Georgia Department of Public Health

HIV Prevention
Georgia Test, Link, and Care (TLC) Network

Presented To: TLC Network /MAI members TA Call

Presented By: Jamila Ealey, MPH

Date: July 23, 2015

We Protect Lives.

Overview

- Test, Link, and Care Network
- ARTAS forms
- ARTAS database
- Upcoming TA calls

Georgia's HIV Prevention Goals

Reduce new HIV infections	•By increasing the provision of routine-opt screenings for HIV in Georgia where there are high concentrations of HIV infection. •By increasing the number of HIV tests conducted at public supported non-clinical sites in areas with high concentrations of HIV in Georgia. •By distributing condoms in clinical and non-clinical sites.
Increase Access to Care and Improving Health Outcomes for people living with HIV	•By increasing the provision of linkage to care, treatment, and prevention services for HIV-diagnosed individuals in Georgia. •By increasing the number of HIV-positive individuals in Georgia's public health districts who are linked to other HIV-related medical and social services. •By increasing the capacity of public health supported entities to refer all newly diagnosed person to partner services (PS).
Reduce HIV-Related Health Disparities	•By funding a statewide social marketing campaign with tailored messages aimed at reducing HIV infection rates among gay and bisexual men. •By re-launching the Georgia Taking Control initiative to increase HIV testing and linkage to care for gay and bi-sexual men. •By funding a statewide social marketing campaign with tailored messages aimed at reducing HIV infection rates among black heterosexuals.

Roadmap to HIV Prevention

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV

Georgia's Test, Link, and Care Network

- **HIV Prevention (CDC)**
- Newly Diagnosed
- Previously Diagnosed
- Seven Public Health Districts (Clayton, Macon, Cobb-Douglas, Columbus, Waycross, Albany, Valdosta)
- Seven ALCMs

- **Ryan White Part B (MAI)**
- Previously Diagnosed, Newly Engaged
- Seven Public Health Districts (Clayton, Fulton, Coastal, Albany, Augusta, Columbus)
- Seven ALCMs

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

1. Identify and promptly link 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

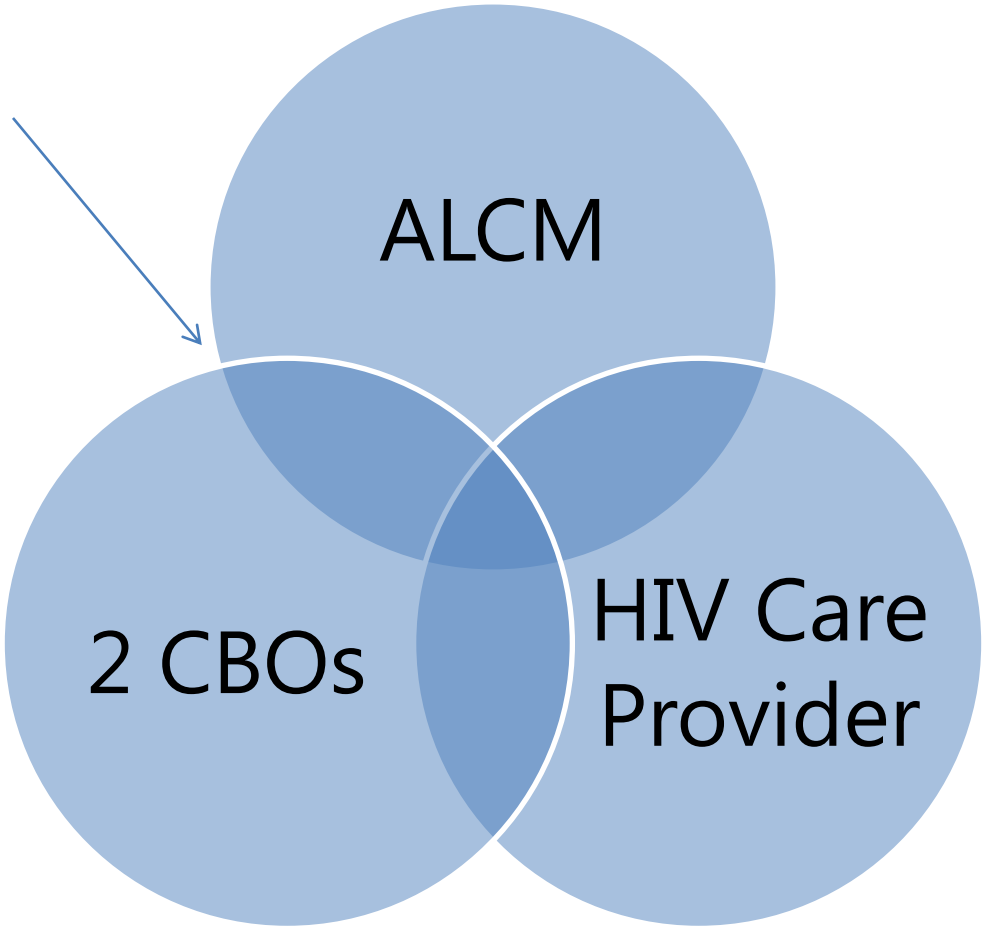
3. Treat

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

Support for Linkage and Retention:

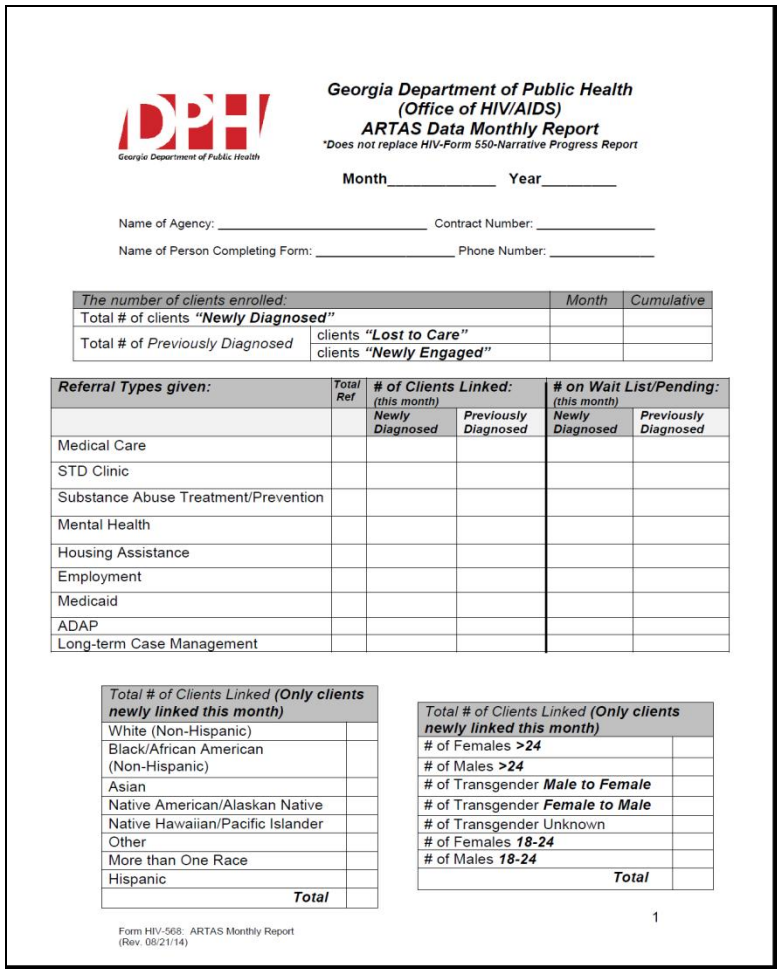
•Linkage Case Managers trained on ARTAS
•Create a wrap around approach to linkage services
•Create client empowerment videos
•Create strong inter-agency collaboration to facilitate communication and data sharing
•Reinforce and replicate linkage and retention best practices as identified using the "Plan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

Each Core TLC Network:



After establishing the core network, providers of other supportive services are invited to participate.

ARTAS Monthly Report Form



Georgia Department of Public Health
(Office of HIV/AIDS)
ARTAS Data Monthly Report
**Does not replace HIV-Form 550-Narrative Progress Report*

Month_____ Year_____

Name of Agency: _____ Contract Number: _____

Name of Person Completing Form: _____ Phone Number: _____

The number of clients enrolled:		*Month*	*Cumulative*
Total # of clients ***"Newly Diagnosed"***			
Total # of *Previously Diagnosed*	clients ***"Lost to Care"***		
	clients ***"Newly Engaged"***		

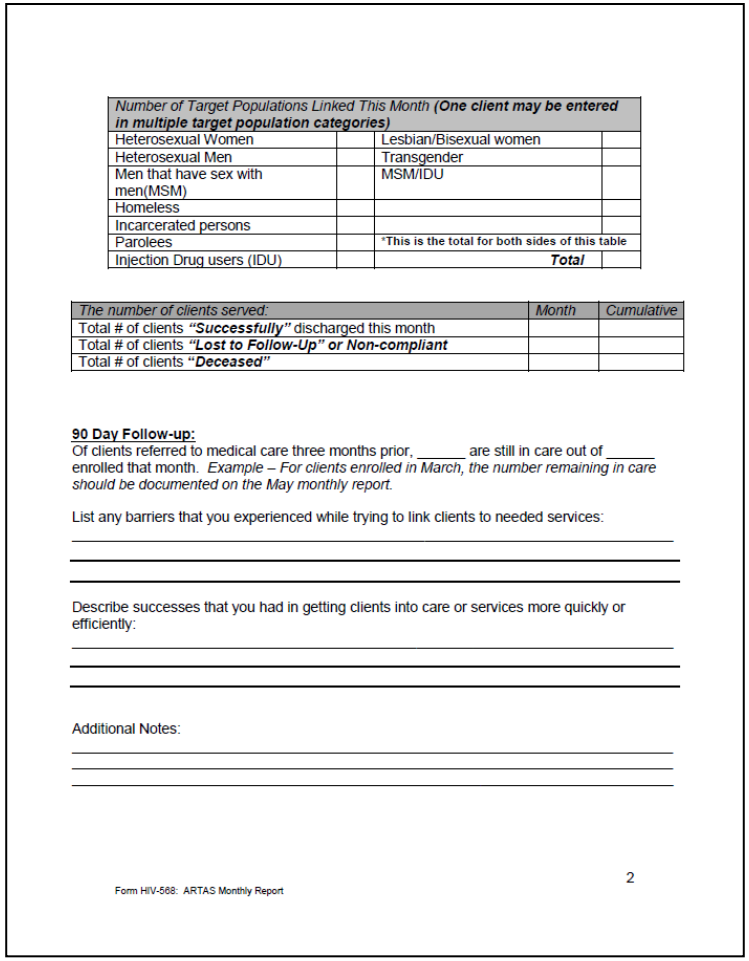
Referral Types given:	***Total Ref***	***# of Clients Linked:*** *(this month)*		***# on Wait List/Pending:*** *(this month)*	
		Newly Diagnosed	***Previously Diagnosed***	***Newly Diagnosed***	***Previously Diagnosed***
Medical Care					
STD Clinic					
Substance Abuse Treatment/Prevention					
Mental Health					
Housing Assistance					
Employment					
Medicaid					
ADAP					
Long-term Case Management					

Total # of Clients Linked ***(Only clients newly linked this month)***	
White (Non-Hispanic)	
Black/African American (Non-Hispanic)	
Asian	
Native American/Alaskan Native	
Native Hawaiian/Pacific Islander	
Other	
More than One Race	
Hispanic	
Total	

Total # of Clients Linked ***(Only clients newly linked this month)***	
# of Females ***>24***	
# of Males ***>24***	
# of Transgender ***Male to Female***	
# of Transgender ***Female to Male***	
# of Transgender Unknown	
# of Females ***18-24***	
# of Males ***18-24***	
Total	

1

Form HIV-568: ARTAS Monthly Report
(Rev. 08/21/14)



Number of Target Populations Linked This Month ***(One client may be entered in multiple target population categories)***			
Heterosexual Women		Lesbian/Bisexual women	
Heterosexual Men		Transgender	
Men that have sex with men(MSM)		MSM/IDU	
Homeless			
Incarcerated persons			
Parolees		****This is the total for both sides of this table***	
Injection Drug users (IDU)		***Total***	

The number of clients served:	*Month*	*Cumulative*
Total # of clients ***"Successfully"*** discharged this month		
Total # of clients ***"Lost to Follow-Up" or Non-compliant***		
Total # of clients ***"Deceased"***		

90 Day Follow-up:
Of clients referred to medical care three months prior, _____ are still in care out of _____ enrolled that month. *Example – For clients enrolled in March, the number remaining in care should be documented on the May monthly report.*

List any barriers that you experienced while trying to link clients to needed services:

_____

_____

_____

Describe successes that you had in getting clients into care or services more quickly or efficiently:

_____

_____

_____

Additional Notes:

_____

_____

_____

2

Form HIV-568: ARTAS Monthly Report

ARTAS Monthly Report

- Completed monthly by ALCM
- Signed by Supervisor
- Aggregate data describing linkage activities under ARTAS program and in some cases general linkage
- Should reflect data for month of reporting period as well as cumulative data
- Due by the 15th of the following month
- Important for aggregate quarterly, interim, and annual reports to federal funders.

ARTAS Monthly Report

- Largely quantitative data
- Some qualitative data sections to describe:
  - Barriers to linking clients
  - Successes, moderators, or best practices to linking clients
  - Additional information that may be useful for reporting
- Monthly narrative report document to capture important descriptive information (Form HIV-550)
  - MAI sites, monthly narrative incorporated on form

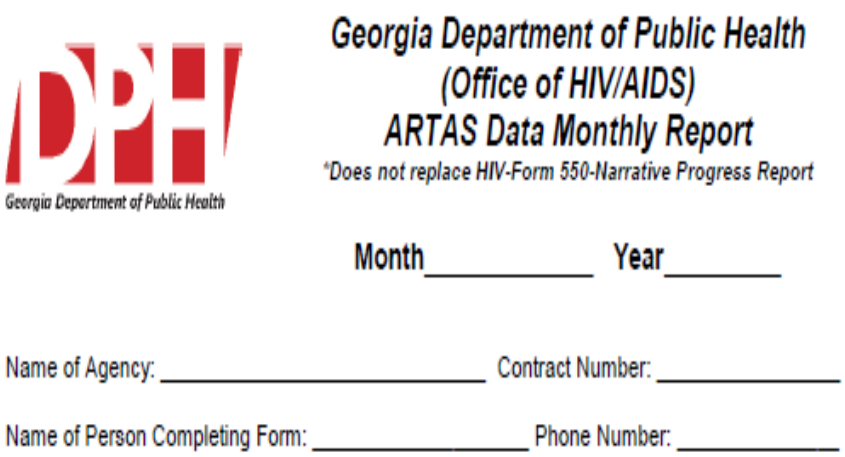
ARTAS Monthly Report Definitions

- **Linkage to medical care**- process of assisting HIV-diagnosed clients into medical care with an HIV primary care provider following receipt of an HIV diagnoses. Linkage requires follow up and documentation.
- **Linkage to support services**- process of assisting HIV diagnosed clients in accessing critical needs for supportive and ancillary medical services that may serve as barriers to HIV primary medical care. Linkage to supportive services requires follow up and documentation.
- **Referral** – process of providing information but not assistance to accessing the service, does not require follow up to determine outcome of the referral (passive)

ARTAS Monthly Report Definitions

- **General Linkage**- process of assisting HIV-diagnosed clients into medical care or support services without enrolling them into the ARTAS intervention. Requires follow up and documentation.
- **Newly Diagnosed** – Having received an HIV diagnosis within the previous 12 months.
- **Previously Diagnosed** - Having received a previous HIV diagnoses NOT within the preceding 12 months.
  - Newly engaged
  - Lost to care
- **Lost to follow up (designates linkage attempts)** – three (3) unsuccessful attempts to contact the client within a 90 day period.

ARTAS Monthly Report Form



Georgia Department of Public Health
(Office of HIV/AIDS)
ARTAS Data Monthly Report
*Does not replace HIV-Form 550-Narrative Progress Report

Month_____ Year_____

Name of Agency: _____ Contract Number: _____

Name of Person Completing Form: _____ Phone Number: _____

- **Month**-reporting month that reflects the data being submitted
- **Year**-current reporting year that reflects data
- **Name of Agency**-name of your health department
- **Contract Number**-# of funding source (i.e. 104)
- **Name or Person Completing Form/Phone Number**-include the name and contact # of personnel completing monthly report

ARTAS Monthly Report Form

The number of clients enrolled:		*Month*	*Cumulative*
Total # of clients *"Newly Diagnosed"*			
Total # of *Previously Diagnosed*	clients *"Lost to Care"*		
	clients *"Newly Engaged"*		

1

2

- This table should include <u>enrollment status</u> of:
  1. Clients enrolled for the reporting month
     - **Newly Diagnosed** – Diagnosed within the previous 12 months
     - **Previously Diagnosed 'Lost to Care'** –A previous HIV diagnoses, without a visit for routine HIV medical care in the preceding 12 months
     - **Previously Diagnosed 'Newly Engaged'** – A previous HIV diagnoses, but never having entered into HIV medical care
  2. Clients enrolled to date, including reporting month

ARTAS Monthly Report Form

Linkage Status of those Enrolled & Referred

Referral Types given:	Total Ref	# of Clients Linked: 3 (this month)		# on Wait List/Pending 4 (this month)	
	5	Newly Diagnosed 1	Previously Diagnosed 2	Newly Diagnosed	Previously Diagnosed
Medical Care					
STD Clinic					
Substance Abuse Treatment/Prevention					
Mental Health					
Housing Assistance					
Employment					
Medicaid					
ADAP					
Long-term Case Management					

- Include the number of clients enrolled this month, based on their enrollment status,

1 newly diagnosed

2 previously diagnosed who were referred and 3 received services (linked) for the respective categories OR 4 waiting receipt of services.

5 Total # of referrals given that reporting month

ARTAS Monthly Report Form

Race and Ethnicity

Total # of Clients Linked ***(Only clients newly linked this month)***	
White (Non-Hispanic)	
Black/African American (Non-Hispanic)	
Asian	
Native American/Alaskan Native	
Native Hawaiian/Pacific Islander	
Other	
More than One Race	
Hispanic	
Total	

The **Total** should equal the total number of clients who were linked for that reporting month and should match that of the next table.

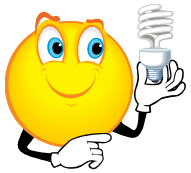
- Only include clients linked this reporting month.
- Provide the race and ethnicity counts, exclusively.
  - If a client is reported as Hispanic, they should only be captured in the Hispanic field.
  - A client who identifies as more than one race should only be counted in the More than Once Race field, NOT in multiple race categories.

ARTAS Monthly Report Form

Gender and Age

Total # of Clients Linked ***(Only clients newly linked this month)***	
# of Females ***>24***	
# of Males ***>24***	
# of Transgender ***Male to Female***	
# of Transgender ***Female to Male***	
# of Transgender Unknown	
# of Females ***18-24***	
# of Males ***18-24***	
Total	

- Only include clients linked for the reporting month
- Provide the gender and respective age breakdown for those clients linked in the reporting period



The **Total** should equal the total number of clients who were linked for that reporting month and should match that of the previous (Race/Ethnicity) table.

ARTAS Monthly Report Form

Behavioral Risk Category

Number of Target Populations Linked This Month ***(One client may be entered in multiple target population categories)***			
Heterosexual Women		Lesbian/Bisexual women	
Heterosexual Men		Transgender	
Men that have sex with men(MSM)		MSM/IDU	
Homeless			
Incarcerated persons			
Parolees		*This is the total for both sides of this table	
Injection Drug users (IDU)		***Total***	

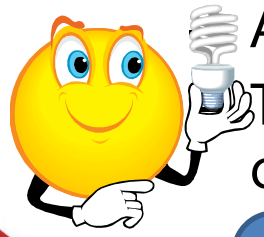
- Only include clients linked for the reporting month.
- A client can be entered into multiple categories therefore the total will not always add up to the total number of clients linked for the month.

ARTAS Monthly Report Form

Outcome Status of clients served

The number of clients served:	*Month*	*Cumulative*
Total # of clients ***"Successfully"*** discharged this month 1		
Total # of clients ***"Lost to Follow-Up" or Non-compliant*** 2		
Total # of clients ***"Deceased"*** 3		

- Include clients who received services as apart of the ARTAS intervention.
  - Newly Diagnosed and Previously Diagnosed clients
  - All clients who received services for the reporting month AND
  - All clients who received services to date



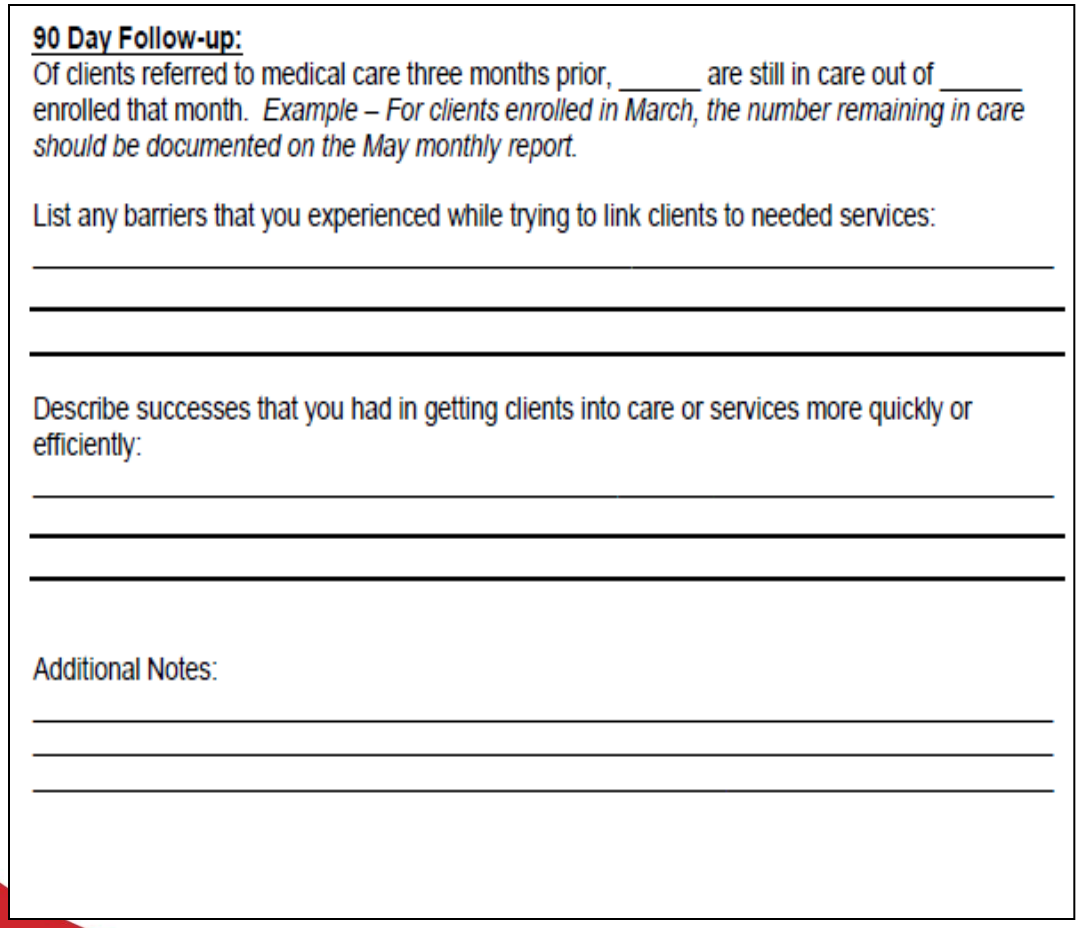
The cumulative count should increase each month as more clients complete the intervention and are:

1 Successfully linked within 90 days

2 Lost to follow up

3 Deceased

ARTAS Monthly Report Form



90 Day Follow-up:
Of clients referred to medical care three months prior, _____ are still in care out of _____ enrolled that month. *Example – For clients enrolled in March, the number remaining in care should be documented on the May monthly report.*

List any barriers that you experienced while trying to link clients to needed services:

_____

_____

_____

Describe successes that you had in getting clients into care or services more quickly or efficiently:

_____

_____

_____

Additional Notes:

_____

_____

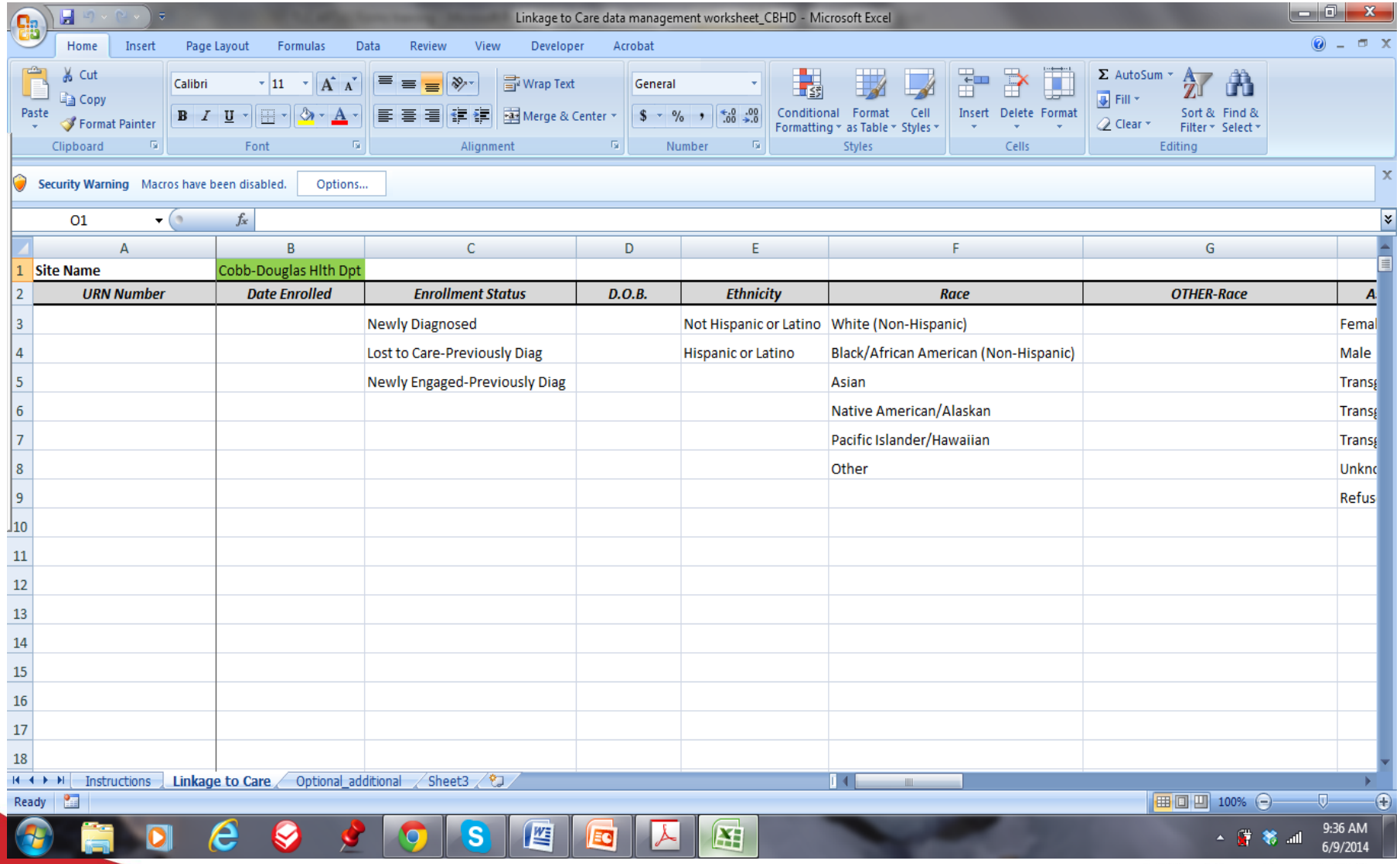
_____

- Descriptive narrative about linkage efforts during the reporting month.
- Barriers/Challenges
- Facilitators
- Successes

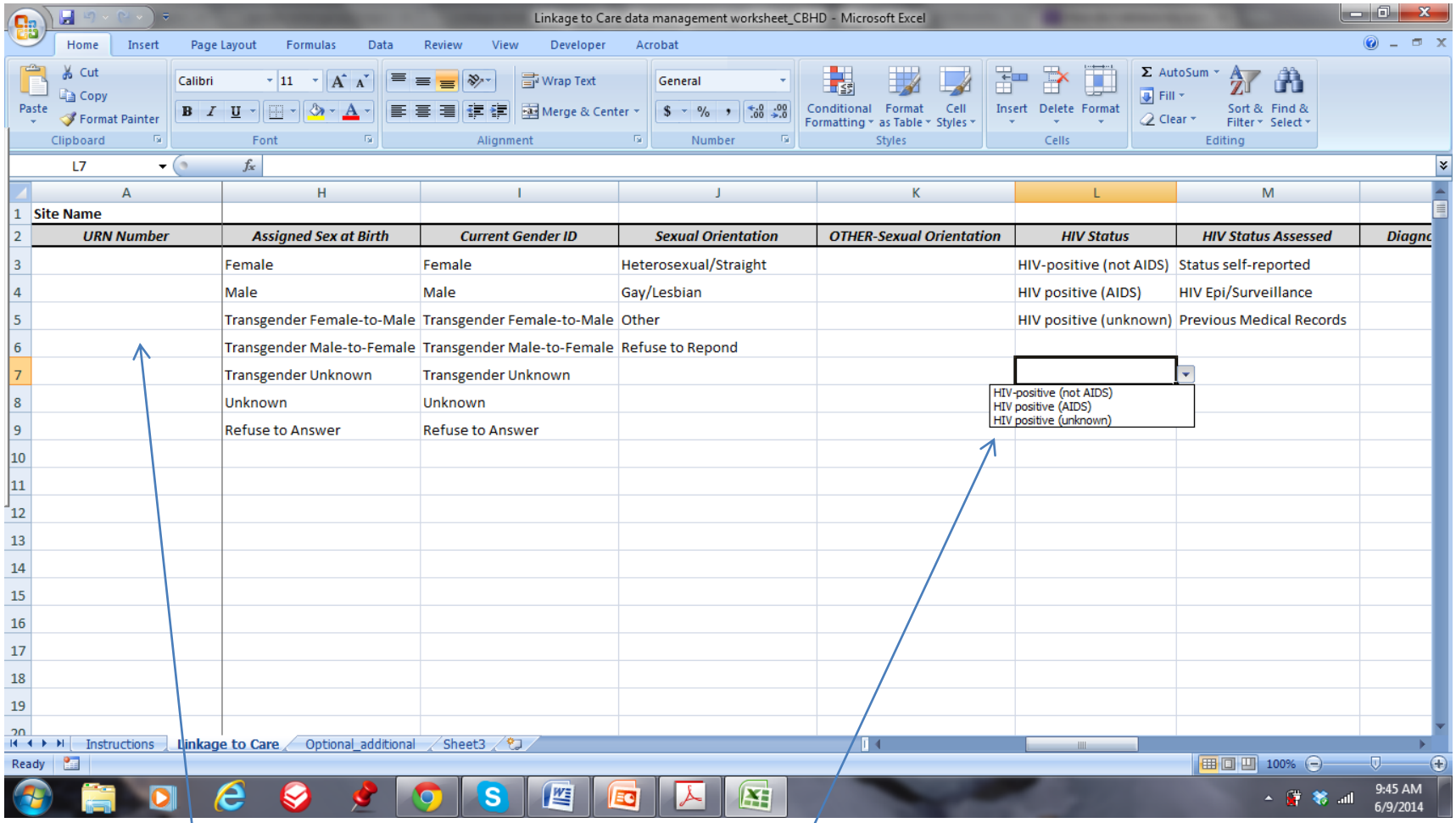
ARTAS Excel Database

- Electronically capture client level information for more detailed analysis.
- Help organize ARTAS client enrollment and linkage information
- Password protected
- If you already have an electronic system to monitor and store client level information, excel worksheet is not necessary.

ARTAS Excel Database



ARTAS Excel Database



Free Text

Drop down menus

Georgia Test, Link, & Care Network

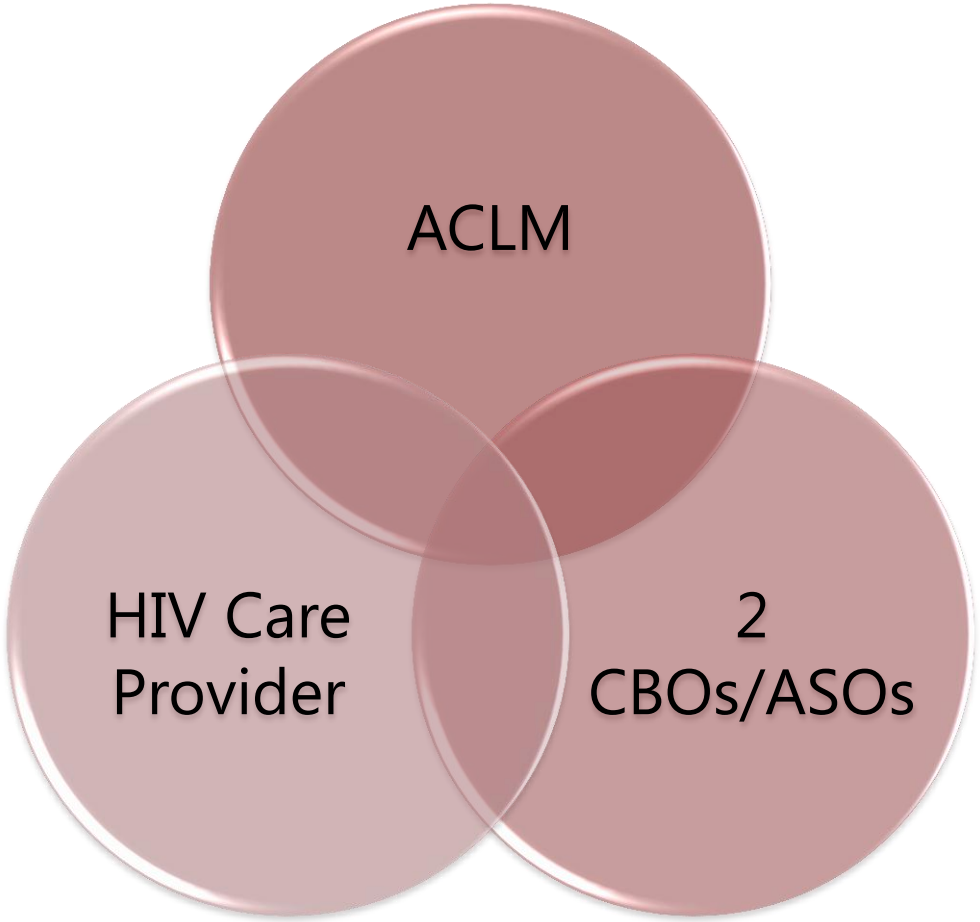
- Statewide Continuous Quality Improvement meeting held December 3, 2013
- 71 attendees from rural and urban areas
- Topics discussed
  - navigating the linkage process
  - identifying community and private healthcare partners
  - Facilitators and challenges of linkage
  - other factors needed for successful linkage outcomes

Test Link Care Network

- **Purpose**
  - To utilize inter-organizational collaborations aimed to coordinate HIV testing, HIV primary care, and supportive services by:
    - Identifying and promptly linking to care persons newly diagnosed or living with HIV but not receiving care (aware and unaware of their HIV status).
    - Improving patient retention in HIV primary care.

Test Link Care Network

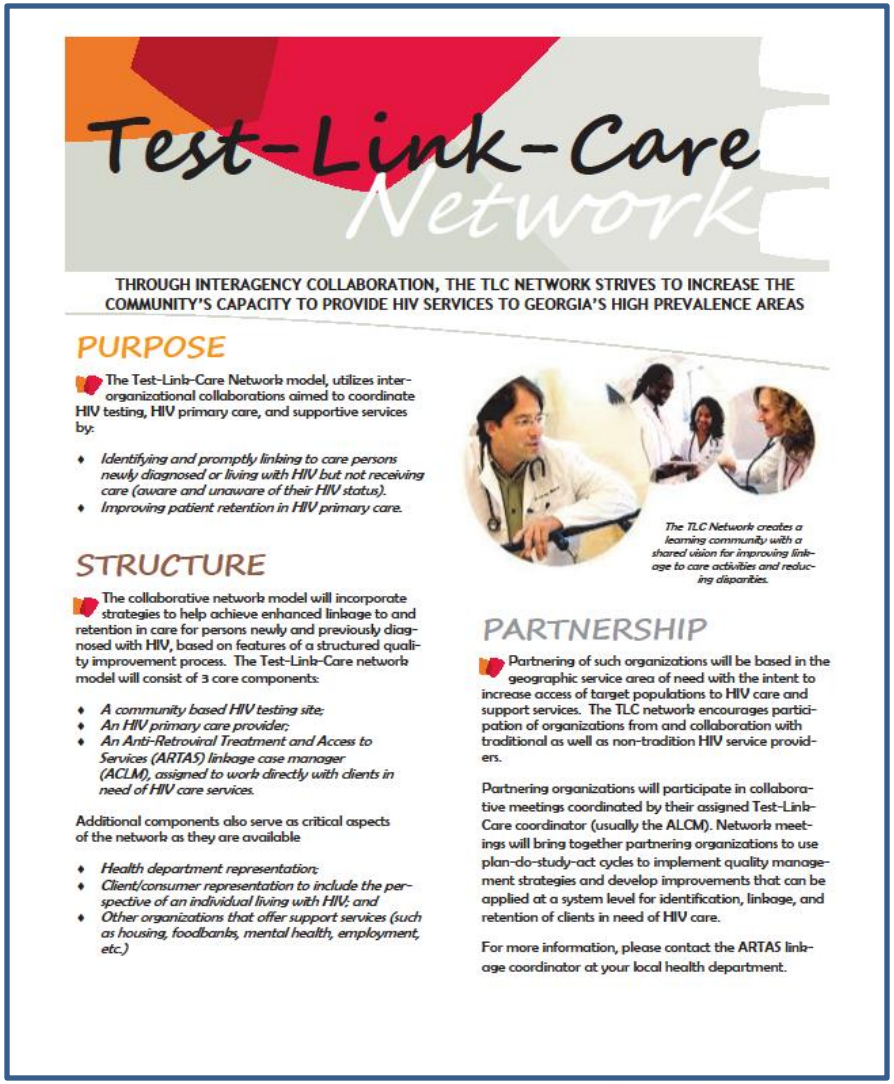
- Core components of the network.



Test Link Care Network

Helpful Documents

- Refer to the "TLC Network" one pager (PDF). The document can be used as a template in order to recruit providers and CBOs/ASOs for your TLC Network.



Test-Link-Care Network

THROUGH INTERAGENCY COLLABORATION, THE TLC NETWORK STRIVES TO INCREASE THE COMMUNITY'S CAPACITY TO PROVIDE HIV SERVICES TO GEORGIA'S HIGH PREVALENCE AREAS

PURPOSE

The Test-Link-Care Network model, utilizes inter-organizational collaborations aimed to coordinate HIV testing, HIV primary care, and supportive services by:

- *Identifying and promptly linking to care persons newly diagnosed or living with HIV but not receiving care (aware and unaware of their HIV status).*
- *Improving patient retention in HIV primary care.*

STRUCTURE

The collaborative network model will incorporate strategies to help achieve enhanced linkage to and retention in care for persons newly and previously diagnosed with HIV, based on features of a structured quality improvement process. The Test-Link-Care network model will consist of 3 core components:

- *A community based HIV testing site;*
- *An HIV primary care provider;*
- *An Anti-Retroviral Treatment and Access to Services (ARTAS) linkage case manager (ACLM), assigned to work directly with clients in need of HIV care services.*

Additional components also serve as critical aspects of the network as they are available

- *Health department representation;*
- *Client/consumer representation to include the perspective of an individual living with HIV; and*
- *Other organizations that offer support services (such as housing, foodbanks, mental health, employment, etc.)*

The TLC Network creates a learning community with a shared vision for improving linkage to care activities and reducing disparities.

PARTNERSHIP

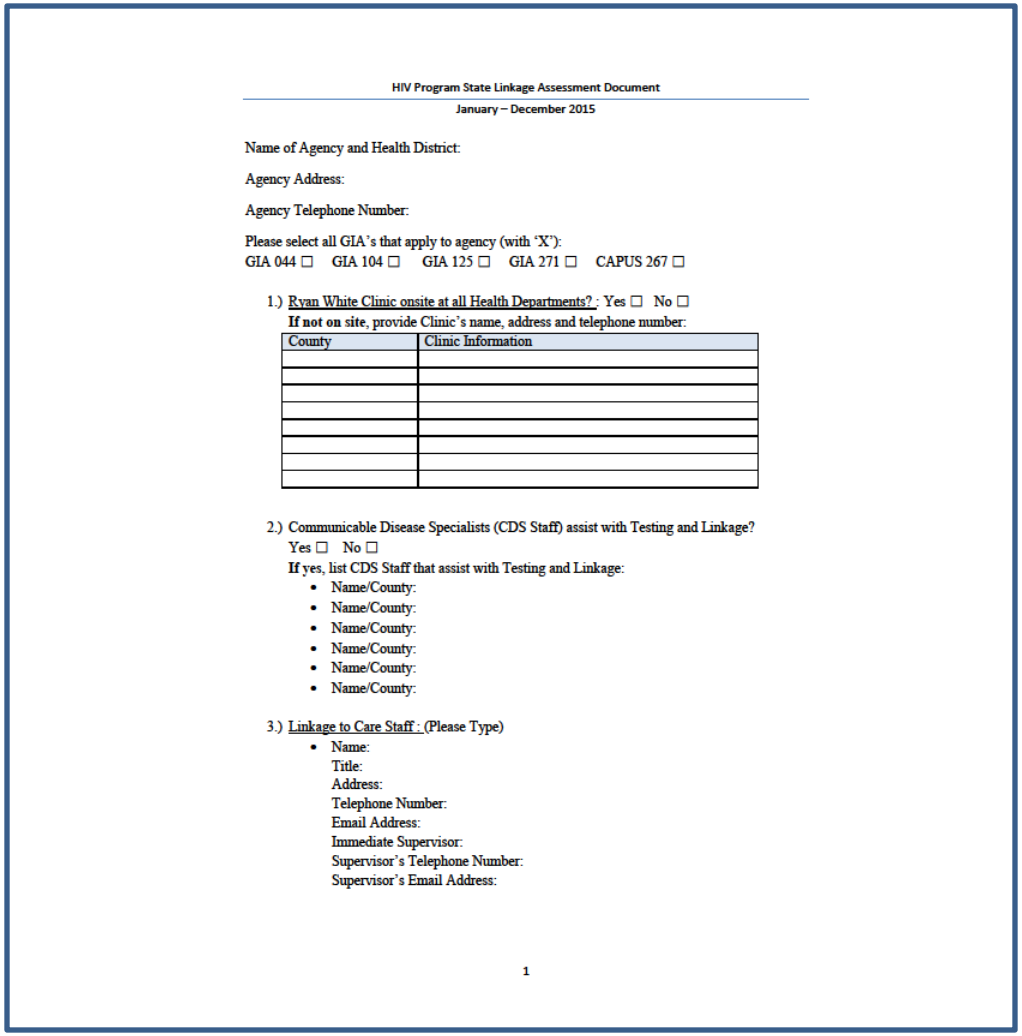
Partnering of such organizations will be based in the geographic service area of need with the intent to increase access of target populations to HIV care and support services. The TLC network encourages participation of organizations from and collaboration with traditional as well as non-tradition HIV service providers.

Partnering organizations will participate in collaborative meetings coordinated by their assigned Test-Link-Care coordinator (usually the ALCM). Network meetings will bring together partnering organizations to use plan-do-study-act cycles to implement quality management strategies and develop improvements that can be applied at a system level for identification, linkage, and retention of clients in need of HIV care.

For more information, please contact the ARTAS linkage coordinator at your local health department.

Test Link Care Network

- List the components of your TLC Network.
  - Forward your completed Excel spreadsheet by 7/31/15 to your contract monitor



HIV Program State Linkage Assessment Document

January – December 2015

Name of Agency and Health District:

Agency Address:

Agency Telephone Number:

Please select all GIA's that apply to agency (with 'X'):
GIA 044 ☐ GIA 104 ☐ GIA 125 ☐ GIA 271 ☐ CAPUS 267 ☐

1.) Ryan White Clinic onsite at all Health Departments? : Yes ☐ No ☐
If not on site, provide Clinic's name, address and telephone number:

County	Clinic Information

2.) Communicable Disease Specialists (CDS Staff) assist with Testing and Linkage?
Yes ☐ No ☐
If yes, list CDS Staff that assist with Testing and Linkage:
- Name/County:
- Name/County:
- Name/County:
- Name/County:
- Name/County:
- Name/County:

3.) Linkage to Care Staff : (Please Type)
- Name:
  Title:
  Address:
  Telephone Number:
  Email Address:
  Immediate Supervisor:
  Supervisor's Telephone Number:
  Supervisor's Email Address:

1

Test Link Care Network

Expectations

1. Network meetings should take place once a month
   - Meetings can be in person or over the phone
2. **Meeting agenda and notes should be forwarded along with your monthly ARTAS narrative/aggregate reports to your contract monitor**
3. Meeting highlights/outcomes can be shared in the successes/ accomplishment section of your ARTAS narrative reports

Test Link Care Network

Expectations

- The network meeting agenda can include the following items:
  - Agency updates (personnel, changes in services, etc.)
  - Facilitators for linkage to care
  - Opportunities for collaboration
  - Upcoming events
  - Other pertinent information
- The meeting notes can be in a bulleted format. Be sure to include:
  - Date, time, and location of meeting
  - List of attended
  - A synopsis of the meeting outcomes

Questions???

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