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

Select Topic
Recruit Faculty

Develop Framework and Changes

Enroll Participants

Prework

LS1
AP1

LS2
AP2

LS3
AP3

Summative Congresses and Publications

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessments

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act
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
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

<table>
<thead>
<tr>
<th>Medical Case Mgmt Levels</th>
<th>Areas of Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intensive</td>
<td>• Care adherence</td>
</tr>
<tr>
<td>• Moderate</td>
<td>• Medication adherence</td>
</tr>
<tr>
<td>• Basic</td>
<td>• Current health status</td>
</tr>
<tr>
<td>• Self-management</td>
<td>• Health literacy</td>
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<tr>
<td></td>
<td>• Insurance status</td>
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<td></td>
<td>• Housing</td>
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<td></td>
<td>• Mental health</td>
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<td></td>
<td>• Substance use</td>
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</table>
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

<table>
<thead>
<tr>
<th>Medical Case Management Levels</th>
<th>Areas of Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intensive need</td>
<td>• HIV care adherence</td>
</tr>
<tr>
<td>• Moderate need</td>
<td>• Current HIV health status</td>
</tr>
<tr>
<td>• Basic need</td>
<td>• Other non-HIV related medical issues</td>
</tr>
<tr>
<td>• Self-management</td>
<td>• Medication adherence</td>
</tr>
<tr>
<td></td>
<td>• Health insurance/HDAP</td>
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<td></td>
<td>• Sexual and reproductive health</td>
</tr>
<tr>
<td></td>
<td>• Current mental health status</td>
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<tr>
<td></td>
<td>• Current substance use</td>
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<tr>
<td></td>
<td>• Support systems &amp; relationships</td>
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<td></td>
<td>• Current legal status</td>
</tr>
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<td></td>
<td>• Current income/personal finance</td>
</tr>
<tr>
<td></td>
<td>• Transportation</td>
</tr>
<tr>
<td></td>
<td>• Nutrition</td>
</tr>
</tbody>
</table>
# Acuity Tool: Sample Page

## Area of Functioning: Adherence to Medical Care

<table>
<thead>
<tr>
<th>Intensive Need (3)</th>
<th>Moderate Need (2)</th>
<th>Basic Need (1)</th>
<th>Self Management (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Has missed 2 or more consecutive HIV medical appointments in the last 6 months</td>
<td>□ 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</td>
<td>□ 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</td>
<td>□ Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider</td>
</tr>
<tr>
<td>Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability</td>
<td>Requests accompaniments to medical appointments from MCM or other member of the care team</td>
<td>Needs assistance with making and keeping HIV medical appointments</td>
<td>Does not require any assistance or reminders to schedule or keep medical appointments</td>
</tr>
<tr>
<td>□ Has not been seen by HIV medical team in the last 6 months</td>
<td>□ Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Acuity Score:

<table>
<thead>
<tr>
<th>Dates of Last 2 HIV Appointments:</th>
<th>dd/mm/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd/mm/yyyy</td>
<td></td>
</tr>
</tbody>
</table>
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

Steven Sawicki, MHSA
Program Manager, AIDS Institute, Office of the Medical Director
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 http://www.newyorklinks.org
• Blog at http://linkandretain.wordpress.com/
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).
Prior to Care Coordination...
Previously known 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

Identify HIV incarcerated client

Develop relationship/processes with correctional medical team

Dispense 30-day supply of ADAP medications

Linkage to care and case management services

Address barriers to care and monitor client for 12 months
Care Coordination Resources

ADAP Director, VDH

Carrie Rhodes
Carrie.Rhodes@vdh.virginia.gov

Website:
http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/CareCoordinationServices.htm
Buy-in & Engagement
# VA Care Coordination Partners

<table>
<thead>
<tr>
<th>VADOC</th>
<th>Local and Regional Jails</th>
<th>Community Partners</th>
<th>Correction Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headquarters Medical Unit</td>
<td>Private Medical Contractor Leadership</td>
<td>Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI)</td>
<td>Local Re Entry Council Committees</td>
</tr>
<tr>
<td>Individual Facility Medical Units</td>
<td>Individual Facility Medical Units</td>
<td>Infectious Disease (ID)Clinics</td>
<td>Probation and Parole</td>
</tr>
<tr>
<td>Re-Entry Specialists</td>
<td>Identify Large Jail Authorities</td>
<td>Case managers</td>
<td>Community Based Organizations</td>
</tr>
</tbody>
</table>
Resources & Infrastructure
NY Learning Collaborative
Links

MA Resources:

NY Resources:
http://www.newyorklinks.org/interventions/

VA Resources:
http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/CareCoordinationServices.htm
Evaluation & Data
Acuity Tool Evaluation: Proportion of Client Initial & Final Score Groups (n=564)
Acuity Tool Evaluation: Progress of Intensive Clients

Initial Score

Intensive Clients 14%

Final Score

60% Moderate or Basic

40% remained Intensive
Acuity Tool Evaluation: Progress of Moderate Clients

Initial Score

Moderate Clients 34%

Final Score

28% basic or self-managed

70% remained moderate

2% intensive
Clients Enrolled in Care Coordination from January 1, 2015- December 31, 2015 (N=116)

- **Male**: 87%
- **Female**: 12%
- **Transgender**: 1%

**Transmission Risk**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male-to-male sexual contact</td>
<td>34%</td>
</tr>
<tr>
<td>Injection drug use (IDU)</td>
<td>20%</td>
</tr>
<tr>
<td>MSM &amp; IDU</td>
<td>9%</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>2%</td>
</tr>
<tr>
<td>No risk factor reported or identified</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Current Age**

- 18 - 24: 20%
- 25 - 34: 40%
- 35 - 44: 20%
- 45 - 54: 20%
- 55+: 10%

*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

- **Living with HIV**: 100%
- **Linked to HIV care within 90 days**: 86% for Correctional Intervention Clients, 81% for Virginia PLWH
- **Evidence of a care marker**: 97% for Correctional Intervention Clients, 57% for Virginia PLWH
- **Retained in HIV care**: 91% for Correctional Intervention Clients, 42% for Virginia PLWH
- **Virally suppressed**: 71% for Correctional Intervention Clients, 38% for 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

All peer support intervention sites:
no. of patients eligible, enrolled, met with a peer

# of sites reporting data
All peer intervention sites:
no. of patients who received meet & greet, tour and staff introductions

- Brooklyn Path
- Harlem Hospital (UM)
- North Shore (LI)

Hudson River Healthcare (Hrads) starts

- Harlem Hospital stops
- North Shore stops

- Total # of Patients who met with peer either prior to, on the same day, or within 3 days after their first medical visit
- Total # of Patients that had a Meet and Greet with a Peer this month
- Total # of Patients that were given a tour of the facility this month
- Total # of Patients that were informed of available services and processes this month
- Total # of Patients that were introduced to appropriate staff this month
- Total # of Patients that were given educational or organizational materials this month

Calendar month

# of sites reporting data
Lessons Learned
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