HIV Care Services Fundamentals Call
Linkage and Retention in Care
January 15, 2019

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Presentation Overview

Best practices and helpful tips to create a successful linkage and retention program for HIV medical care:

- **Patient navigation/client flow**
  - Clients meet with Project Champs who refer to LabCorp for completion of labs
  - Clients will either go to Sunset ID Care (if insured) or to Southwest Viral Med (if uninsured)

- **Retention in care and viral suppression data in increased with program**
  - In the last 12 months:
    - 91% of clients have been linked to care
    - 84% have been retained in care
    - 100% retained in care are prescribed ART
    - 89% of those retained in care are virally suppressed

- **Key elements that assisted with improving linkage and retention rates:**
  - Know your community
    - Know the providers that you work with
      - Community service is one way to get to know staff and providers in the community
  - Embrace technology
    - Work cell phone is helpful
    - Software technology to increase work flow efficiency
    - Teach clients how to use phone apps to stay connected

- Set goals
  - Looked at scheduling guidelines – set aggressive goals to improve
    - Have reassessed and set new goals
- Focus efforts and resources
  - Looked at labs to identify who has CD4 count below 200
  - Looked at medical records to see who did not have a medical appointment
  - Individuals who were identified in both criteria were prioritized for outreach and prioritize these clients

- **Elements of successful linkage and retention**
  - Team work
    - Client insurance status
      - 60% are uninsured (Southwest Viral Med)
      - 40% insured
    - Project Champs - case management
    - El Paso Health Department
    - UMC – county hospital that provides majority of referrals to Southwest Viral Med
    - Opportunity Center – homeless shelter
    - Aleviane
    - Borderline Rainbow Center
  - Transition of Care Model (warm hand-off)
    - Get referral from hospital to get basic information
    - Conduct hospital visit with client
    - Complete brief questionnaire, identify barriers to care (transportation, proof of residence, etc.), collect medical records and medication list (want to ensure that client does not miss medications during transition)
    - Provide RW documents (supporter statement, ADAP enrollment paperwork)
    - Enroll client in RW services before they leave hospital
    - Connect patient to case manager or medical provider before patient leaves hospital
    - Schedule 2 appointments (case management and medical provider) before client leaves hospital
  - Tool Kit
    - Enli (workflow management software)
      - bridge that allows different data systems (ARIES) and electronic medical records (EMR) systems to communicate
      - pull reports, set reminders, allow other staff to see client information

        - Hippabridge – secure (and HIPPA compliant) messaging technology (texting clients, sending videos, pictures)
        - Uber health
            - Can schedule client rides to appointments ahead of time or on demand
            - HIPPA compliant
            - For patients who don't have a cell phone staff will meet clients, then request Uber to have client transported to clinic
        - Creativity
            - Set reminders for yourself to call clients
            - Make client outreach personal
                - a client is more than their HIV status – get to know your clients and what is going on in their lives
            - Be resourceful – use what you have and be diligent
            - Meet clients "where they are at" (there favorite bench, the shelter, at the salon, etc.)
            - Practice patience
                - With yourself
                - With the clients – have the same enthusiasm the 11th time you call clients as you did the 1st time
                    - Clients reported that they feel safe with the staff
            - Education
                - Staff need to stay update with latest information via community meetings, learning sessions, etc.
                - With clients
                    - Inform them of the medical care process so they know what to expect
                    - Teach clients to advocate for themselves
                    - Teach clients how to organize their medications
                    - Share resources with client

- **Helpful tips for getting started**
    - Know your agency's data (e.g., treatment cascade, wait time for clients to be seen, etc.)
    - Identify barriers from the client's perspective
        - Identify why clients do not come to their appointments
        - Prioritize
        - Set goals
    - Know your community
        - Conduct outreach

- Collaborate with agencies in your community that fill in the gaps to make care for clients seamless
- Take care of your relationships with community collaborators

Questions from participants:

1) How does Enli work with ARIES? Does it minimize data entry?
    a. Is a lot of work – have to manually enter each client
2) During warm hand-off do navigators give Ryan White referrals? If so, do referrals count as the care plan? Does ADAP enrollment also happen prior to client's being released from the hospital?
    a. Yes, referrals are provided. These don't count toward care plan until clients are enrolled.
    b. The case manager will do all RW enrollment including ADAP.
3) Regarding Enli, do the EMR components mapped to it?
    a. Enlli does communication with our EMR but does take some work
4) What was the transition like to Enli to input data into both systems?
    a. Had weekly meetings during transition for approximately 6 months
    b. Tailored to agency need - prioritized program around patient navigation and capturing referrals
    c. Entered client data manually which took a several days – looking at enhanced platform to eliminate this aspect
5) What were the costs involved in this process?
    a. Don't have exact cost – depends on the platform you use
    b. Used Ryan White Part C capacity building grant to finance project
6) Does Enli populate a chart review summary? What is the upkeep for data validation?
    a. Data input – agency has an enrollment specialist and data manager that enter data
    b. Data staff have to keep up with enrollment dates
    c. Use spreadsheet that case managers had to inform building the data base – we can filter lists, client names
7) Are you able to upload eligibility documents in Enli?
    a. Yes, we can scan them
8) What is staring point for trying to implement technology to enhance linkage to care?
    a. Helpful to have leadership that embraces technology
    b. Ensure that system is HIPPA compliant
    c. Ask your agency leadership if this is something that can be incorporated
9) When you enter data in Enli, are case notes able to be viewed by other staff?
    a. Yes, other staff can do follow-up with clients and document what they have done. This can facilitate communication between staff who are working with the same client and keep information up to date

10) Are applications used for communication? How do you know if an application is HIPPA compliant?
    a. Helpful to have staff who know about technology and HIPPA compliance
11) Have you seen a decrease in your "no show rate" since using Uber health?
    a. Yes
        i. Is very helpful with homeless population and youth who may not have a support system to provide transportation
12) Do you use OAHS to provide telemedicine?
    a. Currently doing research

If you still have questions about discussion from this call please contact:
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Related note: Ryan White HIV/AIDS Program Part C Capacity Development Program currently has a grant available. The deadline to apply for the grant is March 22, 2019. Below is a link to the Part C grant information with some contact information:

https://hab.hrsa.gov/fundingopportunities/default.aspx?id=8cf8e1ba-0d99-4c10-b5ff-a86e1979bb22

Next Call: Tuesday, February 26th
1:00 p.m. – 2:00 p.m.