# HIV Testing and Linkage

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# Georgia's HIV Testing Program

- Health Districts
- Community Based Organizations
- Community Clinics
- Jails
- Colleges/Universities
- Health Fairs
- Clubs/Bars
- Emergency Rooms
- Outreach Events

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# HIV Testing Program

- TOT for district identified CTL Trainers
- Provide a Social Network Strategy training for funded non-clinical test sites to increase targeted HIV testing
- Up-to-date with CTL data in Evaluation Web

# HIV Testing Program

- Assessment of CTL data in Evaluation Web
  - Frequent errors with data collection
  - Numerous sites are not in compliance with deadline submissions of CTL forms
  - Missing or incomplete data recorded for positive results
    - Behavioral risk profile
    - Linkages to care and other services

# What's next for CTL

- Improve the way we capture Counseling and Testing data
- Focus on Data Quality:
  - Reduce data collection errors
  - Improve timely submission of CTL forms
  - Track linkages as documented on CTL forms for positives
- Inform opportunities for training, improved data fidelity and better communication with agencies

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# What's next for CTL

- Re-structure Agency and Site associated testing as captured in Evaluation Web

- Better capture where testing is taking place and what testing events look like amongst DPH funded agencies and across sites throughout Georgia/MSA

# MATLC & HIV CTL

- Development of partnerships that align with the goal of promoting routine HIV testing in healthcare/clinical settings as well as testing in non-clinical settings

- Implement a test event management and planning with testing data from Evaluation Web and other data sources

# MATLC and HIV CTL

- Collaborating with Surveillance
- Better identify target populations and improve programmatic activities
- Identify areas of high prevalence, new diagnosis and positive HIV ratio
- Use of surveillance data to monitor linkages to and retention in care for newly diagnosed and previously positives

# Surveillance  Metrics

- Laboratory reports and dates can be used as proxies for medical visits.
  - CD4
  - Viral load
- Engagement in care
  - A medical visit within 3 months of HIV diagnosis
  - Cases known in surveillance w/ at least one lab (CD4/viral load)
- Retention in care
  - 2 or  more medical visits 3 or more months apart
  - Cases known in surveillance w/ 2 or more labs (CD4/viral load) that are 3 months apart within 12 month period, excluding first lab drawn after diagnosis
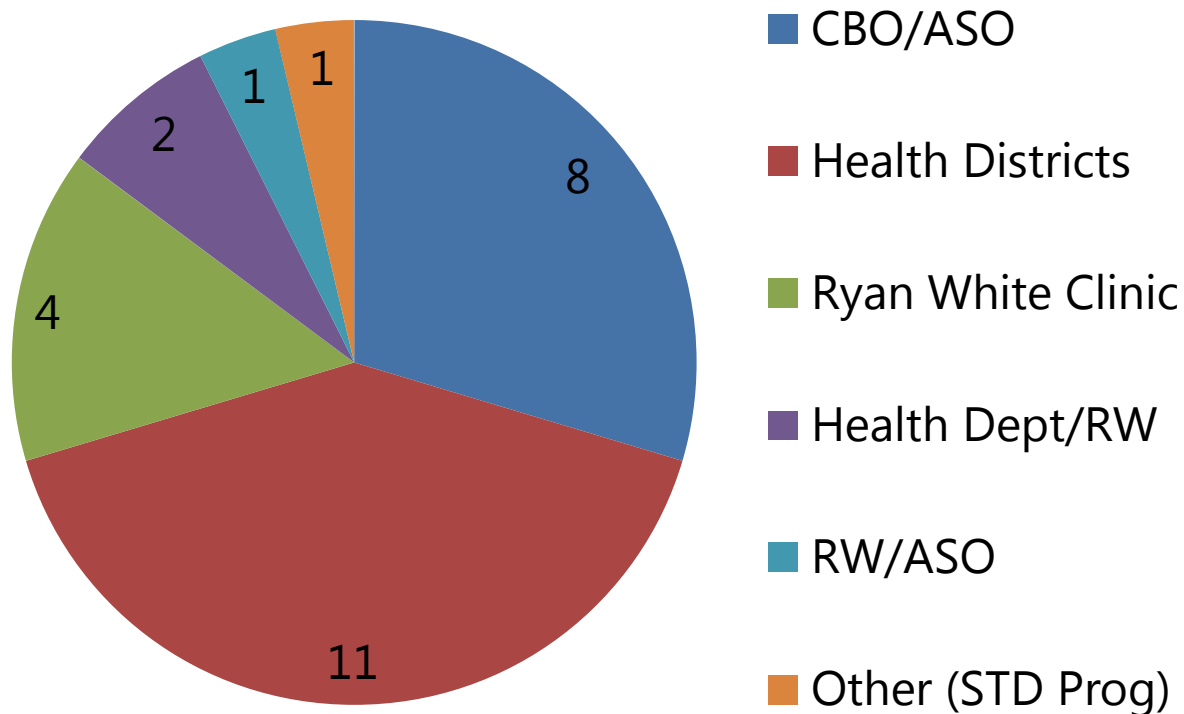
# Surveillance Metrics

- Re-engagement in care
  - Cases known in surveillance with at least two labs
  - Out of care: No labs in 12 months
  - Number of cases without a CD4 or viral load within 12 months or less from the diagnosis date
- Linkage to care, PS, and prevention services is currently captured on an aggregate level for testing events with a positive result
- Linkage and retention in care can be better assessed in eHARS
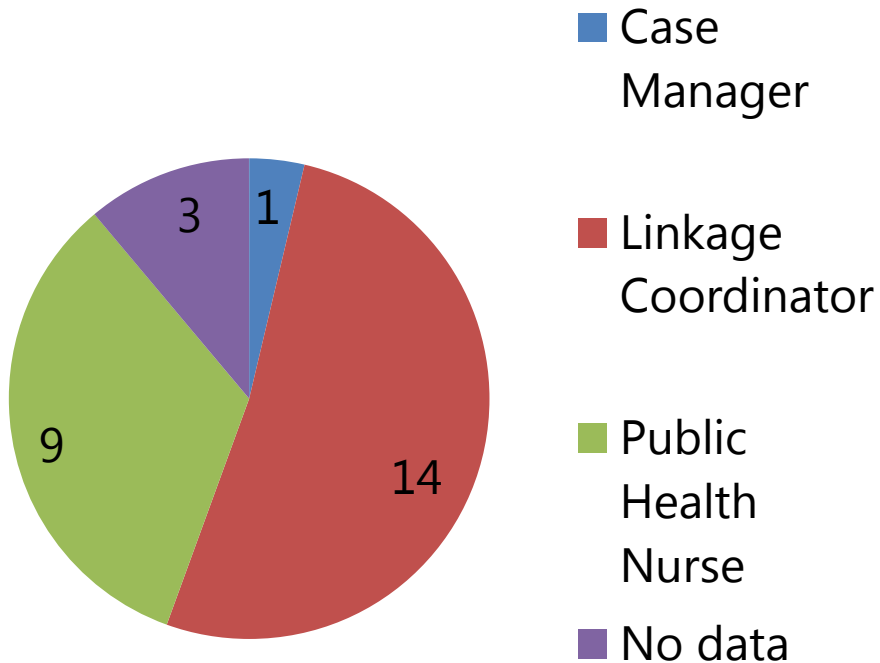  - 3 months, 6 months, and 12 months

# Linkage to Care Survey

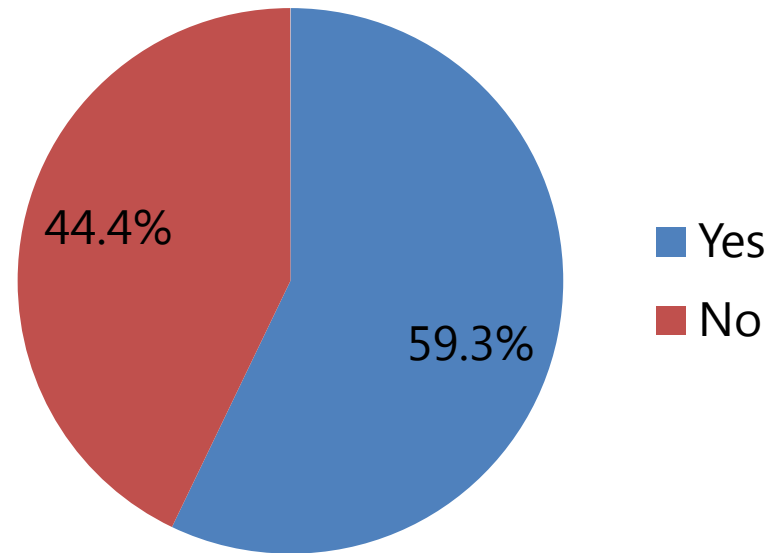Purpose- To see what linkage looks like throughout Georgia



Agencies Represented

- CBO/ASO — 8
- Health Districts — 11
- Ryan White Clinic — 4
- Health Dept/RW — 2
- RW/ASO — 1
- Other (STD Prog) — 1

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# Linkage to Care Survey

**Who is responsible for referrals and linkages?**

- Case Manager
- Linkage Coordinator
- Public Health Nurse
- No data



**Does your agency distinguish between referrals & linkages?**

- Yes
- No



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# Linkage to Care Survey

| Linkage to Care Data | YES | NO |
|---|---|---|
| Does your agency have forms to document linkage activities? | 81.5% (22) | 18.5% (5) |
| Is summary data collected at your site to reflect linkage activities (aggregate data)? | 81.5% (22) | 18.5% (5) |
| Does your agency have written policies and procedures around linkage to care? | 71% (17) | 29% (7) |
| Does your agency have a quality assurance program to monitor linkages to care? | 69.6% (16) | 30.4% (7) |

# Linkage to Care Survey

## Distinguishing between a Linkage and Referral

### Linkage

- "Calling and setting up appointment for patient and do follow-up to see if patient attended first appointment"

- "When a client is successful connected with an agency or individual services needed, and is followed up from the Coordinator"

- "When a client sees a medical provider within 3-6 months of their diagnosis along with follow-up"

### Referral

- "Act of providing list of resources to client or specific care provider"

- "Telling the patient of the services available and providing phone numbers and addresses"

- "Process that connects our consumers to services, resources, and opportunities"

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# Linkage to Care Survey
## Defining a Successful Linkage

- "If a newly positive individual comes in for the appointment and (is) retained in care going forward"

- "Someone who schedules and keep their clinical appointments. Why they miss initial appointment, staff follow up with them. If they miss their medical intake after seeing case management, staff follow-up. "

- "Once a client has attended his or her first appointment."

- "Confirmation of the clients attendance at their first Ryan White appointment"

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# Linkage to Care Survey
## Barriers, Challenges, and Successes

### Barriers/Challenges

- Database needed which all programs can be linked to

- Transportation

- Lack of private providers in the districts for clients who are not eligible for Ryan White

- Getting correct information at onset of reactive test results

- Clients returning for confirmatory test results

### Successes

- Retention specialist contacts patients who are late receiving services

- Case Managers follow-up on referrals to patients leaving the service area

- Linking those who have fallen out of care back into medical care

- Patients wanting to tell their story and help others facing this epidemic

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# Linkage to Care Survey
**We have the results- now what?**

•TLC Network meeting in October 2013

•Focus groups to further vet linkage to care questions, concerns, challenges and other feedback

# The Georgia TLC Network

# Goals of the Georgia Test, Link, and Care Network:

1. Identify and promptly link to care persons who are living with HIV and not receiving care
2. To improve patient retention in HIV primary care

## 1. Test

- Targeted HIV testing

## 2. Link

- Linkage Case Managers (ALCM)
- Network Providers
- Linkage to care tools

## 3. Treat

- Access to treatment
- Increase retention in care
- AIM to achieve viral suppression

## Support for Linkage and Retention:

- Linkage Case Managers trained on ARTAS
- Create a wrap around approach to linkage services
- Create client empowerment videos
- Create strong inter-agency collaboration to facilitate communication and data sharing
- Reinforce and replicate linkage and retention best practices as identified using the "Plan Do Study Act"
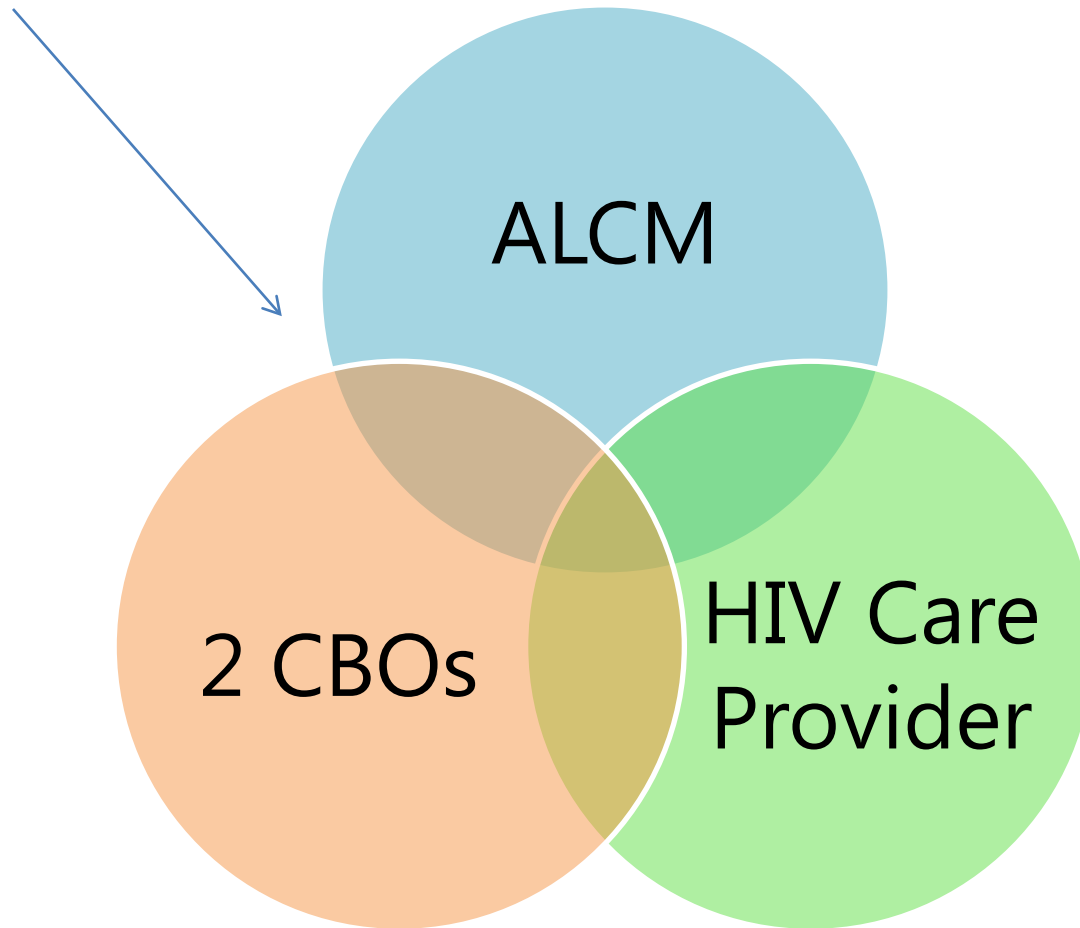
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# What ARTAS?

- Anti-retroviral Treatment Access Study
- Individual, Multi-session, Time-limited intervention
-  Link newly diagnosed clients to HIV
- Strengths-based Case Management

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# TLC Network

- **HIV Prevention**
  - Four Public Health Districts
    - Clayton, Fulton, Cobb-Douglas, and DeKalb)
  - Seven ALCMs

- **Ryan White (MAI)**
  - Five Public Health Districts
    - Clayton, Fulton, Coastal, Albany, Augusta
  - Six ALCMs

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# Each TLC Network:



ALCM

2 CBOs

HIV Care Provider

# 2012 Programmatic Activities

- Funded Spring 2012
- Seamless ARTAS initiative between HIV Care and HIV Prevention (created the GIA annex)
- Staff trained as TOT
- Contract monitors and other health district staff trained
- Feasibility to use CareWare or Access to store ARTAS data
- Peer networking with other states

# Current Programmatic Activities

- HIV Prevention – five ALCMs hired
- HIV Care – six ALCMs hired
- ALCMs all trained
- Data tools specifically for Georgia
- Clayton and DeKalb network meetings
- Funded agencies to implement testing
- Linkage to Care survey statewide
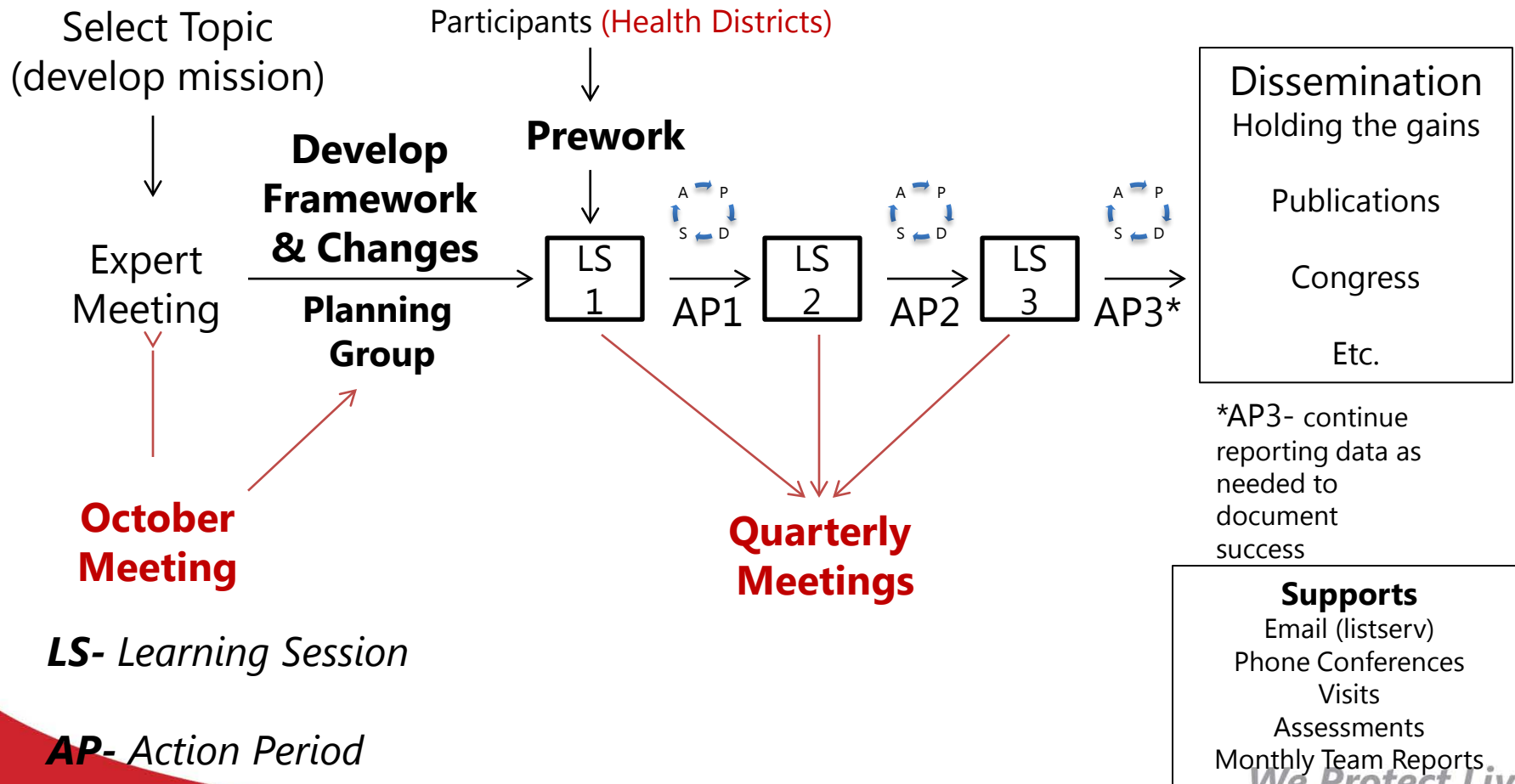- Casting call to create L2C videos (Care, Eligibility, and Patient)

# IHI Collaborative Meeting

- October 2013
  - Host a Metro-wide meeting with those in the 4 TLC Networks
  - Use the IHI Collaborative Model to help those in the TLC Network address their challenges associated with HIV linkage and retention in care
    - Results from the statewide linkage survey will guide the topic(s) of the IHI Collaborative Model exercise

# IHI Collaborative Meeting

## Test-Link-Care Network
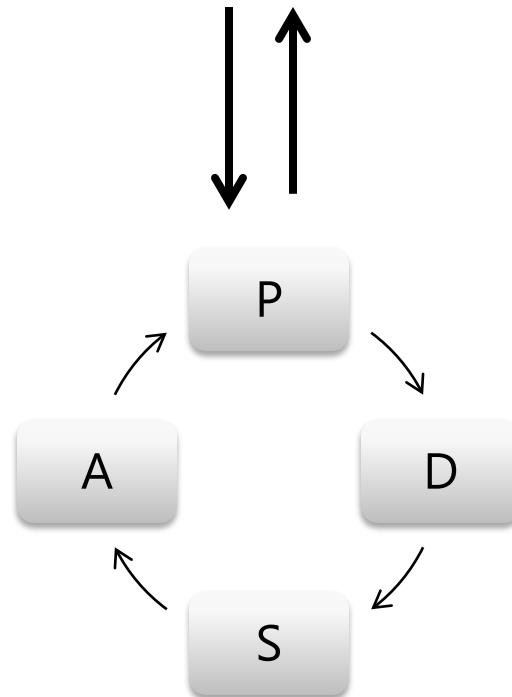
### GA Department of Public Health

Select Topic (develop mission)

Participants (Health Districts)

**Prework**

**Develop Framework & Changes**

**Planning Group**

Expert Meeting

LS 1 → AP1 → LS 2 → AP2 → LS 3 → AP3*

**October Meeting**

**Quarterly Meetings**

Dissemination
Holding the gains

Publications

Congress

Etc.

*AP3- continue reporting data as needed to document success

**Supports**
Email (listserv)
Phone Conferences
Visits
Assessments
Monthly Team Reports

**LS-** *Learning Session*

**AP-** *Action Period*

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# IHI Collaborative Meeting
## Model for Improvement

What are we trying to accomplish?

How will we know that a change is Improvement?

What changes can we make that will result in improvement?

P

D

S

A

# Other Linkage Activities

# Other Linkage Activities

- ARTAS Linkage to Care Meeting- August 6, 2013
  - DeKalb Board of Health

- Modifying ARTAS Linkage Forms for "General Linkage"

# Contact Information

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