *Core team*

"In the middle of everything we were trying to implement, the entire care system was changing, and will continue to change as [our state] grapples with the implementation of whatever components of the Affordable Care Act go into effect here." *Core team*

Conceptual Challenges

"It was frustrating for me to get [providers] to understand what it is I'm trying to do for the patients. . . people who have a similar title as I do don't understand what exactly it is that I'm doing, because I'm not doing the same things that they're doing. So, I think there can be a little hostility …"
Interventionist

"We wrote up a basic [eligibility] criteria to educate the providers about who might be appropriate for SPNS and who won't be. It's taken a lot of education to help people understand …that's an ongoing process." *Core team*

Cross-Organization Collaboration

"There was a little, I don't know if it was turf protection, just a little bit weary of what's this all about and how is this going to affect me, you know what I mean?" *Collaborator*

"…we're a new partner to them, and so there's a lot of different questions that need to be answered…And, sometimes that means that there's just a lot of extra steps, or extra relationships that have to be built for people to be comfortable about some of the information that we're sharing." *Core team*

Lessons Learned

- Systems Linkage Initiative heightened awareness of the gaps along the HIV care continuum at the state, regional and clinic level encouraging partners to take action to retain greater proportion of patients in care.
- Facilitated the design of programs to better support a population that had been underserved because they were not routinely presenting for care.
- State-led initiative enabled effective involvement of key players from a wide assortment of departments, community-based agencies and clinics serving people living with HIV.

Lessons Learned

- The Collaborative Model was an effective structure and included sufficient time for key stakeholders to come together and work towards a common vision to improve services for people living with HIV.
- The Collaborative Model allowed stakeholders to implement and refine interventions during the pilot phase, which were then expanded on a wider-scale in the latter years.

Acknowledgments

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For More Information

http://spnsetac.ucsf.edu/

http://hab.hrsa.gov/abouthab/special/systemslinkages.html