Monroe County Department of Public Health

HIV Linkage in Monroe County

06/01/2012 – 11/30/2013

Linkage QI Team

- **Leadership Support**
  - Dr. Byron Kennedy, Health Commissioner
  - Mary Younge, Outreach Services Coordinator
- **Quality Improvement Support**

  - Nanette Magnani, Quality Lead WNYS NY Links

- **Team Members**
  - Team Leader - Kimberly Smith, Supervising Public Health Representative
  - Roxana Inscho, Supervising Public Health Representative
  - Katherine Herpin, Assistant Public Health Representative
  - Mathew Kole, Data Manager

Background
NYS Surveillance Data Report 2011

- 3,800- Estimated number of people living with HIV in 2011 within the Rochester Ryan White Region
- 3,124 PLWDHI within the Rochester Ryan White Region
- 42% (1,600) of 3,800 had no care during 2011.
- 74% (2,285) of 3100 of PLWDHI resided in Monroe County during date of diagnosis.
- Information pending re % of 2,285 with no care in MC

Background
MCDPH Data

- **2010 and 2011 - 200 Newly Diagnosed Cases**

Background

Relationships:

Established formal relationships with individual agencies to assist us in reaching our goals focused on compliance.

Clinical

AJHC, Trillium, Threshold

Non – Clinical

Catholic Charities, ABC, MOCHA, ABW

Background
MCDPH Approach to Partner Services & Notification

- The focus of STD/HIV Prevention and Control was risk reduction, education, Partner Services, some referrals, some informal linkage

- No formal system in place to track and link clients to care particularly within 30 days. “Show up at providers office (AJHC, Trillium) and request clients be seen.”
- No system in place for accepting community referrals and for follow up linkage to medical care

Aim Statements

To increase linkage to HIV medical care of:

Project 1. newly diagnosed clients within 30 days.

Project 2. clients who have dropped out of care within 30 days.

Project 3. previously known HIV positive and co-infected clients within 30 days.

Project 4. Clients known to be out of care for 13-24 months within 30 days.

Project 1 - Measurement

Newly diagnosed:

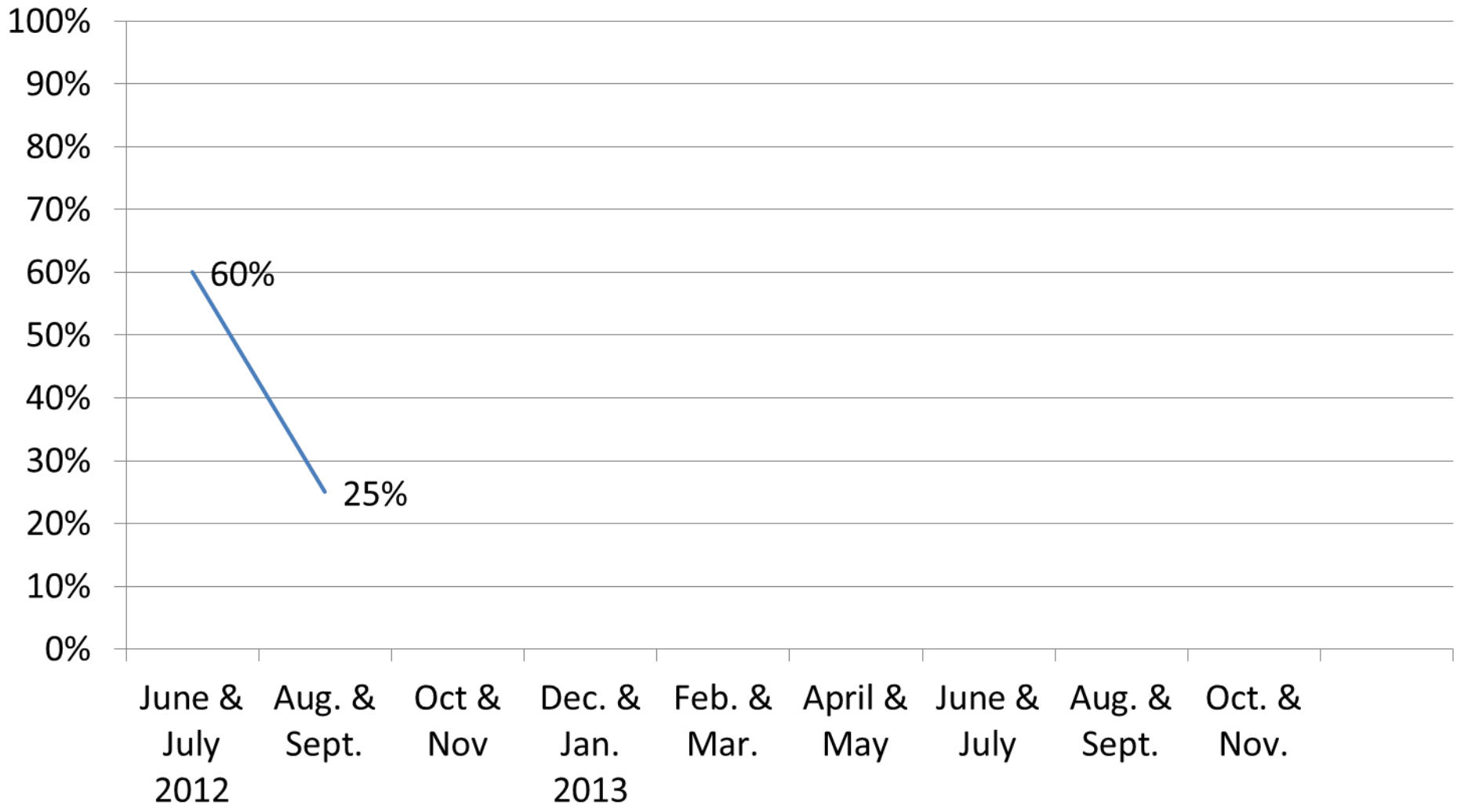
Measure	Percentage of newly diagnosed patients in the reporting period who had their first HIV clinical care visit within 30 days of the date of their confirmatory HIV test result
Numerator	Number of newly diagnosed patients in the reporting period who had their first HIV clinical care visit within 30 days of the date of their confirmatory HIV test result within the measurement period
Denominator	Number of newly diagnosed patients within the reporting period
Patient Numerator and Denominator Exclusions	
1. Patients who are documented to be deceased at any time in the measurement period 2. Patients who relocated out of the service area in the measurement period	
Important Definitions	
An **"HIV clinical care visit"** is defined as a visit with a medical provider with prescribing privileges. A **"provider with prescribing privileges"** is a health care professional who is licensed in their jurisdiction to prescribe ARV therapy (i.e., physician, physician assistant, and/or nurse practitioner).	
Additional Note	
Linkage of a patient to another institution such as a mental health inpatient unit, inpatient drug detox program, or correctional facility would, for purposes of this measure, count as "linkage." Ongoing efforts to assure engagement and retention or a follow-up linkage to an outpatient program are not the responsibility of the primary referring entity.	

Baseline Linkage Data and revised AIM statement

Average 42% based on initial 4 months prior to interventions

Increase linkage to HIV medical care of newly diagnosed clients within 30 days from an average of 42% to 90%.

HIV Linkage Baseline Data



Project 1- Causal Analysis

A. External/Community Level

Compliance Orientation

- MCDPH agreements with external agencies were agency focused on adhering to Public Health Regulations and not time specific
  - Met client at appt.
  - On time reporting of newly diagnosed cases

Project 1 – Causal Analysis

B. Internal Processes/Organizational Level (Traditional Partner Services)

- No Intake Referral Form (Paper or Electronic)
  - Documented all follow up activities on NYS Field Record
- Provider communication was not linkage focused
  - No 30 day linkage agreement
  - Focused on Patient's awareness of results
  - Waited for Provider to contact client for post test results (ED visits)
- Inability to document and monitor follow up electronically
  - Appt. compliance, referrals, Lab compliance with reporting requirements

Project 1 – Causal Analysis

C. Client Level

- Perceived as “sex police”
- Complex needs of clients that were barriers to linkage
- Not fully understanding the benefits of being in care

Project 1 - Interventions

A. External/Community Level

Agency relationships

- WNY Links Collaborative brought agencies together to serve a common goal

- Shifting from Compliance to Partnership
  - provider takes lead in Partner Service follow up with MCDPH
  - Working towards the same goal (NY Links)

- From MOU to Linkage Agreement
  - 30 day linkage agreement
  - Agency Contact available as needed

Project 1 - Interventions

B. Internal Processes/Organizational Level

Creating a shift from Traditional Partner Services to include linkage, re-engagement and retention

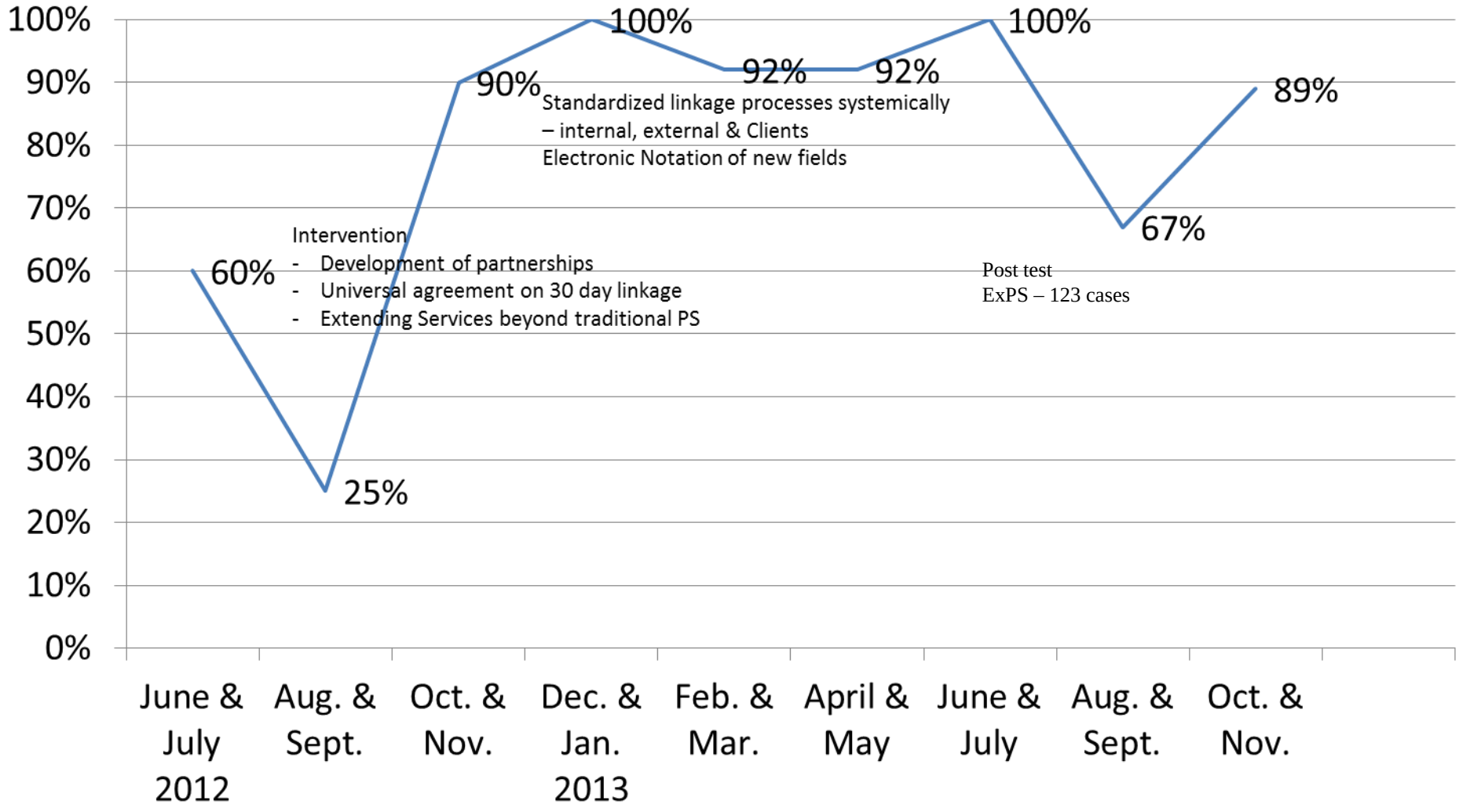
- Create a referral process for linkage that addresses client needs
- Created a Client centered Bi-Weekly Case Review
- Revised/created new data fields in order to document
  - Appt. verification
  - Outgoing Referrals to clinical and non clinical
  - Lab compliance
  - Post test counseling
- Enhanced our communication with providers
  - Confirm 30 day linkage
  - Provide assistance with Post test Counseling
- Reviewed QI and Process diagram with Program Staff

Project 1 - Interventions

C. Client Level

- Changing approach to clients
  - Educate on importance of being in care
  - Become aware of community resources in order to choose care options
  - Involve Client in extensive risk reduction
  - Address Complex needs/barriers of clients in order to link them to care

HIV Linkage Interventions and results



QI Project Step 5: Sharing results

- Post results on Staff bulletin board
- Present and discuss results with WNY Collaborative
- Schedule meetings with Partners (Road Shows) to discuss results
- Share results with NYS Quality of Care Advisory Committee
- Discuss with Dan Tietz and consumers (Forum to share results)

QI Project Step 6 – Systematize Changes

- Improved workflow Processes have been standardized with Leadership Support
- Approach to clients has been standardized

  - an additional worker assigned to cases

- Linkage Agreement in Process

  - AJHC drafted and in review
  - UR Well Clinic
  - St. Joseph Villa
  - URMC
  - Trillium
  - Genesee Specialty Care
  - Non Clinical Providers

Next Steps

Integration of work processes across sub populations

- Newly diagnosed
- Previously known positives out of care
- Clients suspected of dropping out of care
- Clients known to be out of care for 13 to 24 months

Discuss data reports on sub populations with leadership and staff

Create integration plan and roll out to staff